YOUTH, ILLICITS & THE MEDIA

MANDATORY REPORTING: PARENTS WHO USE DRUGS

CANNABIS & THE LAW

OPEN ALL HOURS: Drug help in the online era

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Contents

Editorials ........................................................................................................................................ 2

News ........................................................................................................................................ 3

Letters ..................................................................................................................................... 5

From the field:
  The case of Ben Cousins ........................................................................................................... 6
  Decade of monitoring trends ..................................................................................................... 7

Book review: *After the War on Drugs* ....................................................................................... 8

Indigenous issues: Listening, learning and leading ................................................................. 9
  A landmark conference puts the focus on Indigenous drug and alcohol issues.

Research digest .......................................................................................................................... 10
  Benzodiazepine dependence is often overlooked in the world of addiction treatment.
  We discuss the latest research and how this may apply on the frontline.

Open all hours: Drug help in the online era .............................................................................. 12
  The internet has changed our world. Discover how it’s changing service delivery.

Youth, drugs and the media: Creating attitude ......................................................................... 16
  The way the media reports illicit drug issues may determine whether or not youth will use them.

Interview: In the needle’s eye ...................................................................................................... 18
  For almost a decade, Dr Ingrid van Beek led the fight to establish Sydney’s Medically Supervised Injecting Centre.

Protecting children:
  Parental drug use and mandatory reporting ......................................................................... 20
  Some people who use drugs are parents, too. How do clinicians protect their children?

Cannabis: The gap between law and enforcement ................................................................ 24
  Cannabis laws differ around Australia. But more importantly, how are they enforced?

National Drug and Alcohol Awards 2010 .................................................................................. 26
  The sector celebrates its highest achievers.
Welcome to the November issue of Of Substance.

In the past decade or so, our world has undergone a digital revolution. Thanks to the internet, the way we communicate and search for information has changed completely – people around us are constantly ‘tweeting’, ‘blogging’, ‘googling’ and ‘Facebooking’.

Although the alcohol and other drugs sector has been a little slower to climb on board this digital freight train, it is now happening. In our cover article, we discuss the ways different organisations are utilising the internet to offer new and additional programs to the ones they have traditionally provided. And with a new generation of switched-on younger people seeking treatment for their substance use, this is entirely appropriate.

Much of this issue looks at the perspectives of young people. In a fascinating article on page 16, researcher Caitlin Hughes and her colleagues discuss how media portrayals of drugs can influence the decisions teens and young adults make about whether or not they will use illicit substances. She points out that the drug and alcohol sector could do more to use this medium to communicate the health impacts of drug use.

In a follow-up to last issue’s article on the link between drugs and childhood sexual abuse, we turn to the question of working with child protection issues. We know that many of our clients are parents and that drugs can greatly impact the development and experiences of their children. We explore these issues and look at programs specifically designed to help people become better parents.

At Of Substance, our aim is to support the work of people who are on the frontline of dealing with substance use problems. Australia boasts many outstanding individuals and organisations who are truly adding value for their clients and their communities. I am delighted that we can report on the many winners and finalists at the recent National Drug and Alcohol Awards. In coming months, Of Substance will be launching a new electronic service which will bring you some of their stories and programs.

As we draw to the close of 2010, I hope you can look back at a year that has been one of both service and achievement. As always, we love to hear from readers via our website at www.ofsubstance.org.au or by emailing editor@ancd.org.au.

Jenny Tinworth – Managing Editor

Impacts of the internet for alcohol and other drugs clients and their practitioners

Associate Professor Nicole Lee, Health Services Consultant

Bill Gates calls it ‘the town square for the global village of tomorrow’, but just how can the internet be harnessed for the alcohol and other drugs sector?

There has been rapid growth and increasing interest in the field about internet-based options to support prevention and intervention activities as we move from static informational websites to dynamic online self-help treatment and beyond. And there is increasing evidence from well-conducted studies that show that online options for treatment are at least as good as face-to-face options.

The internet opens up a whole new world of possibility – potentially reaching a large group of people who may never enter treatment otherwise, expanding options for primary and secondary prevention, reducing public health costs and avoiding the stigma often associated with drug and alcohol issues.

This brave new world does have important implications for drug and alcohol workers, however, that shouldn’t be overlooked. On the up side, the internet can offer support for practitioners through provision of additional client resources, additional support for clients during treatment and online professional development for the practitioners themselves.

On the other hand, evidence suggests that the online treatments are better utilised by young, less-dependent users of alcohol and other drugs and women, leading to at least two possible scenarios. Less severe users will find effective options online and early, and never need to seek traditional treatment options and people who would really benefit from face-to-face treatment may persevere with online treatment for some time before entering traditional treatment at a time when they are further along the severity continuum. As a result, alcohol and other drugs workers will be required to respond to a more complex group presenting for treatment.

Even now there have been questions raised about our current specialist capacity, with inadequate funding, favouring of generic positions and only one state with specified minimum qualifications. Professional development, workforce development and service capacity-building are going to become increasingly important as the complexity of clients continues to increase in our specialist services, both for client outcomes and our reputation in the health sector as a specialist field.

As Rupert Murdoch noted, the internet is probably the most fundamental change we will see in our lifetime. And we all watch with interest and look forward to seeing where it takes us.
MSIC to get legal status

The NSW Government will be seeking to legislate the removal of the ‘trial’ status of Sydney’s Medically Supervised Injecting Centre (MSIC), making it the only legalised injecting centre in Australia.

As a trial, it has been subject to numerous evaluations over the last nine years. As a legal entity, the MSIC would continue to be monitored under the terms of the legislation. It would also undergo regular statutory evaluations every five years, an independent evaluation after four years, and NSW Health would continue to conduct routine inspections of the centre.

An independent evaluation by KPMG found the MSIC has:

- managed 3426 overdose-related events without a fatality
- helped more than 12 000 injecting drug users
- referred more than 8500 drug users for help and treatment
- distributed more than 300 000 clean needles and syringes.

The MSIC arose from the 1999 Drug Summit and has operated at Kings Cross since May 2001. A report by the NSW Bureau of Crime Statistics and Research, released in September, found robbery and theft had fallen significantly in the Kings Cross Local Area Command since the MSIC opened.

Snapshot of Australian health

*Australia’s Health* 2010 report, released by the Australian Institute of Health and Welfare in June, provides key statistics and commentary on: determinants of health and keys to prevention; diseases and injury; how health varies across population groups; health across the life stages; health services, expenditure and workforce; and the health sector’s performance. In relation to alcohol and other drugs/mental health issues, the report notes:

- Australia’s level of smoking has continued to fall, and is among the lowest in OECD countries at one in six adults smoking daily. Death rates from diseases associated with smoking have also decreased. However, smoking continues to be the single most preventable cause of illness and death in Australia.
- Many Australians experience mental illness – around one in five Australians aged 16-85 years has a mental disorder at some time in a 12-month period, including one in four of those aged 16-24 years.

Hidden harms of alcohol

A report prepared by the Alcohol Education and Rehabilitation Foundation’s AER Centre for Alcohol Policy, and released in August, found the hidden cost of harms caused by someone else’s drinking brings the total economic impact of alcohol misuse to $36 billion annually, more than double previous estimates.

The report, *The Range and Magnitude of Alcohol’s Harm to Others*, found the cost of harm to others totalled more than $20 billion annually. The report provides an insight into how individual acts of alcohol misuse ripple through families and communities. It analyses the connections between child protection, health, law enforcement and family services. Researchers drew on and analysed a wide variety of existing and newly developed data, including a national survey completed in 2008 of more than 2600 Australians aged 18 years or older.

Fetal alcohol study to start

Australia’s first study into the prevalence and impact of fetal alcohol spectrum disorder on Indigenous children was launched in July by Federal Indigenous Affairs Minister, Jenny Macklin. The study, titled *Marulu: The Lililwan Project*, is being introduced at the request of the Fitzroy Valley community. It will pool the expertise of paediatricians, allied health professionals and social workers from the George Institute for International Health, University of Sydney, and the Nindilingarri Cultural Health Service. Macklin said alcohol abuse was the main risk factor in Indigenous family violence and the government would work with communities on this issue as well.

New government action on health care?

The Alcohol and other Drugs Council of Australia (ADCA) says that a priority for the new Gillard Labor Government is to deliver on its election commitment to tackle alcohol and other drugs (AOD) misuse as part of the National Primary Healthcare Reform.

Prior to the election, the government stated that it would support better integration and links between AOD prevention services and other service providers across the health and well-being sectors. ADCA has urged the government to also seize the opportunity to revisit the alcohol taxation reform recommendation (in the Henry Tax Review) which could provide a source of funding to help address the consequences of excessive consumption of alcohol, and also the misuse of prescription and/or illicit drugs. However, there is some uncertainty as to whether this recommendation will be included in discussions at the taxation summit proposed for next July.
ACT, NT and QLD liquor reforms

A number of liquor reforms have recently been announced around Australia. Following is a snapshot taken from their media releases:

An overhaul of liquor laws in the ACT will take effect on 1st December. The reforms are designed to tackle the problem of alcohol-fuelled violence and irresponsible service of alcohol in the community. The new Bill will allow the government to implement a range of community safety reforms including:

• a licensing system that measures the amount of risk posed to the community based on opening hours
• the provision for lockouts at licensed premises
• a new ‘fail to leave’ offence for police to fine intoxicated people who refuse to move from a licensed premise.

Meanwhile, the Northern Territory Government announced in September reforms to curb alcohol-fuelled violence and crime. A new five-point plan would tackle alcohol abuse and reduce antisocial behaviour in the territory. According to the NT Government, alcohol continues to be involved in 60 per cent of all assaults and 67 per cent of domestic violence assaults. Alcohol abuse costs the NT community a staggering $642 million nationally.

The new proposed reforms include:

• banning problem drinkers from purchasing takeaway alcohol
• introducing mandatory rehabilitation treatment for problem drinkers

• rolling out a new territory-wide Banned Drinker Register in all takeaway liquor outlets
• replacing the existing Alcohol Court with a Substance Misuse Assessment and Referral for Treatment Court – although funding has yet to be outlined for this.

In Queensland, the state government will declare special Drink Safe Precincts (DSPs) in key locations across Queensland under a $4.2 million plan to counter alcohol-related violence. Police numbers will increase during peak times in some areas and better supervised taxi zones, and the creation of special safe zones will all feature. The government will also legislate for new powers to ban people committing alcohol-related violence in the areas and it will become mandatory for pubs and clubs to offer free drinking water to patrons. Premier Anna Bligh said the pilot DSPs would be run like major sporting events with coordinated policing, security and support services provided to deliver a safe environment for patrons.

Mobile phone quit service

South Australians who want to quit smoking can be among the first in Australia to tap into a new SMS support service. Quit SA has launched a 12-month statewide trial of a mobile text service – ‘Quit on Q’. The program sends users free text messages every day – as many times a day as they want or need them. Smokers can also get extra help. For example, if they experience cravings they can text ‘TEMPT’ or ‘SOCIAL’ or ‘STRESS’ and they’ll receive a rapid response text message to help them through. Similar programs operate in the United Kingdom, the United States and New Zealand. For more information, visit www.quitonq.quittsa.org.au.

Working with trauma?

Do you work with traumatised clients in alcohol and other drugs (AOD) services? How does this affect you? Over recent years there has been growing recognition of the high frequency of trauma exposure among clients of AOD services. Less is known however, about how this impacts those who work with these clients. The National Drug and Alcohol Research Centre (NDARC), in collaboration with the National Centre for Education and Training on Addiction, is looking for people who work in AOD settings (e.g. nurses, medical practitioners, psychiatrists, psychologists, counsellors, social workers, and other AOD workers) from across Australia to participate in a study which aims to examine the impact of working with traumatised clients.

Participation involves completion of an anonymous online survey that takes approximately 15 minutes to complete. If you are interested in completing the survey and would like further information please go to the NDARC website, www.ndarc.med.unsw.edu.au, and click on the homepage link.

MERIT to expand in NSW

The NSW Government will expand the Magistrates’ Early Referral Into Treatment (MERIT) program to include alcohol, and roll it out to more courts. The MERIT program offers drug treatment before sentencing as a voluntary option for non-violent defendants in local courts where the defendant has a drug problem, could be released on bail and is motivated to undergo treatment.

The program was introduced a decade ago, following the NSW Drug Summit. Now, a small number of courts have begun to offer alcohol treatment under the program, which is to be made available to nine courts by the end of 2010.
Needle and syringe program in Macau

The Special Region of Macau was a Portuguese colony until the end of 1999 after which it became a special administrative region of China, similar in status to that of Hong Kong.

Macau is today probably famous for being the casino capital of Asia, but with such high levels of tourism and gambling comes a range of social problems related to sex work and drug use. Being one of the major providers of drug treatment and prevention services in Macau gives our organisation, the Association of Rehabilitation of Drug Abusers of Macau (ARTM), a unique window into the often hidden world of illicit drug use in Macau – and as a result, the need to reduce HIV transmission has become one of our primary concerns.

In 2007 we took the opportunity during an international NGO consultation meeting in Macau to enlist the assistance of the Australian National Council on Drugs (ANCD) in our discussions with the AIDS Prevention and Control Commission on the need to establish a needle and syringe program (NSP) in Macau. After many discussions, the Macau Administration agreed to establish and fund our first NSP in 2008.

The first NSP service in Macau began as a fixed outlet from the ARTM offices but today operates an outreach service as well. Establishing the Macau NSP has been a real step forward for Macau and the region and we are pleased to acknowledge the support and assistance of our good friends in Australia, and in particular the ANCD, that have helped to make this happen.

Mr Augusto Noriguera, Director ARTM, Macau

International OST programs

In the past six months, a number of countries around the world have begun opioid substitution treatment (OST) programs – namely in Cambodia, Morocco, Tajikistan, Bangladesh (and soon to be in India). This follows on from an OST program commencing in Afghanistan in February. While they are small operations to begin with (some reporting only a handful of initial clients), they represent large leaps for their (mainly) developing countries’ approach to opioid addiction.

These OST programs have essentially started independently to each other. However, the ongoing activity by international organisations (including UN agencies), advocates and scientists, and hard work by local teams, have all contributed to getting these programs up and running.

For example, the first methadone maintenance treatment clinic in Bangladesh opened in July 2010. The service was set up with support from a UNODC project at the premises of the government’s Central Drug Treatment Centre, and two more centres are planned to be set up in the near future, aiming to provide services for 200-300 injecting opiate users over the next year.

Expanding the impact of Drug Action Week

Readers would be familiar with Drug Action Week. A more accurate title might be Drug Inaction Week insofar as governments are concerned. Many governments interpret action as a need to increase the law enforcement side of the equation; whereas most evidence suggests that treatment options are a more effective way to reducing drug-related problems.

How refreshing it would be if, during Drug Action Week, we had intelligent debates involving community leaders on the merits of evidence-based options. Law enforcement authorities, educators, church leaders, politicians and drug and alcohol professionals, from here and overseas, could be included.

An authority from Portugal should be invited who would explain how decriminalising drugs in that country has worked. Now that would be an attention-getting starting point!

Evan Thomas
West Pennant Hills, NSW
Board Member and Volunteer at Family Drug Support

Thanks

I thought I would take the time to let you know how valuable I thought the article in your last issue [July 2010] on ‘Childhood trauma, adult pain’ was.

As a counsellor, most of my clients present with trauma and AOD addictions. The article was informative and easy to understand (which is not usually the case) and relevant. Thanks.

Nancy Bannerman
Counsellor
The WASH House, Mt Druitt

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On our website, you can now scroll through an online index of all past Of Substance articles, sorted by topic – then access a PDF of the issue it appears in. We will update the index with each new issue published.

Go to www.ofsubstance.org.au
Many of you will be aware of the recent airing of the Ben Cousins’ documentary on Channel 7 in August. *Such is Life* was an extraordinary and frank ‘tell-all’ about the champion AFL player’s repeated falls from grace, with graphic depictions of his illicit drug use. A very public story, attracting polarised reactions.

I, for one, am pleased about the discussion and reaction it raised, because the denial about alcohol and drugs that exists in our community gets broken down a little as people become aware of these stories. People also start talking and, even though a lot of the discussion is quite judgmental and opinionated, with debate comes knowledge – sometimes.

**Mental health factors**

Much has been debated about the impact of mental health or personality disorder on Cousins’ activities. My view on this is that it is impossible for anybody watching from the sidelines to diagnose another’s mental health – even family members close to affected people cannot do this without assessment from mental health specialists. It is quite normal for families to desperately want to know why people behave in certain ways and, in some situations, long for a justification for bad behaviour.

One fundamental personality trait that I observed in my own son was the capacity for taking incredible risks, with reckless lack of concern for health and well-being. Cousins admitted this is a big part of his personality. Much of the negative behaviour that sometimes goes alongside drug use is unacceptable and needs addressing. Some families have to make the heartbreaking decision to remove affected people from their homes because of the risk they pose to others in the family. It is an indictment on our society that there is often nowhere for them to go, and they and the rest of the community are then at risk.

Celebrities like Cousins can afford the best treatment centres in the world, but like most others they have to have the mental determination to succeed. It is interesting to see that it was a public treatment service – Cyrenian House in Perth, with its well-respected CEO, Carol Daws – that appears to be the catalyst for Cousins’ recovery, not the upmarket private centre in Los Angeles that he initially went to.

**Impact on families**

Cousins still has hard roads to travel, and I wish him well. The main issue for me now revolves around his family, and again there is polarised media and community opinion.

The Cousins family has been attacked in the media for their own reactions to, and handling of, Ben’s addictions. The shame and stigma attached to substance abuse, and to a lesser extent mental illness, is massive. Drug users and their families are treated like modern-day lepers.

To expose yourself publicly is not only asking for judgment and condemnation, it also leaves you open to future impact on careers, finance, travel etc. Families dare not and do not often speak out – if they are willing to expose themselves, their drug users don’t want them to. Therefore, I am grateful to the Cousins family for speaking out.

*‘By the time we found out, the damage was done’ – Bryan Cousins (father)*

So true, most families don’t become aware until there is crisis. Our own denial and the obviously secretive behaviour of the user conspire to hide the reality.
The case of Ben Cousins: how a celebrity's drug use affects them and their families

Tony Trimingham*

We can see things in hindsight – in fact they seem to stand out like the proverbial. The problem is that what is an obvious signpost in the light of subsequent events may have been a minor incident at the time. Guilt and self-blame are normal responses to these happenings. Most affected families are caught in the dichotomy of loving and caring for the affected person, and at the same time being quite angry at having to deal with it.

‘One time, in a desperate attempt to negotiate safety, I went with Ben to get drugs. It was early in the morning and I curled up in a bus shelter in my pyjamas while Ben went off to the dealers’ – Bryan Cousins.

Again, opinion about this incident seems incredulous, while to me, having spoken to so many families and having been there myself, this is a quite normal event in this most abnormal of conditions.

Support and respect

When I look at and listen to this family, I see people trying to come to terms with the last thing they expected. The pain in their eyes is obvious, but it is the continuing hope in their voices that inspires.

Alcohol and drugs are part of modern-day life. Most will survive their encounters with substances, some won’t. Families deserve respect and compassion. Remember, it could be your family. Above all, we should see that families are given support in their often long and difficult journey.

*Tony Trimingham is founder and CEO of Family Drug Support. His son Damien died of a heroin overdose and he wrote his story in his book Not My Family, Never My Child. Tony was the Prime Minister’s Award winner at the National AOD Awards in 2008.

FDS national 24-hour 7-day a week support line: 1300 368 186. Website: www.fds.org.au.

Decade of monitoring trends

Natasha Sindicich and Jenny Stafford, National Drug and Alcohol Research Centre

This year marks the 10-year anniversary of the Illicit Drug Reporting System (IDRS), a monitoring program which annually maps drug trends in capital cities across the country. Surveying people who inject drugs and others who work in the illicit drug area (e.g. police, health workers), along with drawing on other data collections, the IDRS identifies emerging patterns of drug use and enables governments, police and health workers to prepare for likely consequences of that drug use.

Key findings from the 2010 study include:

- Heroin remained the most commonly reported drug of choice for participants who inject drugs. Its frequency of use and price remained stable. Availability was reported as ‘very easy’ or ‘easy’ and purity ‘low’ or ‘medium’.
- Nationally, recent use of speed and base has decreased, while recent ice use remained fairly stable. The frequency of use of ‘any form’ of methamphetamine (speed, base and/or ice/crystal), was lower in 2010 although it was ‘easy’ or ‘very easy’ to obtain.
- NSW was the only place where sizeable numbers of participants reported recent cocaine use and could comment on price, purity and availability. In Sydney, the recent use, and frequency of use, of cocaine was stable, while elsewhere, use was low and sporadic.
- The cannabis market remained stable. Use was common, with most people using daily or near-daily. High-quality hydroponic cannabis dominated the market.
- Non-medical use and injection of pharmaceutical preparations continued to occur, with jurisdictional differences in patterns of use.
- Borrowing of needles was reported by 10% of respondents in the month preceding interview, while sharing of other injecting equipment was common.
- Nearly half of the national sample self-reported a mental health problem in the last six months, most commonly depression, followed by anxiety.

Since 2003, the IDRS has been coupled with a national survey of people who are regular ecstasy users (REU). The Ecstasy and Related Drugs Reporting System (EDRS) maps illicit drug use trends in a different population of people who tend to frequent nightclub and entertainment events. It also draws on other data sources and the knowledge of people working in those industries, such as DJs, police and health workers.

- Ecstasy remains the drug of choice for 38% of the REU sample. Cannabis (16%), followed by cocaine (13%) and alcohol (12%) are next in terms of preference. This marked an increase in preference for cocaine from 2009.
- Ecstasy consumption patterns remained stable, however market characteristics signified a change in trend, with prices fluctuating. National and global indicators suggest a decrease in availability and purity of ecstasy’s key ingredient MDMA. Survey participants agreed, reporting ecstasy availability as ‘difficult’ to ‘very difficult’ and purity as ‘low’ compared with 2009.
- All forms of methamphetamine remained at low levels of use.
- Recent cocaine use has steadily increased since monitoring began in 2003 and is currently at the highest prevalence reported to date (48%). Frequency of use remained low at three days in the past six months across all states except NSW (five days).
- A synthetic substance known as mephedrone has been consumed sporadically in powder and capsule form by 16% of the national sample of REU, with the majority of use in Tasmania and Victoria.

For further information please see: www.ndarc.med.unsw.edu.au and click on ‘Drug Trends’.
Supporters of drug prohibition often argue that there are no properly considered alternatives to banning illicit substances. However, in November 2009, the Transform Drug Policy Foundation – a British think-tank dedicated to drug law reform – released After the War on Drugs: Blueprint for regulation. The book details how regulatory control of drugs might be a safer, more responsible alternative to non-medical drug usage than the unregulated, black-market environment we have now.

Blueprint for regulation does not advocate drug use; indeed, its main focus is on reducing the incidence and intensity of non-medical drug usage. It simply states that 40 years of the ‘War on Drugs’ has not worked, and that the only effective control of drugs has been through government regulation.

The strength of the book is that none of its proposals are untested, and it recognises that there is no one-size-fits-all solution. It uses real-world systems as templates for regulating production and supply.

Regulation models

Blueprint’s proposals are based on five existing regulation models:

• The Prescription model: the strictest control model, this is currently used in Australia for the sale of many medicinal drugs, and for some opiate maintenance programs.
• The Pharmacy model: Australia uses this model for the sale of codeine- and pseudoephedrine-based medicines.
• The Licensed Premises (‘Coffee Shop’) model: as used in Amsterdam for the sale of cannabis, this is the equivalent of a wine bar where substances are sold and consumed onsite.
• The Licensed Sales model: the equivalent of our bottle shop or tobaccocon, where substances are sold over the counter for consumption elsewhere.
• The Unlicensed Sales model: a supermarket-style model with no barriers (like age limits) to sales. This is the ‘nightmare scenario’ model harped on by opponents of regulation, but is referenced in the book simply for comparison, and is not offered as a serious model.

The point that the book makes about these five models is that they not only exist in the real world, but they all include specific controls and rules to reduce harm to users. The benefits of existing regulation for prescription medicines, alcohol, tobacco, etc. could be extended to drugs that are currently illicit.

Consistent quality and purity are major elements of regulation. For non-medical drug usage, regulation would work to reduce the risk of accidental overdose and avoid the roulette wheel of cut supply.

A regulated market means that governments can also control prices. This has three effects: first, it raises tax revenue which can be invested in education, treatment and prevention programs. Second, prices can be set at a low enough level to squeeze out black markets, and to reduce the rate of crime for funding drug habits. Third, prices can be adjusted to discourage over-consumption.

Regulation also encourages increased safety of drug use. Regulated packaging helps ensure tamper-proof containers and strict dosage control. The amount of drugs sold at any given time or place can be limited and checked. Retailers of drugs would be subject to strict guidelines. Tough penalties including loss of licence could be imposed for breaking rules. The number, location and opening hours of licensed outlets or premises could also be controlled.

So what would a regulated drug market look like? A couple of examples Blueprint discusses are:

Cannabis
Cannabis would likely be the first illicit drug to be regulated. Following Amsterdam’s example, Blueprint recommends a ‘coffee shop’-style licensed premises model, possibly membership-based. The book points out that most cannabis use is ‘moderate, occasional and not significantly harmful’ and that regulation and resources should target the minority of users who experience real problems.

Heroin and other opiates
The book recommends the strictest form of medical prescription model for injected heroin. It refers to existing models that include mandatory supervised use in a clinical setting (such as Sydney’s Medically Supervised Injecting Centre). However, it also suggests a more relaxed model for unrefined opiates. For instance, opium poppy tea could be supplied in coffee shop-style premises.

Blueprint calls for thorough research and for much more international cooperation. It is a sober, methodical book that suggests common-sense solutions to a range of problems whose solutions become more distant as the years roll on.

*Gideon Warhaft is the Editor of Users News, NSW Users and AIDS Association

Reference
More than 550 people attended the landmark conference which attracted Indigenous leaders and representatives from Aboriginal and Torres Strait Islander communities across Australia.

With a theme of Listening, Learning and Leading, the conference was the first time people working across Indigenous services had had the opportunity to come together nationally to discuss issues specific to Indigenous substance use and its impact on families and communities.

The conference was hosted by the National Indigenous Drug and Alcohol Committee (NIDAC), which is chaired by Western Australia’s Ted Wilkes. Through its auspicing body, the National Australian Council on Drugs, NIDAC advises governments on Indigenous substance use issues.

Delegates developed a number of resolutions calling on government to address areas of urgent need (see panel).

Keynote speakers included:
• Cindy Shannon, who spoke about substance use in urban Indigenous settings
• Tom Calma (‘justice reinvestment’, where money is invested in programs in communities which have a high rate of members being imprisoned)
• James Ward (blood-borne viruses in the Indigenous population)
• Ian Anderson (policy initiatives to close the Indigenous health gap)
• Tim Costello (international development and Indigenous Australians)
• Gerard Neesham (sports as an education tool).

Concurrent sessions throughout the conference addressed areas as diverse as workforce development, differing drugs and patterns of use, justice, interventions, treatment, partnership approaches and mental health issues.

Delegates at the first National Indigenous Drug and Alcohol Conference agreed on a number of resolutions which have been forwarded to the federal government. Below is a summary of the key points made in those resolutions.

1 That the appalling over-representation of Aboriginal and Torres Strait Islander people in juvenile justice centres and adult prisons be addressed as a matter of urgency.
2 That the current preventative health and chronic disease agendas for Aboriginal and Torres Strait Islander people include a substantial focus, as well as specific funding, for addressing substance use.
3 That greater resources be provided to increase the level of ongoing training and capacity of Aboriginal and Torres Strait Islander health workers in the substance use sector.
4 That governments at all levels recognise that one-off projects and pilot projects are not sustainable and therefore need to increase the provision of recurrent funding for culturally appropriate, evaluated, evidenced-based Aboriginal and Torres Strait Islander alcohol and other drugs (AOD) services. Wherever possible, services should be provided by Aboriginal and Torres Strait Islander community-controlled organisations.
5 That there is an urgent need for accessible up-to-date Aboriginal and Torres Strait Islander specific data on substance use issues.
6 That the widespread diversity of need and location (remote, rural, regional and urban) of Aboriginal and Torres Strait Islander people is recognised by appropriate funding being provided in all settings.
7 That there needs to be a separate National Aboriginal and Torres Strait Islander AOD Strategy which is supported with clearly identified funding.
8 That as injecting drug use is increasing at a concerning rate in Aboriginal and Torres Strait Islander populations there is a need for increased attention to address the risk of HIV/AIDS and hepatitis C transmission among Aboriginal and Torres Strait Islander people.
9 That the government be called on to use the most effective interventions available to reduce alcohol-related harm among Aboriginal and Torres Strait Islander people, by adopting: a tiered volumetric taxation system; minimum floor pricing; restrictions in advertising and promotions; restrictions on licensing and the introduction of labelling on alcohol products.
10 That a quarantined levy be placed on all alcoholic beverages to fund the implementation of Aboriginal and Torres Strait Islander developed alcohol management plans as well as appropriate services to reduce the harms caused by alcohol use.
11 That greater investment is provided for a wider variety of sports and other cultural activities for Aboriginal and Torres Strait Islander youth.
12 That federal legislation be implemented that potentially compels retailers to make Opal fuel available in sites of strategic importance.

For full details, visit www.nidac.org.au.
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Benzo dependence:
The case for substitution

Libby Topp

For dependent opioid users, the authors advocate the rigorous evaluation of a maintenance approach for BZD-dependent clients, asserting that their inability to achieve abstinence has for decades forced clinicians to prescribe informal BZD ‘substitution’. Whereas opioid-dependent clients are motivated to participate in long-term maintenance, dependent BZD users are routinely withdrawn, even those for whom detox has failed previously.

Which agent to substitute?

Although BZDs have similar pharmacological effects, differences in their onset of action, half-lives, the way they are metabolised, and the ease with which they enter the brain underlie their diverse range of therapeutic indications, ranging from fast-acting anxiolytics to long-acting anti-convulsants. These differences also explain the variable abuse potential of drugs of this class. BZDs with a slower onset of action appear less likely to be abused, whereas those with a faster onset and pronounced euphoric effects (e.g. flunitrazepam or Rohypnol) appear more readily abused. Consequently, the authors suggest the ideal substitution agent is a long-acting (i.e., long half-life), slow-onset BZD. Ideally, its use would not induce immediate euphoria, and repeated use would result in little change in its blood concentration.

Could it work?

Some limited evidence suggests that a controlled evaluation of BZD maintenance may prove fruitful. A small study of 33 methadone maintenance clients prescribed maintenance doses of BZDs found that 26 (78%) refrained from additional BZD use for 12 months. The British Association for Psychopharmacology acknowledges in its guidelines for the management of illicit BZD users that maintenance prescribing of BZDs among opioid maintenance patients occurs more commonly in practice than is recognised; and


Introduced in 1960, benzodiazepines (BZDs) are today among the most widely prescribed drug classes, used to treat anxiety, insomnia, muscle spasms and epilepsy. Although initially thought to be associated with a low risk of dependence, it is now recognised that dependence commonly develops among long-term BZD users, including those who use only normal and even low doses. Dependence may arise in patients legitimately prescribed BZDs to treat underlying sleep or anxiety disorders who then progress to inappropriate use; or in individuals who use BZDs for recreational purposes, such as to enhance the effects of other drugs or reduce withdrawal symptoms. These Swedish authors consider problematic pattern of BZD use including high-dose and/or long-term consumption; mixing different BZDs; repeatedly escalating doses; use to enhance the effects of other drugs; and reliance on black-market BZDs.

Treatment approaches

Alternatives to abstinence-oriented treatment for BZD dependence are rarely discussed in the literature; even large-scale reviews and meta-analyses focus solely on abstinence-based approaches. Although a range of interventions have been investigated – from gradual tapering with a long or short half-life BZD; switching to non-BZD anxiolytics; to prescribing additional medications such as anti-depressants or anti-convulsants – the common aim nevertheless remains abstinence from BZDs. However, many high-dose and otherwise problematic BZD users, and/or those suffering polydrug dependence, do not achieve long-term abstinence following cessation. Pointing to the vast literature demonstrating the efficacy of substitution pharmacotherapy...
tolerance is a serious limitation for a substitution approach, unborn babies and increased service utilisation by users. BZD treatment, traffic accidents, accidental falls, adverse effects to function impairment, poor outcomes of cognitive behavioural BZDs are associated with cognitive and psychomotor

What are the risks?

BZDs are associated with cognitive and psychomotor function impairment, poor outcomes of cognitive behavioural treatment, traffic accidents, accidental falls, adverse effects to unborn babies and increased service utilisation by users. BZD tolerance is a serious limitation for a substitution approach, although some evidence suggests BZDs retain their anxiolytic effects even over years. Possible cognitive effects include amnesia, impaired spatial and movement skills, coordination, information processing, verbal learning, memory and concentration. Concurrent use of alcohol increases the risks, and declines may be more apparent as patients age. Some BZDs have less pronounced cognitive effects than others; and following withdrawal, long-term users show improvement in cognition, but deficits remain, and even under optimal substitution treatment, patients are likely to show impairment relative to healthy controls. The risk of cognitive dysfunction dictates that BZD maintenance should be considered only among clients who have attempted other treatments.

A stepped-care approach

The authors call for the rigorous evaluation of the following clinical procedure. Chronic high-dose users suffering cognitive impairment and/or wishing to quit should be supported to withdraw through gradual tapering. Clients unable to cease high-dose use could be prescribed maintenance doses of a slow-onset long-acting BZD. Just like opioid maintenance, this might prove a viable treatment option for those unable to cease problematic BZD use.

View from the coalface ... Redfern, inner Sydney

After many years of wrestling with the problem of benzodiazepine use in opioid-dependent patients, it was reassuring to read this prominent paper by Liebrenz and colleagues. Their hypothesis is an approach using what appear to be harm reduction principles, parallel to methadone maintenance. Our original practice policy was to ‘just say no’ but despite our entreaties, about one-third of our patients continued to use benzodiazepines on urine testing. A number did succeed at abstinence, only to relapse with significant harms occurring due to disinhibited behaviour, often involving amnesia of the events.

Some patients were able to function almost normally while taking illicit benzodiazepines. Others became disorganised regarding their finances, housing and interpersonal relationships, some even coming to the attention of the police or emergency departments.

Although there appeared to be a number of patterns of tranquilliser use, from binge and recreational use to quasi-therapeutic, we treated all such patients the same way initially, using diazepam 5mg tablets supervised at the clinic. Those currently abusing alcohol were excluded. Each patient needed to return at least once, about three hours after a witnessed dose for a brief examination to confirm their tolerance and exclude intoxication. All patients also had to agree to random urine testing and regular medical consultations to assess progress.

Our impression has been that when given access to diazepam under close supervision, stability returned to most such patients. A recent audit of our referral dependency practice showed that of 167 pharmacotherapy patients (80% methadone, 20% buprenorphine), 30% were being prescribed benzodiazepines, mostly under supervision. The mean dose was 14 mg daily (range 2 mg-25 mg). One-third were gainfully employed.

Thus we can confirm that some of the protocols alluded to in the forward-thinking item in Addiction are feasible and are ripe for research. Inquiries showed that many of our colleagues had one or two pharmacotherapy patients taking long-term benzodiazepines and nearly all had organised supervised dosing at least once.

Benzodiazepine use has been the ‘elephant in the room’ in addiction treatment. While most centres still use an abstinence approach, many patients continue to use these drugs. Since benzodiazepines, along with alcohol, constitute a major source of drug-related harm, it may be timely to reassess our approach. Severe restrictions on supply alone have historically never solved drug problems. Such restrictions also necessarily reduce access to those who need the drugs therapeutically. As with many other areas of public health, we believe that it is possible to translate the principles of ‘harm reduction’ to benzodiazepine use by utilising the protocols of ‘universal precautions’ espoused by Dr Gourlay in Canada.

The use of benzodiazepine maintenance is probably at the same stage of ‘evidence’ as methadone treatment was in about 1980. It appears to be acceptable to the patient population; it appears to be safe in practice, yet definitive research is awaited to prove its effects ... and to identify optimal dosing, supports and necessary supervision.

* Dr Andrew Byrne is a Sydney GP specialising in drug dependency.
The power of these novel communication tools in many fields of human endeavour is well documented, both in terms of the opportunities they provide and the risks they pose. The content they deliver includes voice messages and conversations, text, images, interactive forums and web-based films. They constitute a virtual online world, instantly accessible, almost anywhere at any time.

In this introductory article examining the impact and application of new communication mediums, we will outline some of the key areas in which the alcohol and other drugs (AOD) field will potentially benefit from it, and showcase how web-based information directly applies to young people. Future articles will look at other issues such as online AOD prevention, treatment and professional development, as well as looking at how consumers use these technologies.

Online advice

One of the enormous growth areas in internet applications has been the provision of health care information and advice. Estimates of the numbers of people looking for health information online were staggering even a decade ago: 60 million worldwide in 1998; 100 million in the United States in 2001 (Gedge 2002).

In Australia these tools were taken up while still in their infancy by the mental health sector and the broader health sector, but only more recently by the AOD field. In all these sectors their uses are still evolving, and their impacts are not yet well understood; however, they will increasingly influence the way we do our work.

Where they are used, their purpose is generally to supplement or enhance, rather than replace, traditional interventions such as face-to-face counselling, residential and outreach programs, and printed materials.

In a special issue of Drug and Alcohol Review in January 2009, guest editors Kip Kypri and Nicole Lee presented a range of work from around the world that uses non-traditional tools for research and intervention (Drug and Alcohol Review 2009). The editors suggest a number of likely benefits from increasing the use of new technologies in the AOD sector, including to:

• help broaden the base of treatment
• increase provision of a stepped care approach
• facilitate strategies that overcome distance and other barriers
• develop approaches that engage young people more effectively.

Some of the issues and opportunities explored in the featured studies highlight the potential of new technologies to assist prevention and treatment services, including:

• collection of data during or shortly after substance use via mobile phone technology
• development and design features of web-based interventions
• use of wireless keypads to provide real-time normative drinking feedback
• use of chat room-style technology to provide information and counselling

• use of the internet to access web-based services in languages other than English
• providing online support for smokers while quitting.

Negative impacts

There is no doubt that for all the benefits that online access to information and help can offer, there is a flip side of negative influences. These include the proliferation of online pharmacies offering easy access to prescription drugs; cyber bullying; inaccurate content and online marketing and blogging by alcohol and drug companies (D&A Review 2009).

Better or just different?

One interesting question is whether the techniques used in online interventions, such as interactive counselling and support, deliver a different type of therapy, or simply deliver conventional therapy differently.

‘Quite a lot of research in recent years shows that online treatment is at least as effective as or better than conventional methods, raising questions about what are the key mechanisms of change in therapy,’ says Associate Professor Nicole Lee.

Another key question, according to Lee, is whether technology somehow enhances outcomes or just creates better and greater access. ‘This is all so new. We need much more research on what works and why it works, and on how to guide people towards the best treatment option for them. There are also implications for training and development,’ she says.

Counselling and support services

Tele-counselling and online counselling are now significant players in the mental health field, having first been funded by the Commonwealth in 1996-97. However, a comprehensive review in 2002 found that these modes faced substantial challenges, often to do with accessibility (Department of Health and Ageing 2002). While some of these have been largely overcome (e.g. wider broadband access) others remain significant: funding and management, staffing (including training and support), service standards, challenges to accepted practice and lack of evidence on efficacy, and relationships with the broader health sector. As well, ethical challenges to web-based counselling can include confidentiality, privacy, cyber stalking and identity theft, and credentialing.

Within the AOD field, a leading model of online support is CounsellingOnline, a free 24/7 service run by the Turning Point Alcohol and Drug Centre. It aims to improve access to drug treatment and referral services, particularly in rural and regional areas, providing online drug and alcohol counselling, using text-interaction, and information, support and referral for people who use drugs, family members and others. It can include web chat in real time, email communication, or remote communication using videoconferencing.

Engaging young people

Research findings cited by health information website ReachOut Pro (www.reachoutpro.com.au) show that young people generally spend their time online in information seeking, socialising (chat/instant messaging, email, social networking sites), creative expression (blogs, flickr, YouTube etc.), downloading media (music, films, pictures), shopping (online auctions, classifieds, commerce) and gaming. One of the big challenges of health-related sites is the need for constant ‘churning’ of information, to keep up to date and interesting.

The youth work and mental health fields pioneered the use of novel technologies, offering targeted websites for information, intervention and support to young people, and mobile phone services.

In Australia, two of the first websites were ReachOut (www.reachout.com) and Somazone (www.somazone.com.au), both established in the late 1990s. ReachOut was launched to tackle Australia’s then escalating rates of youth suicide, while Somazone is a broad-based youth health site in which drug use features as one element.

According to Jack Heath, Executive Director of the mental health charity Inspire Foundation, which sponsors the ReachOut site, well over 90 per cent of young people are regularly online.

Immediacy and connectivity via technology, and the involvement of young people, are at the heart of Inspire’s work. These are backed up with social marketing campaigns that help reduce the stigma around mental health and help-seeking, and partnerships with other youth-related organisations.

Today, Inspire connects each year with more than 300 000 people aged 14-25 through the internet and related technologies (Inspire Foundation 2009). Its ReachOut Pro site is a comprehensive resource for health professionals on using technology in psychosocial support and mental health care of young people, and includes a section on AOD.
The ReSet program (www.reset.org.au) is an online health assessment project that combines internet tools with social marketing and peer-led outreach. Funded by the Department of Health and Ageing, it is the brainchild of the team at Manly Drug Education and Counselling Centre (MDECC). The centre enjoys a high level of trust, having served Sydney’s northern beaches for decades.

“We recognise that people in the 18-24-year age group don’t necessarily access services unless they perceive they have a problem. We were looking for ways to engage with them, before problems arise,” says Amanda Watkins, MDECC Health Promotions Coordinator.

The ReSet program has accomplished much in a short time. In August 2009, the project recruited 10 young people as peer outreach workers and provided them with intensive training. They then spent weeks inside gyms and licensed premises armed with laptops, encouraging their peers to complete an online health assessment on their drug use (particularly amphetamine-type stimulants – ATS – and alcohol), health and well-being, and to talk them through the results.

The intensive program covered 40 events in gyms and licensed premises over 11 weeks and yielded survey results for around 650 people in the 18-29-year age group.

“The majority were using lots of ATS, missing sleep, often staying up for days, but because they were still able to work hard and exercise a lot, they saw themselves as healthy and not at risk. Yet some were drinking up to 20 standard drinks of alcohol in a session as well as taking ATS,” says Watkins.

The survey was able to identify a lot of users at an early stage of risk, and they were encouraged to join Club ReSet, a free six-week program focusing on their drug of choice and lifestyle changes. When the survey results indicated that participants had reached the stage where treatment was needed, this was explained and referrals made.

“Providing visual results immediately on computer and on site was very effective,” says Watkins. “After the initial debrief, participants started to reflect on the links between their behaviour, mental health and lifestyle. Reset is all about getting some balance back into their lives.”

The peer outreach team also did most of the work to develop YouTube content and the project website, and there are young people on the steering committee. One of the most effective spin-offs has been instant and easy dissemination of AOD and mental health information, and referral to intervention programs and health services, via social networking sites. The 10 peer outreach workers have attracted around 2000 Facebook ‘friends’ who pass on information about this innovative project and the web link to their friends and contacts.

“The most credible way to reach young people is via their peers, with non-judgmental messages couched in their language. The peer education model works well – but it needs reliable ongoing funding. We have no resources to continue monitoring the ReSet program or extend it to others. Teachers beg us for copies of our peer outreach resource folders. We’d love to introduce ReSet to schools, and other primary care settings and add cannabis and tobacco into the program,” says Watkins.

Alcohol abstinence and the blog

Personal, immediate and relatively unregulated, ‘blogging’ as a means of online communication has understandably become very popular. While blogging is not confined to younger people, blogging on drug and alcohol issues and stories is commonly linked to youth-directed sites in music, entertainment and social networking sites used by millions worldwide, such as Facebook, Twitter and YouTube.

One Australian blog that rapidly gained readers began in January 2009 when Chris Raine decided to abstain from alcohol for a year and research what it would take for a young person to change their drinking behaviours. During the 12 months he documented the process on a blog at www.hellosundaymorning.com.
Hello Sunday Morning (HSM) was actually an orchestrated project, funded by FRESH, a youth advertising agency based in Brisbane. It describes its mission as ‘to provide opportunities for young people … looking to shift their belief systems around alcohol’.

HSM now attracts a large volume of responses on its website (hosted by Facebook) and has become a mutually supportive and reinforcing online community of people who commit to giving up alcohol for periods from between 3 and 12 months, and who blog about their experiences during abstinence and after they resume drinking (if they choose to).

References


Youth-focused websites

Along with the key websites featured above (ReachOut, Somazone, Reset and Hello Sunday Morning), many other Australian websites cater specifically to helping young people understand AOD issues, including:

- **Highsnlows** Focus on cannabis use by young people. Includes educative videos, fact sheets, information for parents, personal stories of users and links to support services. Run by the Australian Drug Foundation and Somazone. [www.highsnlows.com.au](http://www.highsnlows.com.au).

- **Cautious with cannabis** Information site sponsored by Uniting Care and Moreland Hall, with links to program providers. [www.cautiouswithcannabis.com.au](http://www.cautiouswithcannabis.com.au).

- **Don’t get used** Focus on ecstasy, cocaine, hallucinogens, methamphetamine, GHB. Links to support services nationally and other drug information websites. Run by NSW Health and ACON. [www.dontgetused.com.au](http://www.dontgetused.com.au).


- **Counselling online** Free 24/7 professional service run by Turning Point Alcohol and Drug Centre. [www.counsellingonline.org.au](http://www.counsellingonline.org.au).

- **What’s the rush** Information on AOD, safety and risks aimed at adolescents. Developed by a Tasmanian AOD counsellor in consultation with teenagers. Comprehensive links to related sites including AOD research groups. [www.whatstherush.org.au](http://www.whatstherush.org.au).

- **OxyGen** Only Australian website dedicated to informing young people about tobacco use. Interactive content and video clips about smoking and the tobacco industry. Includes fact sheets, links, news items and games. Also a portal for educators. Managed by Quit Victoria with Cancer Council SA and Heart Foundation WA. [www.oxygen.org.au](http://www.oxygen.org.au).

- **Drug info @ your library** Up-to-date information about AOD on websites and in hundreds of libraries, 230 of these in regional areas. Contains specific sections for parents and carers, young people, students and teachers, Indigenous people and information in 32 community languages. Run by NSW Health and State Library of NSW. [www.druginfols.nsw.gov.au](http://www.druginfols.nsw.gov.au).


- **Meth.org.au** Site created by Turning Point Alcohol and Drug Centre in Melbourne, it specifically aims to help people self-manage common meth use-related issues, along with options for specialist treatment. [www.meth.org.au](http://www.meth.org.au).

- **Just ask us** Also operated by Turning Point, this site is aimed at students and other young people, with information about a wide range of AOD, plus links to further help/advice. [www.justaskus.org.au](http://www.justaskus.org.au).

- **Bluebelly** A site that aims to work collaboratively with users to reduce the harms associated with the use of amphetamine-type substances, including MDMA and cocaine, developed by Moreland Hall Alcohol and Drug Service Melbourne. [www.bluebelly.org.au](http://www.bluebelly.org.au).
When we think about what affects youth attitudes to drugs we tend to focus on factors such as family upbringing, socio-economic status, peers and psychological predispositions towards drug use (Spooner 1999). Yet, what of other factors, such as the innocuous and ever-present news media?

**Media impact?**

Our knowledge is scant about first, whether or not media affects attitudes towards (or demand for) drugs, and second, how these effects operate. Evidence from numerous fields tells us that media has the power to sway public opinion (e.g. Beckett 1994; Fan 1996) and affect individual perceptions of risks and norms (Anderson et al. 2003). But in spite of the pervasive presence of illicit drugs in mainstream media (Bell 1985; Blood et al. 2005), the impacts of media coverage on attitudes to illicit drugs has to date been relatively unexplored.

In this article, we discuss an Australian study that pondered the link between news media reporting on illicit drugs and demand for drugs (see box). This was part of a broader study that sought to identify the dominant media portrayals on illicit drugs in Australian newspapers and their impacts on youth attitudes to drugs (Hughes et al. 2010).

**Why should news media matter?**

The way the media ‘frames’ a story affects the way we, as the audience, interpret the messages we receive. Research indicates that framing provides a contextual cue which may significantly influence decision-making or changes of opinion (Iyengar 1991). We also know that youth have a high level of contact with media, and this includes news and current affairs. Youth are integrating multiple sources of news and current affairs into their existing multimedia experience (Ang et al. 2006).

**Findings**

**How is Australian news media framed?**

Given the high level of youth media exposure, the pervasiveness of messages around illicit drugs and the fact that young adulthood is the time at which people are...
most susceptible to taking up illicit drugs, the question emerges: what is the impact of news media reporting on youth attitudes to illicit drugs? Can news media make youth more likely to use drugs? Conversely, can it discourage youth from trying illicit drugs? And do the effects depend on prior drug experience or knowledge?

Drugs are highly pervasive in Australian newspapers. Indeed over the period 2003-2008 an average of 19 articles relating to drugs were published every day. Criminal justice and law enforcement topics overwhelmingly dominated print news media reporting on illicit drugs, with 55.2% of the sample denoting criminal justice action regarding users, dealers or traffickers. Only 4.8% of articles discussed harms and 14.2% denoted health problems as consequences of illicit drug use.

**Does the media affect attitudes?**

Youth attitudes to drugs were influenced by news media. Particular populations of youth were more influenced by media reports: this included females (compared to males) and non-users (compared to recent users and non-recent users). Attitudes of the general population of 16-24-year olds were also highly affected (with comparable or larger effects to those elicited in other fields such as smoking).

Media could increase or decrease intentions to use illicit drugs. The direction of effect was based on the explicit or implied message about drugs. That is, portrayals that endorsed low risk (such as ecstasy is safer than binge drinking) or acceptability of drugs (such as celebrities behaving badly) increased stated intentions of using illicit drugs. Conversely, portrayals that suggested potential problems from drug use (such as being arrested or having mental health problems) reduced stated intentions to use.

The most interesting finding was that portrayals depicting health and social problems were more effective at reducing intentions to use than those depicting problems with the law. Even recent users who tended to be much less affected by media portrayals were in some cases also affected by portrayals of health and social problems.

**Why does news media affect youth attitudes?**

Media effects were shaped by a number of factors including message construction. That is, to what extent messages were deemed believable and meaningful to youth. As shown by two young people, some messages were rejected outright: ‘that’s just propaganda’. Others were rejected because they did not accord with their direct or indirect knowledge about drugs: ‘that’s ridiculous … there are so many people that are taking drugs’.

Portrayals of health and social problems were more effective than portrayals of arrest because they were more persuasive to youth. Youth perceive health and social problems as the more probable and severe risk of illicit drug use. The irony is that, in Australia, health and social problem messages accounted for only small proportions of the news media reporting on drugs.

**Policy implications**

This study suggests that the seemingly innocuous news media is one of the many factors that affects demand for drugs and that Australian news media can play a role in current and future prevention of illicit drug use. But given the dominant messages are not those deemed most persuasive to Australian youth this research suggests that the preventative role is currently being stymied. There is a clear opportunity to increase engagement with media outlets. We suggest this is likely to pay dividends, because as summed up by one young Australian: ‘Media is probably one of the few ways that prevention message(s) can keep being pushed’.

This work has arisen from the report:


The project was funded by the Commonwealth Department of Health and Ageing under the National Psychostimulants Initiative.

*Caitlin Hughes, Kari Lancaster, Bridget Spicer and Francis Matthew-Simmons write from the Drug Policy Modelling Program at the National Drug and Alcohol Research Centre, while Paul Dillon writes from Drug and Alcohol Research and Training Australia.

For a full list of references cited in this article, contact the Editor via email: editor@ancd.org.au.
In the needle’s eye

Jenny Tinworth

DR INGRID VAN BEEK WILL TELL THE WORLD THAT SHE’S ‘NO REVOLUTIONARY’, BUT INSTEAD BELIEVES IN ‘INCREMENTAL CHANGE EVOLVING OVER TIME’. MANY NSW POLITICIANS WOULD DISAGREE.

From the mid-70s until the mid-80s, Ingrid van Beek worked at Sydney’s St Vincent’s Hospital, which borders the famous red-light district of Kings Cross. Those years would set the direction of her career, working with, and becoming an advocate for, some of the area’s most disadvantaged people.

Since its early days, van Beek has headed the Kirketon Road Centre, a primary health care facility for ‘at risk’ young people, sex workers and people who inject drugs. What began as a small seven-staff service has expanded to almost 60 staff, offering a diverse range of services which includes pharmacotherapy treatment, primary health care, needle exchange, outreach and youth services. The centre has also produced important frontline research over the years.

However, it is her eight-year stint as the founding medical director of the controversial Sydney Medically Supervised Injecting Centre that forced van Beek into the public and political spotlight and established her as an agent for change.

Against strong opposition from many quarters, the injecting centre was established as a trial after NSW’s landmark Drug Summit in 1999. Despite intense evaluation, the centre remained as a trial for almost a decade. For its first eight years, van Beek worked two full-time jobs, one as the director of Kirketon Road, the other as the head, and public face, of the injecting centre.

It was a situation that she had, naively in retrospect, expected to last for a maximum of three years – just long enough to see the injecting centre move through its initial 18-month trial phase and be established as a permanent health entity in the Kings Cross area. However, the NSW Government extended the trial three times rather than make a final decision on the centre’s status.

In 2008, van Beek resigned as medical director, unable to continue the workload imposed by two managerial positions, with no real end in sight.

Community development

Van Beek’s heritage ideally placed her to head the controversial project. The daughter of Dutch resistance workers, she grew up in Sydney’s western suburbs, surrounded by inequity and disadvantage. ‘I was offered a lot of opportunities in comparison to my cohorts,’ she says. ‘My parents believed in education.’

She realised that by moving into public sector health she could create positive outcomes for a larger group than just her individual patients. Alongside her directorship at the Kirketon Road Centre, she worked in community development – meeting with local residents to discuss the provision of contentious health services such as needle and syringe programs, working with police and local members of parliament to balance the needs of all sectors of the community.

Harm reduction’s poster girl

Her appointment to the injecting centre catapulted van Beek onto the national stage. ‘I didn’t predict the publicity that would ensue. Suddenly I found myself going from being relatively low-profile in the field to walking into shops and having retailers wanting to engage me in a discussion about national drug policies.’

The establishment of the injecting centre drew much criticism, and as its medical director, van Beek became
the target. ‘I would get phone messages saying I was cooperating with the devil, and not to expect any mercy when my time came.’ A politician used parliamentary privilege to publicly attack van Beek, accusing her of wasting public money and having a vested interest in keeping people addicted to drugs.

‘Some zero tolerance groups came to see the injecting centre as symbolic of the harm reduction approach in general, and figured that if they could take that down, they would bring down the whole concept. So I began to feel not only responsible for the centre’s survival, but for the future of the harm reduction approach in Australia more generally.’

While van Beek accepted that as the medical director, she would cop some flak; she felt most for the staff at the centre. ‘They didn’t ask for it. They had to be very careful about their actions. If one or two of them smoked a cigarette outside the building, they could end up in a pixellated photo on the front of one of Sydney’s daily papers, accused of dealing in drugs.’

Beyond the Cross

Given her prominence in the NSW drug and alcohol sector, has van Beek ever been tempted to move on to other roles beyond her Kings Cross health service?

‘Where would I go after Kings Cross?’ she quips. ‘Seriously, I’ve been able to remain here in this role and do many diverse things. Kirketon Road has been the site of some very groundbreaking frontline research, I’ve had the opportunity to also work with the World Health Organization in different countries, to advocate for this as a best-practice model for HIV prevention among commercial sex workers and injecting drug users, and to look at various European models of providing supervised injecting centres.’

One of those many work opportunities also brought personal happiness. On a flight to Indonesia for AusAid in early 2009, van Beek happened to sit next to former Western Australian Premier Dr Geoff Gallop. Now Director of the Graduate School of Government at Sydney University, Gallop was also travelling on AusAid business. The two struck up a conversation and found they had many common interests, including the delivery of primary health care. Gallop later visited Kirketon Road and in April this year, the couple married. ‘They are developing joint projects, coupling her experience of public health management in controversial settings with his academic public sector management program.

The relationship has been a nice reward for van Beek after almost a decade of working in dual management positions. ‘They were long hard years running the two services, so it’s been wonderful to be able to step back out of the firing line and enjoy more of a life/work balance,’ she says.

Message for others

What messages can van Beek share with others working with drug and alcohol issues?

‘I think what the field now really needs to focus on is better communicating the evidence that we have to put pressure on policy makers and legislators to ensure that their policy making really is evidence-based.

‘Ten years ago, I really thought that the injecting centre was going to be the epitome of this type of approach. But if anything, despite the incredible success of more socially progressive approaches to illicit drug use issues, we’ve seen a capitulation in that policy area. So when we health professionals talk evidence, clearly that’s a different type of evidence from when politicians talk evidence.

‘We need to talk in plain language and put a human face on it.

‘At times we felt we had to somehow apologise for wanting to keep people who use drugs alive. That’s horrid. We need to use stronger language and say to politicians, “OK, if you close this, then the first person to die in a back street is your responsibility – their blood will be on your hands”.

‘Most politicians go in there for good reasons, so we need to talk about what is good, what is right, what is for humanity. Most politicians essentially want to make a real difference to people’s lives, but I think we’ve got to pave the way a bit for them.

‘We can do this by sensible discussion with individuals in their offices, not via the front pages of the tabloid newspapers. You never know when a politician is going to have a rush of courage to make a change, and we need to be uppermost in their minds when they do.’

Further reading

van Beek, I 2004. *In the eye of the needle: diary of a medically supervised injecting centre*, Allen & Unwin, Sydney, NSW.
The strong body of research that supports this finding helped inform the Australian Government’s ‘Protecting Children is Everyone’s Business: National Framework for Protecting Australia’s Children 2009-2020’ (Council of Australian Governments 2009).

As the document points out, parental alcohol and other drugs (AOD) abuse, along with domestic violence and parental mental health issues, are ‘the problems most commonly associated with the occurrence of child abuse and neglect and identified in families involved with child protection services’.

However, children in the child protection system ‘are the tip of the iceberg’ (Scott 2009). There are many more children in the wider community with substance-dependent parents. While it is estimated that 60,000 children in Australia have a parent attending drug treatment, tens of thousands of others are likely to be affected by substance misuse of parents who don’t access treatment (Gruenert, Ratnam & Tsantefski 2004).

Other research reveals that approximately 13 per cent of Australian children are exposed to at least one parent who binge drinks regularly (Dawe, Harnett & Frye 2008). Parental alcohol misuse greatly increases the risk of emotional abuse, neglect and physical and sexual abuse (Scott 2009).

Why the increased risk?

When parents engage in substance misuse their ability to parent appropriately is compromised. They are less able to function well, and so they may not be able to attend to caretaking tasks such as preparing meals, washing clothes, and maintaining regular school and bedtime routines. Most importantly, they may not be able to respond to their children’s emotional needs, and parents’ emotional involvement is acknowledged as essential for a child’s development of secure attachment and emotional health (Dawe et al. 2008).

Research indicates that children with substance-dependent parents have more emotional and behavioural problems, higher rates of school failure, and are more likely to develop AOD use and mental health problems than other children (Dawe et al. 2003).

‘Substance-dependent parents tend to have had higher rates of childhood trauma and abuse so they are traumatised people,’ says Menka Tsantefski, lecturer in Social Work at the University of Melbourne. ‘They are often struggling with a range of complex problems along with substance misuse, such as poverty, mental illness, social disadvantage and isolation. In terms of child abuse, they are most often reported for neglect, and neglect opens the child up to many risks, including exposure to a range of other people who may not be safe or appropriate company.’

For her PhD thesis, Tsantefski followed 20 substance-dependent women in the first year of their infants’ lives. By the end of that year, five babies were in foster care, and of those five, four of the mothers had been in care themselves as adolescents. In some cases, the reason was sexual assault by a family member. ‘When you’ve been sexually abused in childhood you’re more likely to have a substance use problem,’ says Tsantefski. ‘These women were more likely to suffer from depression, more likely to be continuing with substance use after the birth of the infant, and using more heavily.’

The cycle of abuse

As reported in the July issue of Of Substance magazine, sexual abuse is strongly correlated with substance abuse. The article ‘Childhood trauma, adult pain’ referred to the findings of Stone and Clifton (2005) that ‘71 per cent of clients accessing sexual assault services with a history of child and adult sexual assault also had combined mental health and drug and alcohol issues’.

The idea that the maltreatment of children is passed down through generations is one of the earliest and most widely accepted theories of why child abuse and neglect happen in the first place, says Dr Adam Tomison, Director of the Australian Institute of Criminology. According to the social learning theory, children learn how to behave from the behaviour of others, in particular their parents. According to the biological/genetics theory, there is an inherited trait that may cause people to behave aggressively towards others.
‘More recently there is an understanding that parents may be abusive or neglectful because of the interaction of genetic and social influences,’ Tomison says.

While some people go on to commit the same harms as their parents did, ‘the reality is that often it’s the emotional trauma or suffering they were exposed to as children that is transmitted, rather than any specific behaviour,’ he says.

‘That is, there is no straightforward link. Those children who grow up to commit maltreatment often commit a different form of maltreatment or violence. It’s more about the fact that they’ve been traumatised, and their approach to dealing with their own children is not appropriate in some way.’ Tomison gives the example of a person who was sexually abused as a child who may go on to be emotionally or physically abusive towards their child, or to neglect them.

‘A lot of work has been done looking at the rates at which young people who have been abused or neglected go on to become abusive or neglectful themselves,’ says Tomison. ‘The most reliable estimate would be that around 30 per cent of maltreated children may go on as adults to commit some kind of maltreatment. The majority won’t, and that’s an important point. Experiencing child abuse does not doom a person to repeat the maltreatment and there are things that can be done to ensure the intergenerational transmission of maltreatment is minimised.’

**Protective factors**

One of the key findings of the ‘Nobody’s Client’ Project, an early intervention program conducted by Odyssey House in Victoria for children whose parents were in treatment for substance dependencies, was that not all children of problem AOD users had major problems. About 55 per cent of the children had minor emotional or behavioural problems, comparable to most other Australian children.

The project identified a number of protective factors including:

- strong family bonds
- clear rules of conduct
- parental involvement in a child’s life
- a positive temperament

SOME FACTS

- Emotional abuse and neglect are now the most commonly substantiated types of child maltreatment, followed by physical abuse.
- Many children experience sexual abuse that is often undetected or not reported.
- The number of children removed from their parents has more than doubled in the last decade.
- Indigenous children are six times more likely to be the subject of child abuse and neglect substantiation than other children.

• a range of problem-solving skills
• successful school performance
• strong bonds with positive institutions such as school and religious organisations.

Clients as parents

‘The client isn’t just someone with a substance misuse problem,’ says Professor Dorothy Scott, from the Australian Centre for Child Protection at the University of South Australia. ‘The client is a person with a range of roles including all their familial roles. The drug and alcohol sector has been slow to recognise that the children of people with a substance misuse problem also need attention.’

Scott has emphasised to both AOD workers and those in the child protection sector the importance of being mindful of the parenting role of clients and of the well-being of their children. ‘Our centre has been encouraging child and parent-sensitive practice in the AOD sector, to address the needs of both the parent and children,’ she says.

To this end, the Centre collaborated with the National Centre for Education and Training on Addiction (NCETA) to conduct a survey of AOD workers and examine factors that influence child and parent-sensitive work practice in the AOD treatment field.

‘The sample [responding to the survey] is small, and it probably is over-represented by AOD workers who are actually very interested in children and parenting, so it gives a rosier picture than is the case,’ says Scott. ‘But still, it highlights the gap between people’s aspirations and the reality.’

Key recommendations emerging from this study, titled Taking first steps – What family sensitive practice means for alcohol and other drug workers: a survey report (Trifonoff et al. 2010), include:

• ensuring that organisations have child-friendly policies and procedures in place
• providing more education and training in child and parent-sensitive practice for AOD workers
• including questions regarding clients’ parenting roles and responsibilities as part of a routine assessment.

For a copy of the NCETA report, visit: www.nceta.flinders.edu.au.

MANDATORY REPORTING

Mandatory reporting — the legal requirement to report suspected cases of child abuse and neglect — exists in all jurisdictions in some form. What varies across Australian states and territories is:

• the people mandated to report
• the abuse types for which it is mandatory to report.

Some states, such as Queensland and Victoria, have a limited number of occupations listed (such as medical practitioners, registered nurses, teachers), while other jurisdictions such as the ACT, South Australia and Tasmania have extensive lists (including pharmacists, dentists, psychologists, police officers, family day care providers).

In some jurisdictions it is mandatory to report suspensions of all recognised abuse types: physical abuse, emotional abuse, sexual abuse and neglect (NSW, Northern Territory, Queensland, South Australia, Tasmania, Western Australia). In others it is mandatory to report only some of the abuse types (ACT, Victoria).

According to the National Framework, in 2007–08 there were 317,526 reports to child protection services in Australia. The vast majority of these reports (more than 80 per cent) were not substantiated, and ‘in these cases, other forms of support would have been a more appropriate response’.

While acknowledging the need to report suspected child abuse and neglect, Dr Adam Tomison has two main concerns about the value of mandatory reporting. ‘First, there is a “fire and forget” mentality, where some professionals take the view that after making a report, their obligation is finished. Often these professionals can play key roles in ongoing work with the family to reduce the risk of harm to a child. Second, the extent of mandatory reporting has flooded the system with suspected maltreatment cases, and sifting through the many cases where maltreatment isn’t confirmed makes it harder for child protection workers to identify and focus on the cases where the child is at real risk.’

But physical or sexual assault is a crime and must be reported, says Menka Tsantefski. ‘There is what’s called “a hierarchy of interventions and strategies” beginning with supporting the mother and child, and then moving on to helping the perpetrator deal with their difficulties and problems. The child’s safety is critical, so I would not handle a child sexual assault, nor would I encourage anyone else to. It’s a specialised field.’

HELP FOR PARENTS UNDER PRESSURE (PuP)

The intervention program Parents under Pressure (PuP), established in 1999, has won the Prevention Category of the 2010 National Drug and Alcohol Awards. The program was developed by Sharon Dawe, Professor in Clinical Psychology at Griffith University, and Dr Paul Harnett, Senior Lecturer in Psychology at the University of Queensland to address the relationship between parents’ substance misuse and poor outcomes for their children.

The PuP program is delivered on a one-to-one basis in the family’s home by a trained therapist over a 10-12 week period. The unique needs of each family are taken into account and the program is adjusted accordingly. Modules include ‘View of Self as a Parent’; ‘Managing Emotions When under Pressure’; and ‘Managing Substance Use Problems’.

In 2009, the results of a five-year study in the United States found that the program significantly lowers rates of child abuse injuries and foster care placements when offered to parents community-wide (Prinz et al. 2009). It was the first large-scale study showing that when all families are provided with proven parenting information and support, and not just families at risk, rates of child maltreatment are reduced.

For more information about the Parents under Pressure program, visit: www.pupprogram.net.au.

POSITIVE PARENTING PROGRAM

The internationally acclaimed Triple P – Positive Parenting Program, developed at the University of Queensland, has twice won the National Violence Prevention Award from the Commonwealth Heads of Government in Australia. Based on 30 years of clinical research, it is an evidence-based support strategy for parents and families. It aims to prevent behavioural, emotional and developmental problems in children by both developing the knowledge and skills of parents and building their confidence.

The program is made up of five levels of intervention for parents of children and adolescents from birth to the age of 16. These levels increase in strength and intensity, depending on the needs of the family. For example, while Level 1, or ‘Universal Triple P’, provides brief information on how to solve developmental and minor behavioural problems for all parents, Level 5 includes ‘Pathways Triple P’ for parents at risk of maltreating their children, targeting anger management problems and other factors associated with abuse.

In 2009, the results of a five-year study in the United States found that the Triple P program significantly lowers rates of child abuse injuries and foster care placements when offered to parents community-wide (Prinz et al. 2009). It was the first large-scale study showing that when all families are provided with proven parenting information and support, and not just families at risk, rates of child maltreatment are reduced.

For more information about the Triple P – Positive Parenting Program, visit: www.triplep.net.
Cannabis: The gap between law and enforcement

Snapshot of cannabis laws

Jenny Tinworth, Simon Lenton* and Ana Rodas**

Cannabis is the most widely used illicit drug across Australia. Figures from 2007 show that one in three Australians aged 14 years and older had used cannabis in their lifetime. Of these, almost one in ten had used it in the last year.

It is illegal to use, possess, grow or sell cannabis in Australia, however the penalties for cannabis offences differ across jurisdictions. While in all states and territories it is a criminal offence to possess a commercial or traffickable quantity of cannabis, the amount of cannabis which is deemed to be a ‘small amount’ – and likely to be for personal use – differs from one state or territory to the next (see Table 1).

The territories and two states (SA and WA) have decriminalised minor cannabis offences, such as the possession of ‘small amounts’. Decriminalisation means that the offence can be dealt with by civil penalties without the offender receiving a criminal conviction. What happens if an offender fails to pay the penalty varies between jurisdictions (however, see note about changes in WA in Table 1 below). In other Australian states, any cannabis offence is seen as a criminal offence. This means that someone charged with possession of cannabis in these jurisdictions can receive a large fine or even prison time and will have a criminal record.

Each jurisdiction takes one of two approaches to the possession of cannabis for personal use, with minor variations:

1. Decriminalisation

Minor cannabis offences are dealt with by way of a civil penalty (similar to a parking infringement notice) rather than as a criminal offence. The ACT, SA, WA and NT have adopted this strategy.

2. Criminal offence

Tasmania, Victoria, NSW, Queensland and effectively now WA, treat possession of small amounts of cannabis as a criminal offence, punishable by a criminal conviction, a large fine and/or prison time. However, in these states a first offender is unlikely to receive a criminal conviction. Instead they are likely to be cautioned and moved into a diversion program*, which aims to keep non-violent drug offenders out of court.

Table 1 – Minor offences in jurisdictions that have decriminalised cannabis

<table>
<thead>
<tr>
<th>Jurisdiction (year of initiation)</th>
<th>Maximum amount of cannabis to which these penalties apply</th>
<th>Exclusions</th>
<th>Penalty</th>
<th>Alternatives to paying penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>SA (1987)</td>
<td>• 100 grams plant material • 20 grams resin • 1 plant</td>
<td>Artificial cultivation; cannabis oil</td>
<td>$50–$150</td>
<td>Criminal conviction</td>
</tr>
<tr>
<td>ACT (1992)</td>
<td>• 25 grams plant material • 2 plants</td>
<td>Artificial cultivation; cannabis resin and oil</td>
<td>$100</td>
<td>Attend the Alcohol and Drug Program, an assessment and treatment program</td>
</tr>
<tr>
<td>NT (1996)</td>
<td>• 50 grams plant material • 10 grams resin • 1 gram oil • 10 grams seed • 2 plants</td>
<td></td>
<td>$200</td>
<td>Debt to state, no conviction – juveniles are sent to assessment</td>
</tr>
<tr>
<td>WA (2004)*</td>
<td>• 30 grams plant material • 2 plants</td>
<td>Artificial cultivation; cannabis resin and oil</td>
<td>$100–$200</td>
<td>Attend an education session</td>
</tr>
</tbody>
</table>

*Note: Although the repeal of the WA cannabis infringement notice scheme and establishment of a new cautioning scheme is yet to pass Parliament, WA police have been charging cannabis users with a criminal offence.

Table 2 – Diversion programs for minor cannabis offences

<table>
<thead>
<tr>
<th>Jurisdiction (year of legislation)</th>
<th>Maximum amount of cannabis for option of diversion</th>
<th>Maximum number of cautions</th>
<th>Diversion program description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAS (1998)</td>
<td>• 50 grams</td>
<td>3 in 10 years</td>
<td>• First offence: caution plus information and referral</td>
</tr>
<tr>
<td>VIC (1998)</td>
<td>• 50 grams</td>
<td>2 years</td>
<td>• Cautioning notice plus voluntary education program</td>
</tr>
<tr>
<td>NSW (2000)</td>
<td>• 15 grams</td>
<td>2 years</td>
<td>• Caution, plus information and referral</td>
</tr>
<tr>
<td>QLD (2001)</td>
<td>• 50 grams</td>
<td>1 year</td>
<td>• Mandatory assessment and brief intervention session</td>
</tr>
<tr>
<td>WA (proposed)</td>
<td>• 10 grams</td>
<td>1 year</td>
<td>• Mandatory assessment and cannabis intervention session</td>
</tr>
</tbody>
</table>
away from the criminal justice system and into education and treatment programs (see Table 2). It is usually up to the arresting police officer to decide whether to divert or charge someone with a cannabis offence.

*It is important to acknowledge that police diversion takes place

Law is one thing, enforcement is another

The summaries of the legislation on cannabis in the eight Australian states and territories (see tables on page 24) highlight the diversity of approaches taken to address this drug through the criminal justice system. The diversity exists despite strenuous efforts, over many decades, to produce uniform legislation – a goal unlikely to be achieved so long as we maintain Australia’s current constitutional arrangements. This means that we have a diverse range of legislation, and diversity in how this legislation is implemented on the ground by the police services.

So how can we gain insights into how cannabis law is actually policed in Australia? One approach is to review the number of arrests of cannabis consumers and providers. The key information source is the Australian Crime Commission’s (ACC’s) Illicit Drug Data Report (IDDR), published annually and available online at www.crimecommission.gov.au/publications/iddr/index.htm. The ACC compiles the cannabis arrests data from information provided by the Australian Federal Police and the state/territory police services. They have a difficult task in this, owing to the divergence of legislation and data systems across the country.

They use the term ‘arrest’ to cover the many different forms of law enforcement action provided for in legislation, including actual arrests for cannabis offences and apprehensions (the issuing of infringement notices) under the civil penalty regimes that operate in WA, SA, NT and ACT.

Cannabis consumers and providers

The published data differentiate between cannabis consumers and cannabis providers. In the 2007-08 year there were, nationally, 44,374 consumer arrests and 7,460 provider arrests, a total of 52,465 (the components do not sum to the total owing to missing data). This means that 86 per cent of all cannabis arrests were of consumers, and just 14 per cent were of providers. Furthermore, cannabis consumers were 57 per cent of all drug arrests, for all drugs, in Australia that year.

State and territory differences

The first table (see right) highlights the huge differences in policing cannabis across Australia. Perhaps most prominent is the high rates of arrests in SA, NT, Queensland and Tasmania, and the low rates in the ACT, Victoria and NSW. When we exclude the civil penalty offences (legislated in SA, WA, the NT and the ACT) the pattern changes markedly, as shown in the second table.

The question jumping out of these data is this: what is happening in Queensland and Tasmania? Why are their cannabis arrest rates so high – six times that of the ACT, for example – noting that these are actual arrests, the figures do not include the civil penalty-type infringements?

One possibility is that much higher proportions of the Queensland and Tasmanian populations use cannabis than in the other jurisdictions, but that is not borne out by survey data. The other explanation is that the policies of the Queensland and Tasmanian police services, and/or the way that the policies are interpreted by operational police, result in such high levels of arrests.

Australia’s National Drug Strategy has at its core the principle of harm minimisation. One might well ask, is this principle really being observed given that over half of all drug arrests are simply cannabis consumers, and the likelihood of being arrested, charged and gaining a cannabis-related conviction in two states is hugely higher than in the other states and the territories? Is there a distributive justice issue here that demands attention? Shouldn’t the principles of fairness and consistency in drug legislation and its administration apply equally across Australia?

Cannabis arrests, 2007-08, including civil penalty notices

Cannabis arrests, 2007-08, excluding civil penalty notices

*David McDonald is a Visiting Fellow at the National Centre for Epidemiology & Population Health, ANU

*Simon Lenton is a director with the National Drug Research Institute; **Ana Rodas is a research officer with the National Cannabis Prevention and Information Centre
Achieving excellence

Jenny Tinworth

The National Drug and Alcohol Awards were held in Brisbane during Drug Action Week in June. The annual awards recognise outstanding achievements in addressing drug research, education, prevention and treatment. The most prestigious honour is the Prime Minister’s Award, while awards for excellence are given to programs or people in a diverse range of categories. Each year, several individuals are also inducted into the drug and alcohol sector’s Honour Roll.

The awards are organised by the Ted Noffs Foundation, the Australian Drug Foundation, the Alcohol and Drug Council of Australia and the Australian National Council on Drugs. Sponsors included the Australian Government’s Department of Health and Ageing, Queensland Government, AER Foundation and Brisbane City Council.

Each year, the Prime Minister’s Award is given to an individual who has made a significant commitment and contribution to reducing the impact and negative effects of drug and alcohol use.

This year’s recipient was Garth Popple, who is the Executive Director of We Help Ourselves (WHOS) which operates six residential therapeutic communities within New South Wales and Queensland. Popple began his career in the substance use field in 1981, and along with his work at WHOS, he is also an Executive Member of the Australian National Council on Drugs (ANCD), Board Member and Past President of the Australasian Therapeutic Communities Association (ATCA), and President Elect of the International Federation of Non-Government Organisations (IFNGO).

In his acceptance speech, Popple called for improved funding and commitment to diverse forms of drug treatment, including programs which embrace abstinence and those that work with harm reduction measures. He urged people working in the non-government sector to take an international perspective towards drug treatment and to support the efforts of non-government agencies in other countries.

He also urged for increased support for the self-help movement and for the families of people who use drugs.
The Parents under Pressure (PuP) program from Queensland won the Excellence in Prevention Category at the National Drug and Alcohol Awards. Established in 1999, the PuP program was developed in response to the well-established link between high-risk families with parental substance abuse and poor child outcome. By interacting with parents with substance abuse in their own homes, the PuP aims to improve the well-being of the children. Initially developed to improve child-related outcomes in families on methadone maintenance, the program has been used with Indigenous communities, the families of women leaving prison and families referred by child protection services.

The other two finalists in this category were the ReSet program developed by the Manly Drug Education and Counselling Centre; and the Groote Eylandt Substance Use and Mental Health Project.

A set of television community service announcements produced by Goolarri Media Enterprises in Broome, Western Australia, won the Excellence in Media Category. With extensive participation by local Indigenous youth, Goolarri developed a unique media strategy with a succession of layered television commercials. The six commercials highlighted different aspects of harmful alcohol consumption. The overall campaign successfully addressed issues such as recognising alcohol poisoning, social and peer pressure, making healthy choices, and negative health effects of drinking.

The other two finalists in the Media category were Kirrilly Burton of Sydney for her article ‘The new face of Drug Addiction’ published in *The Medical Observer*; and the Brisbane Indigenous Media Association’s Young, Strong and Proud Project.

The award for Excellence in Services to Young People went to Newcastle City Council’s Loft Youth Arts and Cultural Centre. The Loft is an incubator of arts projects, a hub for social inclusion, and a centre for skill and leadership development for young people. Loft’s drug and alcohol free arts events and activities engage young people as organisers and managers of their own events. Established a decade ago, more than 200 000 young people have accessed the Loft’s services with some 45 to 60 events staged annually.

The other two finalists in this category were the Hello Sunday Morning online blog program; and BushMob, a grassroots community-driven project for young people in Alice Springs.
Mt Isa’s ‘BEER’ program was the winner of the Excellence in Law Enforcement Award. The acronym is short for Guide to Liquor Enforcement – Best Analysis, Enforcement, Education and Relationships.

Developed by the Queensland Police Service in Mt Isa, the BEER model has proven to be so successful it is now recognised as a best-practice model for the Queensland Police Service. A key feature of the proactive enforcement operations in Mt Isa has been a reduction in ‘glassings’ from nine in 2007 to zero over 2009.

A key factor in the success of the new Liquor Accord has been the detailed analysis performed by Mt Isa police officers which has enabled them to act proactively, developing an enforcement schedule which has resulted in an increase in the number of liquor offences detected, as well as a reduction in service calls to licensed premises.

The other two finalists in the Law Enforcement category were the Assertive Youth Outreach Service (AYOS), a partnership between Victoria Police and the Youth Substance Abuse Services (YSAS); and the Weed it Out Project, a partnership between the Queensland Police Service in Cairns and the James Cook University.

‘The Liquor Accord underpinning the BEER model is a collaborative venture between police, licensees, local council and transport services, which has successfully reduced alcohol-related crime.’

The University of Queensland’s Dr Adrian Carter’s ‘Researching Addiction Neuroethics’ project won the Excellence in Research category.

Addiction neuroethics addresses the central question: Do addicted persons have the capacity to make autonomous decisions regarding their substance use? By highlighting the neurobiological changes that focus attention on drug taking and make it more difficult not to use drugs, the hope is that a neuroscience-based understanding of addiction will lead to more humane and effective treatment of those with an addiction.

Dr Carter’s work in the University’s Centre for Clinical Research has highlighted the importance of placing treatment of substance-using people into a human rights framework, rather than using coercive models. Dr Carter’s work has been recognised internationally by the World Health Organization and the United Nations Office of Drugs and Crime.

The other finalists in the Research category were the Groote Eylandt Substance Use and Mental Health Project; and the National Drug and Alcohol Research Centre’s Drug Trends Project.

‘The strategic focus of the group’s research is to analyse public health policy and ethical issues raised by genetic neuroscience research, and their applications to treatment and prevention of drug use and addiction.’
This year, two people were inducted into the National Drug and Alcohol Awards Honour Roll. Western Australia’s Professor Dennis Gray was recognised for the major contributions he has made to addressing alcohol abuse in Australian Indigenous communities over more than a decade, while Canberra’s Lynne Magor-Blatch was acknowledged for her work in the therapeutic community movement for over 30 years.

South Australia’s cross-sectoral Adolescents and Alcohol Initiative was the winner of the School Drug Education Category.

Concluded in December 2009, the project involved 38 government and independent schools. Drawing on key state and federal alcohol-related strategies, the project supported school leaders and teachers to build positive school cultures that promote resilience across the four domains of practice – school environment, policy and procedures, partnerships, and curriculum. This involved teachers in an inquiry-minded improvement approach to promote a deeper understanding of issues, dynamics and consequences of adolescent alcohol use; as well as good practice in teaching and learning consistent with recognised principles for school drug education.

Other finalists in this category were the Drug Education in Victorian Schools Project; and MAKINGtheLINK – a school-based program in Victoria focusing on cannabis use and mental health problems.

‘The initiative provided an opportunity to strengthen or extend alcohol education through the broad and inclusive participation of young people, to involve parents and community, and share learning with colleagues.’
3-5 November
Creating Synergy Drug and Alcohol Conference
Wollongong, NSW
www.creatingsynergy.org.au

17 November
Addiction: The case for recovery in a changing world
London, UK
www.medineo.org

26 November
Talking Point Seminar
Fitzroy, Vic
Ph: (03) 8413 8413

28 November – 1 December
Australasian Professional Society on Alcohol and other Drugs (APSAD) conference
Canberra, ACT
www.apsadconference.com.au

9-11 February 2011
Sport and Alcohol: Finding the balance conference
Auckland, NZ
www.sportandalcohol.com

7-8 March 2011
Young people, risk and resilience: The challenges of alcohol, drugs and violence conference
Melbourne, Vic
Ph: (02) 6260 9272, email: aic.events@aic.gov.au

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