

OF SUBSTANCE

NOVEMBER 2011
VOL. 9 NO. 3

THE NATIONAL MAGAZINE ON ALCOHOL, TOBACCO AND OTHER DRUGS

FEES FOR PHARMS:

**An unfair
burden?**

**BANNED:
SYNTHETIC HIGHS**

**ALCOHOL RESTRICTIONS
PAY OFF**

**CLINICAL PRACTICE:
WHERE'S THE
EVIDENCE?**

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- *Of Substance* is a free magazine published every four months
- Inquiries about overseas subscriptions and for bulk orders (over 10 copies) to distribution@ancd.org.au

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Of Substance is an Australian National Council on Drugs (ANCD) initiative and is produced with funding from the Australian Government Department of Health and Ageing. The Salvation Army (New South Wales) Property Trust has been contracted to provide financial and administration services for *Of Substance*.

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The magazine is designed by Rebecca Horsburgh and printed by GEON.

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Editor's *Letter*

Welcome to the November issue of *Of Substance*.

The provision of methadone and buprenorphine to people dependent on opiates has always been controversial, even in the way it is delivered. Some clients are asked to pay for their 'dose of 'done', yet others aren't.

While many people would consider that paying for any pharmaceutical treatment is a reasonable ask, the cost does have a significant, and often negative, impact on clients. We explore those impacts in our cover article, which begins on page 10.

In the months since we last published, there has been rapid action on synthetic cannabinoids, sometimes known as 'synthetic highs'. Governments have banned the chemicals used, and there has been widespread media attention to problems with these drugs. We invited Gideon Warhaft to explore the subject and talk about the latest developments. His report begins on page 14.

Of Substance's primary readership is people who work on the frontline of drug and alcohol problems. We constantly hear the refrain of 'evidence-based practice' in any discussion about the best way to provide help to people experiencing difficulties in this area. But, what if you are a clinician and you can't find the evidence? Or your clients are young people and the available evidence only talks about what works with adults? Researchers Nicole Lee and Linda Jenner share their thoughts on the steps a clinician can take when confronted with this dilemma.

And finally, we bring you extended coverage of the alcohol and other drug sector's night of nights: the National Drug and Alcohol Awards. This is an important occasion which honours the best programs and people working with drug use.

Look out for regular e-Bulletin updates between now and the next print issue of the magazine (March 2012). To be on our mailing list, visit www.ofsubstance.org.au.

As always, we love to hear from readers by emailing editor@ancd.org.au.

Jenny Tinworth
Managing Editor

Guest editorial

The push for access and equity

Nicole Wiggins,
Manager, Canberra Alliance for
Harm Minimisation and Advocacy
(CAHMA)



The benefits of pharmacotherapy treatment are well documented and widely accepted. Yet, as discussed in the article 'Fees for pharmacotherapy: an unfair burden?' (see pages 10-13), all the positive outcomes achieved through pharmacotherapies are meaningless if consumers simply cannot afford to enter or stay on a program.

All state and territory drug user organisations are frequently contacted by clients who are unable to pay pharmacotherapy fees and are facing involuntary removal from programs. At the national level, the Australian Injecting & Illicit Drug Users League (AIVL) has been working on documenting the cost of pharmacotherapies and has found the cost to consumers ranges from \$15 a week (ACT) to \$80 a week (WA). Consequently, it is recommending urgent policy reforms in order for low-income and highly marginalised clients to gain access to pharmacotherapy which the World Health Organization has declared an essential medication.

One option to address this issue of equity is that legislation be passed to allow for dispensing fees to be included on the Pharmaceutical Benefits Scheme. Another option would be to adopt the subsidy system that operates in the ACT, where consumers pay \$15 a week and the remainder is covered by the ACT Government. This subsidy system is very successful and was negotiated by consumers and drug user organisations. It means that ACT consumers do not experience the weekly stress and anxiety related to high fees that so often disadvantage our interstate counterparts.

Given that unmet need for pharmacotherapy has an upper estimate as high as 49 per cent (which equates to around 40 000 people), it is clear that many people are missing out on the benefits of treatment. Every day, drug user organisations see people who are unable to access treatment, whether this is due to long waiting lists or simply because they cannot afford the fees. At the same time, we also see those whose lives have been changed for the better by being on pharmacotherapy treatment.

In partnership with our national organisation, AIVL, we will continue to lobby and advocate for policy changes that promote access and equity and work towards a system where all those who could benefit and improve their lives through treatment, have the opportunity to do so.

News

Synthetic cannabinoid ban



Eight synthetic cannabis-like substances have been classified as prohibited substances throughout Australia as of July, following the initial push from Western Australia to ban the substances. Little is known about the long-term health effects from continued

use of these substances, however there have been widespread reports of abuse and symptoms, including severe hallucinations, psychosis and heart palpitations. The drugs mimic the effects of existing illicit substances, but have not been uniformly illegal across Australia because they fell outside current controls. *Read our full discussion of this issue on pages 14-17.*

New expert advisory council

The creation of an expert advisory council for the Australian National Preventive Health Agency (ANPHA) to prevent the lifestyle risks of chronic disease in Australia was announced in July. Ten expert members have been appointed to the new advisory council, headed by Professor Christine Bennett, Dean of Medicine, Sydney at the University of Notre Dame Australia. Members of the Advisory Council have been appointed until 6 July 2014.

Drug Action Week 2011

More than 750 activities across Australia registered for Drug Action Week (DAW) 2011 to raise awareness of alcohol and other drugs issues, and to promote the achievements of the frontline workers who strive to reduce drug-related harm.

Initiated by the Alcohol and other Drugs Council of Australia (ADCA) with funding support from the Department of Health and Ageing, DAW 2011 ran from 19-25 June. CEO of ADCA, Mr David Templeman, said that everyone from the health, education, treatment, rehabilitation, community, policing, local government and media sectors were to be congratulated for throwing their support behind DAW 2011.

A round up of DAW 2011 activities can be found at: www.drugactionweek.org.au/index.php.

INTERNATIONAL News

New definition of addiction



In August, the American Society of Addiction Medicine (ASAM) released a new definition of addiction, highlighting that addiction is a chronic brain disorder and not simply a behavioural problem involving too much alcohol, drugs, gambling or sex. This is the first time ASAM has taken an official position that addiction is not solely related to problematic substance

use. *For more information, visit the ASAM website: www.asam.org/.*

UNODC World Drug Report

The 2011 World Drug Report was released by UNODC in June. This annual report highlights developments across the global drug market to explain the factors that drive the world's consumption, production and trafficking of illicit drugs. Report highlights include findings of a decrease in world production of opium and cocaine, however manufacture of amphetamine-type stimulants appears to be increasing. *The report is available to download from the UNODC's website: www.unodc.org/.*

Global Commission condemns war on drugs

The global war on drugs has failed and governments should explore legalising marijuana and other controlled substances, according to a report released in June by the Global Commission on Drug Policy. The 19-member commission includes former UN chief Kofi Annan and former US official George Schultz. Others include former chairman of the US Federal Reserve Paul Volcker,

former presidents of Mexico, Brazil and Colombia, the businessman Sir Richard Branson and the Greek prime minister, George Papandreou. Instead of punishing users, who the report says 'do no harm to others', the commission argues that governments should end criminalisation of drug use; experiment with legal models that would undermine organised crime syndicates; and offer health and treatment services for people who use drugs. *The report is available at: www.globalcommissionondrugs.org/.*

NZ bans synthetic cannabinoids

A law banning synthetic cannabis products in New Zealand will be in place by August, and all 43 products currently available are expected to be out of shops just over a week later. The NZ Government's Cabinet approved amendments to the Misuse of Drugs Amendment Bill that will take synthetic products such as 'Kronic' off the market for 12 months while the government works on its detailed response to a recent Law Commission report. The government has signalled that it is looking at a recommendation to reverse the onus of proof and require the industry to prove its products are safe.

People IN PROFILE

CEO for Preventive Health Agency announced



Ms Louise Sylvan has been appointed as the first CEO of the Australian National Prevention Health Agency, which is a major element of the government's national health reform agenda. Ms Sylvan was previously a

Productivity Commissioner, having been appointed to that role in 2008 and is known for her work in enhancing consumer rights in a range of areas such as health, food safety, and financial services as well as in competition and consumer policy.

New AIHW Chair



The acting Minister for Health and Ageing Mark Butler announced in July that Dr Andrew Refshauge has been appointed as the new Chair of the Australian Institute of Health and Welfare (AIHW) for a three-year term. Mr Refshauge is a

former New South Wales Deputy Premier, Treasurer and Health Minister, and an experienced medical practitioner.

In the alcohol and other drugs sector

Associate Professor Alison Ritter was elected in May to the position of interim Board Vice-President of Alcohol and other Drugs Council of Australia.

Mr Paul Bird has been appointed the new CEO of the Youth Support & Advocacy Service. Mr Bird will be leaving his current role as State Director Victoria of Mission Australia to take up the position.

LIMITED EDITION PRINTS

The National Indigenous Drug and Alcohol Committee (NIDAC) is raising funds to support workers to attend the 2012 NIDAC Conference - *Beyond 2012: Leading the Way to Action*, and is seeking your assistance to help make a difference by purchasing a high resolution limited edition print, in either quality paper print or canvas, of the vibrant painting *Diversity of One Working Together*, 2010, crafted by well known Aboriginal artist Mr Max Mansell.

'DIVERSITY OF ONE WORKING TOGETHER' Year: 2010



Max is a leading Australian Aboriginal artist from the Oyster Bay area and the Big River language groups in Tasmania. *Diversity of One Working Together* was crafted by Max to celebrate and acknowledge the importance of the inaugural National Indigenous Drug and Alcohol Conference held in Adelaide in 2010. Max donated *Diversity of One Working Together* for the purposes of raising funds for the next conference.

To find out more about this offer and to order your copy, visit <http://www.nidac.org.au/> or contact the NIDAC Secretariat on 02 6166 9600, or email nidac@ancd.org.au. For further information about the Conference visit <http://www.nidaconference.com.au/> phone 07 3334 4400 or email info@eventcorp.com.au.

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REPORT Round-up

DUMA report highlights poly drug use

In August, the Australian Institute of Criminology (AIC) released a report on poly drug use by 3852 police detainees who were interviewed through the Drug Use Monitoring Australia (DUMA) program, of which 44% were poly drug users. The DUMA program combines confidential interviews with police detainees (only) and urine tests to build a picture of detainee crime and drug-use behaviours, and for this analysis focused on poly drug use. Nearly a third of detainees reported using two or more drugs in the 30 days prior to being detained. The most commonly recorded poly drug use combination was cannabis and amphetamine (30%), although in the majority of cases, cannabis was used more frequently than amphetamine. One in 10 poly drug users used cannabis and heroin as their primary and secondary drugs of concern. **The report is available on the AIC website: www.aic.gov.au.**

Smoking rates fall, illicit use rises

The number of people who smoke continues to fall, but levels of risky alcohol use remain unchanged and illicit drug use has increased. These are some of the key findings of the 2010 National Drug Strategy Household Survey report, which was released in late July. The 2010 survey had more than 26 000 respondents, aged 12 and over. The findings are compared to previous surveys to show trends in drug-related attitudes and behaviours.

In the 2010 survey, the proportion of people aged 14 years or older smoking daily (15.1%) declined, continuing a downward trend that began in 1995.

The largest falls in daily smoking were among people in their early 20s to mid-40s. Despite this decline in the percentage of Australians smoking tobacco, the number of smokers has remained stable

between 2007 and 2010, at about 3.3 million.

Recent illicit drug use rose in 2010, with people aged 14 or older who had used illicit drugs in the previous 12 months rising from 13.4% to 14.7% between 2007 and 2010.

A summary of the report can be found in our September e-Bulletin, available at www.ofsubstance.org.au. **The full report is available from the AIHW website: www.aihw.gov.au.**

ACOSS survey



More people have been turning to community and social services groups for help, leaving services unable to meet the growing demand, according to the *Australian Community Sector Survey 2011*, released in August by the Australian Council of Social Services (ACOSS). The survey provides a comprehensive picture of how the non-government community services and welfare sector is travelling, and this year shows a 12% increase in assistance provided by agencies. Respondent organisations (745) provided services on 6,180,282 occasions in 2009-10 compared to 5,513,780 instances in 2008-09. Despite the overall increase in services delivered, the majority of organisations (55%) indicated that they were still unable to meet the demand for their services. People were denied services on approximately 345 000 occasions, equating to more than 1 in 20 eligible people seeking social services being turned away. This represents a 19% increase on the 298 000 people turned away in 2008-09. **The report is available on the ACOSS website: www.acoss.org.au.**

Clan lab detections up 245%

The Australian Crime Commission (ACC) released in June its *Illicit Drug Data Report 2009-10* (IDDR)

which reported on 694 dangerous clandestine laboratories detected nationally, representing an increase of 245% since 2000-01. Other key findings from the report include:

- Over 85 000 illicit drug related arrests were made in 2009-10 – the highest in the last decade.
- Drug types that recorded the most substantial increase in arrests over the last decade are cocaine and amphetamine-type stimulants, increasing by 91% and 58% respectively.
- The 63 670 national illicit drug seizures in 2009-10 is the second highest reported in the last decade.
- Over 7.8 tonnes of illicit drugs were seized nationally in 2009-10.

The IDDR is released annually by the ACC and is drawn from law enforcement, forensic laboratories and government agencies across the country. **A copy of the report is available at the ACC website: www.crimecommission.gov.au.**

Older Australians and heroin dependence

The number of Australians receiving pharmacotherapy treatment for dependence on opioid drugs such as heroin continues to rise, and the proportion of older clients is also increasing, according to a report released in June by the Australian Institute of Health and Welfare (AIHW). The findings of the *National Opioid Pharmacotherapy Statistics Annual Data Collection: 2010* report show that on a snapshot day in 2010 there were over 46 000 clients who received pharmacotherapy for opioid dependence.

The report notes a rise of just over 2600 clients between 2009 and 2010 which is consistent with the growth of pharmacotherapy treatment seen in recent years. Since 2006, the proportion of clients aged 30 years and over rose from 72% to 82%, and the proportion of clients aged under 30 fell in 2010. Also consistent with findings in previous years, methadone was the most common pharmacotherapy drug, with close to 7 out of 10 clients receiving this form of treatment. **The report can be downloaded from the AIHW website: www.aihw.gov.au.**

IDRS and EDRS 2011 report: Key findings

Natasha Sindicich and Jenny Stafford*



IDRS findings

The Illicit Drug Reporting System (IDRS) is a monitoring program which annually maps drug trends in capital cities across the country. Surveying people who inject drugs (IDU) and others who work in the illicit drug area (for example, police and 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 use.

Key findings from the 2011 IDRS study include:

- Heroin remained the most commonly reported drug of choice for participants who inject drugs. Its use, frequency and price remained stable. Availability was reported as 'very easy' or 'easy' and purity 'low' or 'medium'.
- Nationally, the recent use of speed and base remained relatively stable, while the recent use of ice/crystal was higher (39% in 2010 vs. 45% in 2011). The frequency of use of 'any form' of methamphetamine (speed, base and/or ice/crystal), was higher in 2011 (14 days in 2010 vs. 19 days in 2011). The availability of all

forms was reported as '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 of cocaine was lower (but not significant; 57% in 2010 vs. 47% in 2011); however the frequency of cocaine use was stable. Elsewhere, cocaine 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 11% 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.

EDRS findings

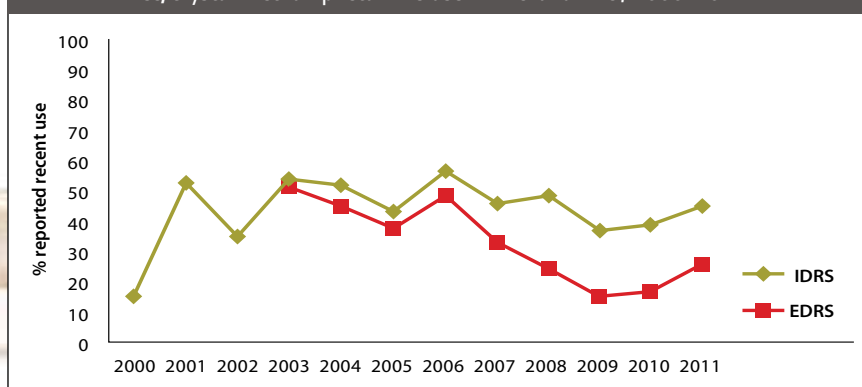
Since 2003, the IDRS has been coupled with a national survey of people who regularly use ecstasy (REU). The Ecstasy and Related Drugs Reporting System (EDRS) maps illicit drug use trends in a different population of people who tend to frequent nightclub and entertainment events. It also draws on other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

Key findings from the 2011 EDRS study include:

- Ecstasy remains the drug of choice for 27% of the REU sample. Cannabis (20%), followed by cocaine (14%) and alcohol (11%) are next in terms of preference. This marked a continued decrease in the preference of ecstasy for this group from 2009.
- Ecstasy consumption patterns remained stable, however market characteristics signified a change in trend. National and global indicators have suggested a decrease in purity of ecstasy's key ingredient MDMA. Conversely this year, REU report that ecstasy is significantly easier to obtain.
- Ice/crystal meth, the most potent form of methamphetamine, reported



Ice/Crystal methamphetamine use in IDU and REU, 2000-2011





an increase from 12% to 26% with the other forms of speed powder and base staying at stable low levels. Days of use remained low at monthly or less often across all forms.

- Recent cocaine use has remained stable this year comparable to levels and market characteristics to 2010.
- Interestingly, we have seen increases in 2011 of the use of the more 'niche' classes of drugs of ketamine (12% to 16%), LSD (38% to 46%), MDA (5% to 12%) and magic mushrooms (18% to 29%). Sporadic use of less than monthly is still reported.
- Prescribed and non-prescribed use of benzodiazepines has also reportedly increased (32% to 43%) in this group.
- Emerging Psychoactive Substances (EPS) including synthetic substances known as mephedrone continue to be reported at low levels by this group. The drugs in this class reported at the highest rates were mephedrone (13%), DMT (13%) and 2CB (8%) with the majority of use in Victoria, Tasmania and South Australia.

For further information please see: www.ndarc.med.unsw.edu.au and click on 'Drug Trends'.

Editor's note: Surveys such as the IDRS and the EDRS provide useful data on current and emerging drug use. To gain the most accurate picture of Australian substance use, these reports should be read in conjunction with other data sources, including but not limited to, the National Drug Strategy Household Survey, treatment data, needle and syringe program surveys, ambulance and hospital emergency department records and data collections maintained by police and the criminal justice system.

***Natasha Sindicich and Jenny Stafford write from the National Drug and Alcohol Research Centre.**

National Drugs Campaign app

The National Drugs Campaign has launched an iPhone app, which allows users to access illicit drug information and advice at a touch of a finger. Aimed at parents and young people, the app includes information on: ecstasy and other illegal drugs; consequences of drug use; advice for young people on avoiding drug use and helping friends; tips for parents on talking to their teens about drugs; and support contacts for youth and families. Featuring GPS functionality, the app helps people find support services based on their location.

The app is available free from the Apple iTunes online store: <http://itunes.apple.com/au/>.



National Minimum Data Set 2011-12

The Australian Institute of Health and Welfare has released its latest manual. The manual has been prepared as a reference for those involved in collecting and supplying the data for the AODTS-NMDS. It should be particularly useful to staff in Australian government, state and territory departments, and alcohol and other drug treatment agency staff directly involved in the collection and reporting of the data set. **Download the manual at: www.aihw.gov.au/.**

Resources

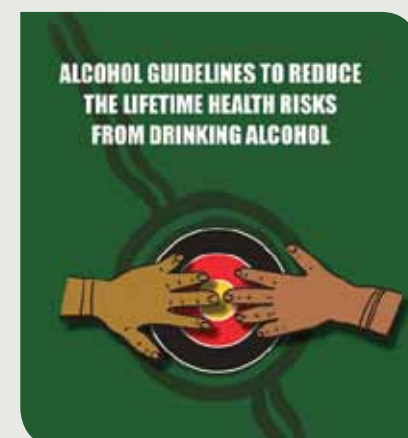
Clinical practice guidelines

Health professionals will have access to the best quality information on diagnosis and treatment with the introduction of the National Health and Medical Research Council's new Standard for Clinical Practice Guidelines (2011 NHMRC Standard). The publication sets out the quality process Australian guideline developers need to follow to produce a world-class resource. It draws on international best practice to support government health reform by contributing to an evidence-based and high performing health system.

More information, including a summary document and the 2011 NHMRC Standard, can be accessed at: www.nhmrc.gov.au/guidelines/information-guideline-developers.

Drinking guidelines for Indigenous communities

As part of the 2011 NAIDOC Week in July, the Aboriginal Drug and Alcohol Council (SA) Inc. (ADAC) launched its revised resource of the National Health and Medical Research Council Australian Drinking Guidelines, which were developed in 2009. They are also based on the ADAC Guidelines (2004) SA, Alcohol and Your Health; and Australian Guidelines for Indigenous Communities. **The guidelines are available at: www.adac.org.au/.**





Research Digest

Libby Topp

Opioid substitution therapy (OST) – prescription of methadone, buprenorphine or buprenorphine–naloxone for maintenance purposes – is highly regulated, available only on prescription from a licensed prescriber and generally requires supervised administration. Supervised administration endeavours to maximise adherence to and benefits of treatment. To enhance public health outcomes, the risks of diversion, injection and overdose must be minimised without compromising the attractiveness of treatment to both clients and prescribers. This issue's Research Digest summarises three Australian studies that examine OST-related risks from the perspective of the prescriber, the dosing pharmacist and the client.

But first, a few terms. **Diversion** is the unsanctioned supply of regulated pharmaceuticals from legal sources to the black market. **Adherence** describes the use of medication in accordance with prescription directions (for example, consumption of specified doses at specified intervals via the intended route of administration and, in most cases, under supervision). **Non-adherence** is use of medication by the person to whom it was prescribed in a manner contrary to directions, including removing a supervised dose from the dosing site for personal use or for diversion to others; stockpiling doses; taking more or less than prescribed; and using alternative routes of administration including injecting.

The prescriber

Larance, B, Degenhardt, L, O'Brien, S, Lintzeris, N, Winstock, A, Mattick, RP, Bell, J & Ali, R 2011. Prescribers' perceptions of the diversion and injection of medication by opioid substitution treatment patients. *Drug & Alcohol Review*. 2011 Jan 5. doi: 10.1111/j.1465-3362.2010.00274.x.

OST clients value flexible treatment models that minimise disruption to daily life; thus good treatment coverage cannot be achieved if OST is regulated too stringently. OST must also attract and retain sufficient numbers of prescribers. Prescribers' beliefs about how clients behave influence clinical decisions to prescribe, medication choice and suitability for unsupervised dosing.

In this unique national survey conducted in 2007, surveys and subsequent reminders were mailed to 1278 authorised OST prescribers to assess their perceptions of (i) the diversion and injection of OST medications; and (ii) the capacity of current OST policies to minimise risks. Participants entered a draw for a \$100 book voucher. Participating prescribers served 49% of all Australian OST clients, with settings for both prescribers (e.g., general practice, public clinics, correctional services) and dosing (e.g., pharmacy, public clinic, hospital) representative of OST settings nationally.

Believing that most clients adhere with OST, prescribers probably underestimate the risks of diversion. They reported that more buprenorphine clients removed supervised doses (7%) and diverted unsupervised doses (20%) than methadone (1% and 4%, respectively) and buprenorphine–naloxone (3% and 2%, respectively) clients. More buprenorphine (6%) and buprenorphine–naloxone (5%) clients were perceived to inject doses than methadone clients (2%). Prescribers identified non-adherence through client self-report (51%) and reports of pharmacists (49%) or other staff (34%); reliance on client self-report may result in risky behaviours going undetected. More prescribers felt confident assessing the risk of injection (54%) than diversion (37%); 67% disagreed that takeaway policies were too restrictive; and 10% indicated that they were not confident in responding to suspected diversion.

High proportions of prescribers across all settings responded 'don't know' to many survey items, and were open about their uncertainties in assessing risks and whether current treatment policies constitute 'best practice'. Such doubts may deter prescribers' participation in OST. Given the emphasis on supervised OST dosing, adherence among this group is likely to be equivalent to or better than among patients treated for other chronic conditions such as depression or schizophrenia. Additional risk management strategies suggested included routine dilution of methadone, greater liaison between prescribers and dosing staff, uniform supervision standards across dosing sites, injectable OST and development of multidisciplinary chronic pain services.

The pharmacist

Winstock, AR, Lea, T & Sheridan, J 2010. Problems experienced by community pharmacists delivering opioid substitution treatment in New South Wales and Victoria, Australia. *Addiction*, vol. 105, no. 2, pp. 335–42.

Much OST is delivered through community pharmacies. Situated within local communities and generally removed

from potentially stigmatised specialist drug treatment services, pharmacies facilitate community integration and, by providing takeaway doses, opportunities for employment, education and family responsibilities. Pharmacists may not embrace service provision to drug users, however. Concerns include role competency, fear of aggression and shoplifting, and impact on other customers and pharmacy staff.

OST delivery differs across jurisdictions. For example, in NSW, clients are generally inducted and stabilised at a specialist clinic with daily supervised dosing for at least three months before transfer to a pharmacy. In Victoria, most clients are inducted directly onto treatment at a pharmacy without specialist support and stabilisation. Although pharmacies provide supervised dispensing of OST, this may be limited relative to that provided by specialist services.

To explore pharmacy OST provision and pharmacists' concerns regarding prescribers and clients, in 2006 all pharmacies authorised to dispense OST in NSW (N=593) and Victoria (N=393) were mailed a survey, to which 669 valid responses were received (68% response rate). Participants, registered pharmacists for an average of 20 years and OST dispensers for nine, entered a draw for a department store voucher.

Pharmacists' most common prescriber-related problems included inability to contact him/her (21%) and prescription of takeaways to unstable clients (19%). In the preceding month, 41% of pharmacists had refused to dose a client, most often due to expired prescriptions (29%) or ≥ 3 missed doses (23%); and 14% had terminated a client's treatment for reasons including inappropriate behaviour (aggression, intoxication) and missed doses. Both dose refusal and treatment termination were associated with higher client numbers, suggesting that an optimal ratio of clients per pharmacy should be determined.

Victorian pharmacists reported significantly more concerns with both clients and prescribers. Given that OST accreditation of pharmacies and treatment population characteristics are broadly equivalent across the two states, differences in medication and dose provision may account for this variation. In Victoria, more people receive buprenorphine, which is more commonly diverted than methadone from supervised dispensing sites; diversion itself is associated with higher rates of dose refusal and client termination. The higher penetration of buprenorphine in Victoria reflects the more extensive use of methadone in NSW before buprenorphine was launched and jurisdictional policy differences. Victorian methadone clients receive lower average doses than their NSW counterparts (50 mg versus 80 mg), and may therefore be less stable, which could contribute to behavioural problems and missed doses. NSW's reliance on specialist clinics to induct and stabilise clients before they transfer to pharmacy dosing may reduce potential problems in that state.

The majority of pharmacists provided credit to OST clients; just one-third reported that all clients were up-to-date with dispensing fees. Non-payment, more common in Victoria where free treatment at public clinics is largely unavailable, often underlay dose refusal or treatment termination.

Financial hardship is prevalent among OST clients. Given the low costs of providing OST through pharmacies and OST's significant cost-benefits, subsidisation of dispensing fees warrants renewed consideration.

The client

Winstock, AR & Lea, T 2010. Diversion and injection of methadone and buprenorphine among clients in public opioid treatment clinics in New South Wales, Australia. *Substance Use and Misuse*, vol. 45, no. 1-2, pp. 240-52.

Most OST clients receive at least some supervised doses, with regular takeaway doses contingent upon demonstrated stability. Supervised administration of oral methadone is effective because the dispenser can generally be confident that the dose has been swallowed; research confirms that the majority of diverted methadone comes from takeaway rather than supervised doses. Many Australian jurisdictions prohibited takeaway doses of buprenorphine following its introduction in 2000; guidelines were changed to allow takeaways following the introduction of buprenorphine-naloxone, which is less likely to be injected due to the potential for precipitated withdrawal. This 2005 study investigated diversion in a supervised treatment setting where takeaway doses were not routinely permitted, conducting brief confidential interviews with 98 buprenorphine clients and 350 methadone clients of nine public OST clinics in metropolitan, regional and rural NSW.

Rates of diversion of supervised doses in the preceding 12 months were significantly higher among buprenorphine (15%) than methadone (4%) clients, suggesting that the under-the-tongue administration of buprenorphine, which is small and slow to dissolve, is more open to abuse than oral methadone. Substantial variation in rates of buprenorphine diversion between clinics probably reflects differences in supervision and dispensing practices.

Widespread provision of takeaway methadone at pharmacies might make diversion of supervised methadone more prevalent at public clinics, where takeaway doses are generally not provided. Other research, however, documents rates of supervised methadone diversion at pharmacies similar to those reported here. Conversely, diversion of buprenorphine (not typically provided as takeaways from pharmacies at the time of survey) is more common at pharmacies, possibly reflecting reduced opportunities for close supervision at these dosing points.

Whereas 27% of current buprenorphine clients had injected buprenorphine, 66% of those prescribed methadone had injected methadone. The majority of participants reported limited experience of injecting their medication, most expressing a preference for taking it as directed. Nevertheless, a subgroup of methadone clients prefer to inject, suggesting that injectable methadone programs may be appropriate.

Attempts to minimise diversion must be weighed against the potential requirements for increased personnel and time resources and the uncertain efficacy of these efforts. For many clients, increased supervision intensity may also decrease treatment acceptability.

Fees for pharmacotherapy: An unfair burden?

Angela Rossmanith

The effectiveness of opioid substitution treatment (OST), or pharmacotherapy, for opioid dependence is well documented, with studies showing a reduction in illicit drug use and improvement in health and wellbeing when people dependent on opioids are maintained on OST (Feyer & Mattick 2008). However, client retention relies on several factors, including the affordability of the treatment (ibid).

The main treatment in Australia for opioid dependence is methadone, with buprenorphine, and buprenorphine-naloxone (Suboxone) also used. All are orally administered. The cost of these drugs is funded by the Australian Government, but while treatment is provided free in some settings, in most cases clients are charged a dispensing fee.

Across Australia, more than half of all prescribing (63%) is done by private medical practitioners, and the majority of dispensing (80%) is carried out in community pharmacies (Chalmers et al. 2009). However, costing systems for pharmacotherapy can be complex since each state and territory administers their own pharmacotherapy program.

Diverging services in Australia

The National Policy on Methadone, adopted in 1993 by the Commonwealth, state and territory governments, provided a national position on the role of methadone, which was the only substitution treatment for opioid dependence at the time. Harm minimisation was already accepted as the principal goal of all drug policies in Australia. The national goals for methadone treatment were to reduce the health, social and economic harms to individuals and the community associated with illegal opioid use.

Although there was national agreement regarding the principles of methadone maintenance treatment (MMT), the program developed in different ways across the states and territories. The result was that the way the service was delivered diverged significantly across and within

jurisdictions, with 'a range of service delivery settings, decentralised versus localised control, different roles for the public and private sectors, and variations in the number of clients treated by individual medical practitioners and clinics' (Commonwealth Department of Human Services and Health 1995).

As an example of the different systems between jurisdictions, in NSW clients may be dosed at public clinics, private clinics or a participating community pharmacy, while in Victoria almost all clients receive pharmacotherapy at a community pharmacy. And while the ACT Government provides subsidies for dispensing fees, there are no subsidies in other states and territories, although in both Tasmania and NSW, pharmacists are offered an incentive scheme.

ON A SNAPSHOT DAY IN 2010:

46 078 clients received pharmacotherapy for opioid dependence

Almost two in three clients were male

There was an overall increase of 2600 clients since 2009

There were 1449 prescribers, 80% of whom were private

There were 2200 dosing point sites in Australia; 86% were located in pharmacies

As in previous years, methadone was the most common type of pharmacotherapy; nearly seven in 10 received methadone, the rest received either buprenorphine or buprenorphine-naloxone

Source: AIHW 2011. National Opioid Pharmacotherapy Statistics Annual Data collection: 2010 report. Drug treatment series no. 12. Cat. no. HSE 109, Canberra.

The impacts of dispensing fees

In public clinics in NSW, OST is provided free to clients, 'although you'd have difficulty getting access to many of the public facilities in NSW', says Denis Leahy, Vice President of the Pharmacy Guild, NSW Branch. 'However there are priorities within the system to allow more ready access for people just out of prison, or pregnant, or HIV positive.'

Once they are stable, public clinic clients are encouraged to move to a community pharmacy or GP for dosing, 'but it's difficult because they don't want to move from a free service', Leahy says. 'In NSW there are shared care arrangements between GPs, public clinics and community pharmacies that allow people who become unfinancial or clinically unstable at the pharmacy to return to the public clinic for stabilisation or financial respite.'

Clients in NSW who attend a private clinic or a pharmacy are charged a dispensing fee which can range from \$30 to \$70 per week. 'Similarly, some clients in Western Australia are paying up to \$80 a week,' says Laura Liebelt, Senior Research & Policy Officer, Australian Injecting & Illicit Drug Users League Inc. (AIVL). In Victoria, clients are charged a dispensing fee of between \$25 and \$50 per week at the community pharmacy, she says. 'The evidence consistently suggests that the high cost of OSTs has negative impacts on the quality of life for clients, with many having to choose between missing doses because they don't have the money, going without food, other required medications, and even rent in some situations,' she says.

Sarah Lord, Program Manager of the Pharmacotherapy Advocacy, Mediation and Support (PAMS) service, an advocacy program of HRVic Inc. (the Victorian Drug User Organisation) agrees. 'Eighty per cent of the people who contact the PAMS service for help have been threatened with program termination and/or dose refusal because they don't have the capacity to pay for dispensing fees on that day, or they've accumulated so much debt they're about to be cut off.'

At Clinic 36, a private clinic in Sydney, many clients are in employment, 'but whether the treatment is affordable is another matter', says nursing manager Kate Origlasso. 'For a dose of methadone it's \$8 and for bupe it's \$10, although it's less if they pay a week in advance. We try to be as creative as we can to help people out who are in dire straits financially.'

A study carried out by Royal Melbourne Institute of Technology academic Dr James Rowe and funded by The Salvation Army found that dispensing fees are the single greatest obstacle to retention in OST (Rowe 2008). The study, involving 120 people recovering from drug use whose main source of income was government welfare payments, revealed that in some instances clients who can't afford to pay off debt to the pharmacy, or the day's fee (if the pharmacy does not provide credit), will commit crime or engage in illicit sex work so that they can continue to receive treatment.

Addressing affordability

In a project commissioned by the Australian National Council on Drugs (ANCD), the Drug Policy Modelling Program at the University of NSW developed a system

OST: Personal stories

Alex*

'I work full time and earn a decent wage but still find I struggle a lot with the cost of my pharmacotherapy and other stuff I need. I thought not using anymore would give me heaps more cash but it's still pricey — I don't know how people on benefits cope. It frustrates me that in general people only pay around \$30 for a normal script that would last for a month or so, yet we have to pay so much. I have to pay nearly \$70 a week for my bupe. No other "special needs" community would have to pay so much for medication that are absolutely essential for us to live/function.'

Gillian*

'I earn \$270 per week. My costs are:
Pharmacotherapy.....\$80 per week
Rent.....\$130 per week
Food.....\$70 per week
Entertainment/Smokes..\$20 per week
Total:.....\$300 per week

'This is my "basic" weekly budget for a roof over my head and at least one hot meal per day, no luxuries afforded here. Luxuries are tobacco, coffee, a nice drink. As you can see, my budget exceeds my income so I have to select which luxury I can afford this week. I will have tobacco this week, which means I cannot have coffee. Next week I will buy some coffee, which will be nice but I will not be able to buy smokes. My methadone keeps me functioning. I would vegetate without it.'

Source: AIVL research

*Names changed to protect privacy



dynamics model of the pharmacotherapy system to explore some of the key issues of concern, including affordability (Chalmers et al. 2009).

The model revealed that the overall cost for the provision of pharmacotherapy is almost \$11.73 million per month, with 43 per cent of this cost borne by state and territory governments, 33 per cent borne by patients, and the remaining 24 per cent borne by the federal government.

The \$11.73 million treatment costs are significantly lower than costs associated with untreated heroin users, which were estimated to be between \$15.8 million and \$31.6 million per month. The 'cost burden' of ongoing heroin use includes:

- health care costs (blood borne viruses, accidents, trauma, overdose)
- crime (associated with heroin)
- family disruption, domestic violence, impact on children.

'It is clear that the provision of pharmacotherapy maintenance treatment, while costly, is outweighed by the economic benefits accruing to the community through reductions in health care utilisation and crime,' the researchers concluded. They added that, if the Federal Government were to pay all dispensing fees, the costs would be close to \$4 million per month, but the reduced fees for patients would lead to greater retention rates and therefore greater cost burden savings.

Accessibility problems

The costs of OST are certainly a major barrier for clients but there is a broader range of obstacles, says Roger Nicholas, Senior Project Manager at the National Centre for Education and Training on Addiction, Flinders University, South Australia. 'For example, the lack of accessibility to programs makes it difficult for folks on OST. If a person

A PHARMACIST'S PERSPECTIVE

In NSW, almost one in three pharmacies provides pharmacotherapy (Feyer & Mattick 2008). Pharmacists are encouraged to be part of the program through an incentive scheme, says Denis Leahy, Vice President of the Pharmacy Guild, NSW Branch.

'This scheme has two elements: when a pharmacist has come on board for the first time and they've had a patient for a period of two months, they can claim a one-off payment of \$1000 for participating in the scheme. If that patient remains with the pharmacy, in April and October the pharmacy is paid \$100 per patient up to a maximum of 20 patients as a further incentive to maintain patients. Above 20 patients there is no incentive, and in NSW the number of patients a pharmacy can dose is capped at 50.'

Leahy stresses that this is an incentive, not intended as a subsidy, and that pharmacists usually regard the provision of OST as a community service. 'The incentive payment represents a small contribution to the overall cost of providing the service,' he says.

Victoria has nothing like an incentive scheme, says Sarah Lord, of Harm Reduction Victoria's Pharmacotherapy Advocacy,

Mediation and Support service. 'The only money pharmacists get is what they charge the client. There is no subsidy and no incentive payment. The OST program is government supported but not government controlled. When it comes to fees, pharmacists can charge what they like.

'What pharmacists get from dispensing a dose of methadone or Suboxone compared to what they'd get for a box of antibiotics is practically nothing. Pharmacists have told me it's possible to make a bit of money if it all runs smoothly: if you don't have to spend time on clients, chasing scripts, ringing doctors, talking with welfare providers. To make any decent profit they need to have at least 80 or 90 clients dosing every day, but then you'd need a separate dosing room, extra pharmacists on duty, and this all means additional costs to the pharmacist.'

Research in NSW revealed that 70 per cent of pharmacies provide credit to clients, and about one in four pharmacies was owed money for treatment (Winstock et al. 2008). Poor remuneration, bad debt, and occasional behavioural aggression among clients are other disincentives for community pharmacies to participate (Feyer & Mattick 2008). Also, difficulty making payments was identified as a major contributing factor to the deterioration of the relationship between dispensing pharmacists and clients (King et al. 2010).

**'HOW MANY OTHER
DISADVANTAGED
POPULATIONS HAVE
TO PAY SO MUCH
FOR ESSENTIAL
MEDICATIONS?'**



has to travel a long distance it can be expensive and an enormous time imposition. People in rural areas may spend half a day getting to and from a treatment point. The infrastructure is not well developed.'

Private clinics continue to do business in NSW because there are no places for people in the public system, says Origlasso. 'We even have people coming here from Newcastle every day, doing a six-hour round trip because there are no prescribers, no waiting list you can get onto in Newcastle. It's the same in other parts of NSW too.'

A survey of NSW public clinics consistently reported that many public clinics had limited capacity to take on new clients (Winstock et al. 2008). And a recent report on OST in community pharmacies states 'the inability of public clinic systems to provide the accessibility and hours of operation achieved by community pharmacies makes the involvement of this sector critical to the effective reach of treatment in Australia' (Feyer & Mattick 2008).

An equity issue

Part of the debate about dispensing fees for pharmacotherapy revolves around the issue of inequity. The Australian Government provides pharmaceutical services through the Pharmaceutical Benefits Scheme (PBS), designed for equity of access to PBS-approved drugs through the subsidisation of the price of prescription drugs, including the dispensing costs. While methadone and buprenorphine are PBS-approved, the Australian Government does not subsidise the dispensing costs (Chalmers et al. 2009).

'A great many of these clients are on low incomes and highly marginalised,' says Liebelt. 'How many other disadvantaged populations have to pay so much for essential medications? AIVL is currently documenting these inequities and recommending the need for policy reform.'

In *A Raw Deal*, a study funded by The Salvation Army and undertaken by academic Dr James Rowe, he asks: 'Are patients on opioid maintenance programs not considered deserving of the same health care as other Australians?' Other Australians, he argues, have dispensing fees paid through the PBS for conditions such as Type 2 diabetes, possibly 'a result of lifestyle "choices" or ... injuries or chronic illness acquired through involvement in illegal activities'.

While an average outlay of \$30 for dispensing fees is relatively modest compared to the costs of active heroin dependency, Rowe says, many undertake OST 'to escape not just heroin, but a lifestyle characterised by illegal income raising activities'. Leaving that life behind often means surviving on government income support, a significant proportion of which can go towards the dispensing fees. Travel costs and the gap between the Medicare benefit and the fees charged for prescriptions by medical practitioners are a further burden, as is the commitment of time, which compromises opportunities for employment and education.

'I'd like to see the program free for anyone on a Centrelink health card,' says Lord. 'Some people argue people should pay even a nominal amount so that they value what they get, but I think they value it already. The World Health Organization has declared pharmacotherapy an essential medicine, and that's how it should be viewed.'



NewsPix / News Ltd

TURNING TO ALTERNATIVES

When access to opioid substitution treatment is difficult or limited, there is likely to be a greater misuse of other pharmaceuticals, says Roger Nicholas, Senior Project Manager at the National Centre for Education and Training on Addiction, the lead agency involved in the development of the National Pharmaceutical Drugs Misuse Strategy.

'Over the last decade we've seen a dramatic increase in the level of opioid prescription in Australia', he says. 'If this increase in use led to better treatment of pain that's one thing. But we are seeing a significant increase in harms, deaths, overdoses and injections of pharmaceuticals intended to be taken orally. One of the factors we believe is impacting on this misuse is access to opioid substitution treatment (OST), including affordability.'

That is, the cost of OST may motivate clients to obtain PBS-subsidised opioid medications. Compared to an average cost of about \$35 a week, the cost of a PBS opioid prescription (at a concessional cost of \$5.60 up to the yearly threshold amount of \$336 after which further prescriptions are free) is far more manageable, Nicholas says.

Into the future

A pragmatic way forward would be for relevant legislation to be amended and the PBS to include dispensing fees for OST pharmacotherapies, says Rowe. This would address the issue of equity in terms of affordability and also in terms of the provision of health care across the whole population. Full subsidisation, Rowe says, 'would go a considerable way towards retaining clients in treatment so that they gain the greatest benefit possible'.

It is clear that the burgeoning growth of this area of health care, coupled with shortage of places for people entering treatment, and the capacity of the system to deal with that, will pose great challenges for the health sector in the future.

Pharmacotherapy is one of the most successful public health programs ever established in Australia, and its future is worth investing in.

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

Not for human consumption?

Gideon Warhaft



The banning of synthetic cannabinoids



Newspix / Liam Driver

SYNTHETIC CANNABINOIDS, SUBSTANCES THAT MIMIC THE EFFECTS OF CANNABIS, ARE RELATIVELY NEW PRODUCTS AVAILABLE TO RECREATIONAL DRUG USERS BOTH IN AUSTRALIA AND OVERSEAS. PART OF A CATEGORY OF DRUGS KNOWN AS 'LEGAL HIGHS', THEY ARE DESIGNED AND MANUFACTURED TO PROVIDE SIMILAR EFFECTS TO DRUGS THAT HAVE BEEN PROHIBITED.

Before June this year they were largely unknown to most Australians, but have gained recent notoriety following media reports of synthetic cannabis showing up in at least one in ten urine samples of mining workers in Western Australia. Since June, several states, as well as the Australian Government, have banned many of the key compounds in a variety of synthetic cannabinoid products. In turn, manufacturers have created variations of these compounds and are still exporting and distributing their products.

Many people associate synthetic cannabinoids with the brand name 'Kronic', but this is just one name among many used to market the drug. Other brands in Australia have included Karma, Voodoo, Kaos and Aussie Gold, while in Europe and the United States, Spice and K2 are among the most recognised brands. Although synthetic cannabinoids are often marketed as 'incense products' or 'smoking herbs', sometimes with the disclaimer that they

are 'not meant for human consumption', they are in reality designer drugs, manufactured and consumed in an attempt to avoid the laws which make cannabis illegal.

What are synthetic cannabinoids?

Synthetic cannabinoids are dry herbs which have been sprayed or soaked in one or more synthetic chemical compounds. Although these psychoactive compounds mimic the effects of cannabis, anecdotal evidence suggests the similarities and differences in the experience of synthetic cannabinoids compared to cannabis can vary widely.

First marketed to the public in the United Kingdom in 2004 under the name 'Spice', synthetic cannabinoids soon gained in popularity across Europe and the United States. By 2006, rival manufacturers also began branding their products 'Spice', causing confusion between company

branding and a description of the actual product. This conflation between brand and descriptor is echoed in the current Australian debate, with many people confusing the brand 'Kronic' with the substance it is promoting.

During the first few years after Spice hit the European market, the psychoactive qualities were thought to come from the mixture of the legal herbs often listed on the packaging, sometimes by their common names, for example Red Clover, Red Raspberry Leaf, Pink Lotus, Wild Dagga, Skullcap, Coltsfoot and Rose Petals; and sometimes by their scientific names, including *Canavalia maritima*, *Nymphaea caerulea*, *Scutellaria nana*, *Pedicularis densiflora*, *Leonotis leonurus*, *Zornia latifolia*, *Nelumbo nucifera* and *Leonurus sibiricus*.

However, a risk assessment of Spice conducted in 2008 by the German Government concluded that it was unclear what the actual plant ingredients were and whether the cannabis-like effects were actually produced by any of the claimed ingredients or instead might be caused by a synthetic cannabinoid drug. The following year researchers at the University of Freiburg in Germany announced the discovery in a Spice sample of an analogue of the synthetic cannabinoid CP 47,497, originally developed by Pfizer in the 1980s for research purposes.

Soon a whole raft of synthetic cannabinoids were found in various herb mixtures, often in combination. Perhaps the best known, and most prolific (until banned in several countries) is JWH-018, developed by (and named after) John W. Huffman, a retired chemist from Clemson University in South Carolina in the United States. Huffman's interest in synthetic cannabinoids was purely for research purposes. For over 20 years he and his team developed more than 450 synthetic compounds to test the effects of cannabinoid receptors in the brain with the aim of understanding diseases and developing medications. But his name has become forever linked with the development of legal highs, a fact he has not shied away from. 'People who use it are idiots', he is quoted as saying. 'You don't know what it's going to do to you.' In another interview he stated: 'It's like playing Russian roulette because we don't have toxicity data, we don't know the metabolites, and we don't know the pharmacokinetics.'

Huffman also stated that he believes the popularity of JWH-018 is because it's more potent than other synthetic cannabinoids and easy to make. But there are several other cannabinoids widely found in synthetic cannabis blends that also bear his initials, including JWH-073, JWH-210, JWH-081, JWH-250, JWH-203, JWH-200 and JWH-122.

Another widely used synthetic cannabinoid is HU-210, synthesised in 1988 by Professor Raphael Mechoulam at the Hebrew University of Jerusalem as part of the development of anti-inflammatory agents for pain management. HU-210 is regarded as a particularly potent cannabinoid, one hundred to eight hundred times more so than natural THC found in cannabis, although the implications for the subjective effects of these cannabinoids are clouded by a lack of quality evidence.

Typically, a synthetic cannabis mixture will contain a combination of one or more of these synthetic compounds, as well as the herbal mixture that essentially acts as a binding medium so that they may be smoked (although

some people claim that the herbs themselves add to the psychoactive experience of the drug).

Distribution

One element of synthetic cannabinoids that is markedly different from other recreational drugs is the manner in which they are marketed and distributed. They are often produced, packaged, branded and distributed by a single company, and include information of variable accuracy about their contents. Far from the nondescript plastic deal bags or foil wraps of illicit cannabis, the packaging is often elaborately designed, with vacuum-sealed pouches sporting brand names in psychedelic styles echoing the 1960s. They are often sold in alternative herbal health shops such as the small Australian chain Happy High Herbs, but have also been sold in adult shops, tobacconists and even some grocery stores. Some distributors have even offered home delivery.

But it is the role of the internet that most differentiates distribution of synthetic cannabinoids from their illicit cousins. Far from the local, street-based and sometimes seedy nature of the retail end of the illicit drugs market, synthetic cannabinoids have been openly and prolifically distributed through the world wide web, whether it be through online marketplaces such as eBay, social media sites like Facebook, online retailers which specialise in alternative or herbal medicines, or dedicated sites marketing particular brands. Built around this online presence is an entire synthetic cannabinoid subculture, with its associated forums, comments threads and chat rooms.

Why people choose synthetic cannabinoids over cannabis

Consumers choose synthetic cannabinoids over natural cannabis for a variety of reasons, including: that they are (or were) legal; that they are easier to obtain; that some prefer the experience; and to evade drug detection when tested. This last preference has been exploited in some of the retailer promotions for the product.

For some people, the availability of a 'legal high' is more preferable than the risk, stigma and hassle of obtaining illicit drugs. Some people have a very real fear of getting snared into the criminal justice system. Others have ethical issues with using illicit cannabis (particularly in the United States, where there is real concern about the violence associated





with Mexican cannabis syndicates). Some might well prefer natural cannabis and would choose it if it were not illicit, but the fact that the synthetic variety is legal trumps any perceived inferiority of the product.

For others, the actual experience of synthetic cannabinoids is superior, or at least different, to natural cannabis, although the nature of those experiences varies greatly from person to person, is often contradictory and is almost exclusively anecdotal. There is a huge number of testimonies about synthetic cannabinoids on cannabis and drug-related community internet forums. The following small sample provides a taste:

It's not the same as marijuana. You think you're walking faster than you actually are. This is the most potent legal smokeable high that I have come across. Moderation is the key with Kronik in order to get in the state of mind that you want to be in.

I didn't feel any of the paranoia I used to associate with marijuana. There's also a very steep drop once the chemicals have done their job. You look up and you're dead sober; this is unlike weed, which always left me lethargic and stupid for an hour or two after smoking. This is the kind of thing you could do on your lunch break and be back to work on time and clear-eyed.

This stuff has caused MAJOR trouble for me – perhaps due to my clinical depression and AS. When I smoked it, it was NOTHING like Mj.

I thought the Blonde was more smooth on the lungs and tasted better.

But it is the motivation to evade drug detection that has put the spotlight on synthetic cannabinoids in Australia and forced policy and lawmakers to respond. Synthetic cannabinoids cannot be detected using the same tests used to screen natural cannabis, so to date they would not show up in standard drug testing regimes in Australia. However, synthetic cannabinoids can be detected if they are specifically targeted. In early 2011, after mining company executives in Western Australia heard anecdotally about a drug called 'Kronic', they began sending drug screening samples from miners to the ChemCentre testing

laboratories in Perth. ChemCentre claimed that up to 10 per cent of the samples tested were positive for the drug, which in an industry where safety is a premium, was a cause for concern.

Government reaction to synthetic cannabinoids

The resultant media attention meant that Kronik went from relative obscurity to almost a household name, as politicians scrambled to respond to the new 'problem' and legislate against it. In Europe and the United States, action against synthetic cannabinoids was already under way. In 2009, Germany, France and Sweden made a host of compounds illegal, including CP 47, 497, JWH-018 and HU-210. In the United Kingdom, Spice was made a Class B drug alongside cannabis. In March this year, the United States Drug Enforcement Agency temporarily classified JWH-018 and four similar cannabinoids as Schedule I controlled substances, making their possession and use illegal in all 50 states until further review in a year. Other cannabinoids have been variously banned in several states. Curiously, in some US states it is still legal to sell certain synthetic cannabinoid products, though not to smoke them. In Canada, JWH-018 as well as Spice, K2 and other popular 'incense products' are still legal and widely available.

In Australia, the situation is changing rapidly. Western Australia, South Australia, the Northern Territory and Tasmania have recently banned a range of synthetic cannabinoids found in Kronik, and in July the Australian Government followed suit. Interestingly, the Department of Health and Ageing acknowledged the difficulty in keeping up with new substances that produced similar effects, and flagged the development of outcome-based classes of drugs that ban either all substances that affect cannabinoid receptors or substances intended to have a 'substantially similar pharmacological effect to cannabis'.

New Zealand's recent reclassification of a large range of synthetic cannabinoids in August may also have an important

impact on the Australian market, because that's where Kronic and several other brands have been manufactured. Synthetic drug production (including amphetamine-related products such as BZP) has been something of a cottage industry in New Zealand over the last decade, spawning a handful of entrepreneurs with small fortunes who have lobbied the government in support of the industry. But in August the New Zealand Government reversed an earlier decision to regulate rather than ban synthetic cannabinoids, which would have restricted sales to people over 18 and regulated their packaging, marketing and sales. The Associate Health Minister, Mr Peter Dunne, said that it was 'clearly unacceptable that psychoactive substances can be sold without regulatory controls or any assessment of their potential harm'. He indicated the government would aim to '... reverse the onus of proof so anyone wishing to sell these products would need to prove they are safe.'

Future concerns

The problem in this debate is that we have little evidence about the risks – short term or long term. This raises questions for legislative and public health responses. Do we prohibit a drug that later will prove to be low risk, or do we allow its regulated availability, later to find it has unexpected adverse outcomes? What are the consumer protection and safety responsibilities beyond any debate about drug regulation? For example, there are expectations that new pharmaceuticals are demonstrated to be safe before being made available. There are similar requirements of many food additives.

But while governments are legislating to ban various cannabinoids, manufacturers have responded with a cat-and-mouse game of creating new compounds with alleged similar effects in place of each previous one banned. Not only is this a potentially cumbersome legislative exercise, it also poses the real risk that sooner or later a compound will be created or marketed that may be more harmful than its predecessors.

It is likely that in the foreseeable future, we are going to be faced with the challenge of new synthetic products, about which we know little, marketed in a manner that creates new challenges. In deciding how we should ultimately deal with these new products, we need to be as well informed as we can. While rigorous clinical studies might be a good place to start, we may need to bring our legislative and public health expertise together to consider more rapid, informed and flexible approaches than currently exist.

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Restrictions reap rewards

Bronwyn Duncan

TWICE THE SIZE OF VICTORIA, THE KIMBERLEY IN WESTERN AUSTRALIA IS A CULTURALLY DIVERSE REGION OF AROUND 30 000 PEOPLE – A SIGNIFICANT PROPORTION (JUST UNDER 50 PER CENT) OF WHICH IS INDIGENOUS. INDIGENOUS PEOPLE ARE THE MAJORITY OF THE POPULATION IN SOME COMMUNITIES.

Statistics show that both Indigenous and non-Indigenous people in the region drink alcohol, and experience alcohol-related harm, at significantly higher rates than for the rest of the state. But in Fitzroy Crossing and Halls Creek, in the central Kimberley, wide-ranging benefits are now flowing from restrictions on supply of full- and mid-strength takeaway alcohol.

Alcohol-related harm is also reducing in a number of remote Kimberley communities which have obtained classification as 'dry' communities (no alcohol allowed within a designated area). As of November 2010 there were nine such communities across the region.

Although alcohol supply restrictions are only one element in any strategy to reduce alcohol-related harm, restrictions imposed in communities in the Kimberley are bringing substantial benefits. There is broad consensus that the restrictions in Fitzroy Crossing and Halls Creek should be continued, while a minority believe they should be modified. Last February similar restrictions commenced in Kununurra and Wyndham, and there is a growing push to introduce some form of restriction on full-strength alcohol throughout the Kimberley.

Local control

Effective though the restrictions have turned out to be, much more needs to be done to break the cycle of damage and to address the long-term causes and effects of excessive alcohol consumption. 'Liquor restrictions work best as part of a comprehensive range of activities that address locally identified issues,' says Neil Guard, Executive Director of the WA Drug and Alcohol Office. 'Supporting activities need to be tailored to communities.'

Guard observes that an increasing number of rural and remote communities in the Kimberley are working to mitigate their own alcohol problems, supported by the WA

Drug and Alcohol Office and local health service providers. Community leadership, especially from the Aboriginal community, has been instrumental in bringing about changes to the availability of alcohol.

Alcohol problems often impact much more on Aboriginal communities. Experience overwhelmingly shows that effective change in these communities comes from within, in partnership with responsive outside agencies, not from policies imposed 'top down' or from a 'one size fits all' perspective.

Professor Dennis Gray, Deputy Director of the National Drug Research Institute (NDRI) has studied Aboriginal health issues for 20 years, including measures to reduce alcohol supply and demand in the Northern Territory.

'Around 80 per cent of the remote communities targeted by the Federal Government intervention in the Territory had already chosen to be dry,' he says. 'Imposition of blanket bans by government are counterproductive. They disempower Aboriginal people and cause resentment.'

The current measures in Fitzroy Crossing began in 2007 after concerted community action, particularly by Indigenous community leaders June Oscar, Emily Carter and others, following a dramatic spike in youth suicides in 2006. The subsequent Coroner's report found that alcohol and other drug use was a key factor in the deaths of 13 young people in the area.

The process in Fitzroy Crossing has been described by Aboriginal and Torres Strait Islander Social Justice Commissioner Mick Gooda as a 'model of how to create change ... from community crisis to community control'. There has been a high level of cooperation between Indigenous and non-Indigenous residents.

Similar restrictions came into force in 2009 in Halls Creek, a contentious move even though most residents agreed the



ALCOHOL RESTRICTIONS AND STIs

The Kimberley region has recorded the highest rates of sexually transmitted infections (STIs) in Western Australia. However, the findings of a recent study suggest there may be a link between the alcohol restrictions and a reduced risk of STIs.

In an article published in the *Australian and New Zealand Journal of Public Health* in February 2011, the authors report that notification rates of STIs from January 2007 to April 2010 significantly decreased after the advent of restrictions in Fitzroy Crossing and Halls Creek. In Fitzroy Crossing there was a significant decline in both gonorrhoea (>50%) and chlamydia (30%) for the two years following the restrictions, compared to the two years prior.

Similar trends have been demonstrated in Halls Creek. The authors recommend that screening for alcohol problems should be considered by all clinicians treating people with STIs (Bangor-Jones et al. 2011).

town's severe alcohol problems had to be tackled. After 12 months, as the benefits emerged, opposition lessened. However, some residents, mainly business operators, still seek a different approach.

Measured benefits

Evaluations published in December 2010, and a report tabled in the Western Australian parliament in March this year, provide compelling evidence of social and health benefits. While there remains a core of heavy drinkers, the ubiquitous practice of binge drinking that was causing the most damage to families and children has significantly reduced.

Health benefits include: reductions in alcohol consumption, in the use of Sobering-up Centres, in assaults and alcohol-related injuries and in alcohol-related hospital presentations; and better nutrition and care of families.

Social and educational benefits include: a reduction in youth suicides and attempted self-harm, increased safety at home, higher school attendance and performance rates, and a cleaner and quieter environment. While reporting of domestic violence has increased, observations suggest it is due not to an increase in the problem, but to more accurate reporting than previously.

Public order benefits include: decreases in traffic offences including drink driving, reduced street drinking and anti-social behaviour and a significant shift in police work from reacting to crises towards community engagement. While anecdotal reports claim that crimes such as break and enter and theft have increased, there has been no corresponding spike in police statistics.

'We're continuing to see positive changes being sustained in these communities,' says Neil Guard. 'But communities adapt, and it's important to respond to emerging issues.'

Impact on children and youth

There are about 5000 children under nine years of age in the Kimberley, or 16 per cent of the population.

Children are hit hardest by alcohol use in these communities. The range and depth of damage can be summed up as the 'cumulative effect of trauma'. Rates of child trauma arising from years of excessive alcohol consumption within their communities are much higher in the Kimberley than in metropolitan areas of the state, but across the region they vary greatly with differences in culture, the strength of families and location. On the Dampier Peninsula, for example, remote from major towns, child safety is reportedly high and extended families keep close watch.

The immediate day-to-day benefits for children from the Fitzroy Valley restrictions are captured by researcher Steve Kinnane, who led the two evaluations: 'We immediately saw children looking healthier ... and happier'.

School attendance and performance rates have risen, but they also vary across the region and between the wet and dry seasons, and in many schools there is a long way to go. This is not surprising given that some are dealing with entrenched alcohol-related behavioural and health problems. For example, in testimony to a WA parliamentary committee Paul Jeffries, Principal of Fitzroy Valley District High School, estimated 25 per cent or 80 of its students are affected by Foetal Alcohol Syndrome Disorder (FASD) (Parliament of Western Australia 2011). The school has also had to invest over \$100 000 in 'protective behaviour programs'.

FASD rates in the Kimberley have rapidly increased over the past decade, and a new generation of FASD-affected children is being born to young women who have FASD themselves, and who continue to drink alcohol while pregnant. The current restrictions should contribute

INGREDIENTS OF EFFECTIVE RESTRICTIONS

Restrictions on the Sale and Supply of Alcohol: Evidence and Outcomes, a 2007 monograph published by the National Drug Research Institute, assessed the evidence of effectiveness of a range of restrictions on the sale and supply of alcohol throughout Australia. The report categorised these restrictions according to their strengths. Some of the key positive findings were:

Restrictions that showed strong evidence for positive outcomes, and evidence of effectiveness, included ones that targeted:

- the economic availability of alcohol, through taxation and pricing
- the hours and days of sale for licensed premises
- the legal drinking age for purchase or consumption of alcohol.

Restrictions that showed evidence for positive outcomes, and which may need ongoing functional support, included ones that targeted:

- access to high-risk alcoholic beverages*
- the outlet density of licensed premises
- ownership of private liquor licences, including direct government control of liquor outlets
- restrictions implemented via liquor accords and community-based programs
- mandatory packages of restrictions for remote and regional communities*
- dry community declarations.*

** Indicates factors which have played a significant role in the success of alcohol restrictions in the Kimberley.*

Reference

Chikritzhs, TN, Gray, D, Lyons, Z and Saggers, S 2007. *Restrictions on the sale and supply of alcohol: Evidence and outcomes*, National Drug Research Institute. Curtin University of Technology, Perth.

to a lower incidence of FASD in future, but specialised support is essential for those already afflicted. Marulu: The Lililwan* Project, the first comprehensive study of the prevalence of FASD and its impacts on Indigenous people, is now underway in Fitzroy Valley under the auspices of Nindilingarri Cultural Health Services, with Federal Government support.

There continues to be a great need for funded diversionary programs and more activities for young people. One highly successful model is the Yiriman Program, which fosters cultural healing and aims to build the resilience of at-risk Indigenous youth and their families.

Mixed outcomes for business and tourism

The relationship between licensees and police in Fitzroy Crossing has been described as 'a cornerstone of the success of managing a changing drinking culture'. There were early tensions and security issues at licensed premises to which drinkers migrated, but uncontrolled drinking at home or in public spaces day and night had caused far greater problems.

Some Halls Creek businesses report significant changes in their operations or reduced trading, while others have been unaffected. Decreased public drinking and a cleaner, quieter town are seen as positive outcomes. The impacts on tourism in Halls Creek are not yet clear, but in Fitzroy Crossing, despite fears that restrictions would deter visitors, its two licensed premises are catering for more tourists.

Negative outcomes

The restrictions are associated with some displacement effects. The main one is the practice of 'sly grogging' and 'rabbit running', where people travel to other towns to drink full-strength alcohol, purchase it for personal consumption back home, or sell to others. As Aboriginal people have always travelled a great deal around the Kimberley it is hard to measure the extent of this practice. Some dry communities are finding it difficult to control

'IMPOSITION OF BLANKET BANS BY GOVERNMENT ARE COUNTERPRODUCTIVE. THEY DISEMPOWER ABORIGINAL PEOPLE AND CAUSE RESENTMENT'



drinking outside their boundaries and the smuggling of alcohol inside. Anecdotal reports suggest these may be escalating problems.

Also difficult to measure is whether the restrictions are playing a part in increasing use of other drugs, especially cannabis ('gunja'). Dennis Gray describes the evidence as unclear and anecdotal.

'Drug substitution is not a simple one-to-one practice. Some people do migrate to other drugs, partly because of increasing availability. The evidence in remote communities in the NT is that cannabis use was increasing prior to alcohol restrictions. Add to this the fact that poly drug use is common, and it's a complex picture.'

Supporters of the restrictions believe these and other problems are not insuperable and are more than compensated for by the tangible benefits – and, more importantly, that it is far too early to assess the long-term benefits of changed behaviour and improved living conditions, as these will only emerge for future generations.

Drinker's alcohol entitlement card

There is minority support, mainly from liquor industry representatives, for a drinker's entitlement card system or a banned drinkers register similar to that operating in the NT, but these are not widely seen as effective alternative measures to the present restrictions.

'As yet there is no evidence of the card's effectiveness in the NT,' says Dennis Gray. 'It may have some impact, but it only targets a minority of those who are drinking at high risk of short-term harm. Better gains are to be had by also targeting a wider population.'

Looking forward

The restrictions have delivered real benefits to the affected communities, but there is a danger that hard-won benefits will dissipate. Restrictions are most likely to be effective when they come with community support and leadership; but restrictions are one part of an overall approach that must include demand reduction and, where needed, treatment responses.

'It's important to understand what is likely to make the greatest difference in preventing future problems,' says Neil Guard. 'There needs to be a greater focus on population-based and targeted preventative measures, connectedness to culture and community, early years strategies and education about the issues.'

Dennis Gray wants to see changes in planning and resourcing of substance use programs for Aboriginal people. 'Nationally, these are more a result of historical accident than good planning. Funds for staff development on the ground are tiny, and the trend to a purchase provider model for these programs often means that Aboriginal people get little training or are relegated to menial roles. A loading on outsourced contracts to build local capacity should be mandatory.'

Previous approaches to alleviating Aboriginal health and social problems – in which affected communities have had

little or no say – have consistently failed to bring sustained improvements. Against this background, long-term gains in well-being for the whole Kimberley population are not likely to occur without strong community leadership and engagement. New types of regional governance structures, as proposed by the report of the WA Indigenous Implementation Board in February this year, may also help realise this vision.

**Lililwan: 'little ones'*

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



'RENAISSANCE' OF HALLS CREEK

Although alcohol supply restrictions have been contentious in Halls Creek, and the pace of health and social improvements slow, there is growing optimism, says Indigenous leader and local high school teacher Doreen Green.

'It's our town's renaissance', she says. 'It's a long journey but we're moving in the right direction.'

The success of the first Halls Creek Music Festival in August 2010 was a high point, and the acclaimed Perth-based Madjitil Moorna community choir has visited three times for concerts and workshops. During its July 2011 visit, the community recorded the 'Halls Creek Rodeo Song' with the choir. 'The whole experience has had a great impact on our kids,' says Green.

Recent investment in housing and construction has increased employment opportunities. In the first 12 months of the restrictions, some 62 people obtained full-time employment as part of the transition from Community Development Employment Program (CDEP).

A 24-bed workers hostel just outside the town, managed by the Wunan Foundation, was built by local Aboriginal people and is the first of its kind in the Kimberley. 'It's a place where our young people are learning to look after their own affairs – a stepping stone, getting them ready for work,' says Green.

Green is now involved in a new children's and family centre in Halls Creek that will care for up to 60 babies and toddlers and their mothers. It is the first of five being built in the Kimberley with Federal Government funding.

Your practice, their evidence?

Nicole Lee & Linda Jenner*

THERE IS INCREASING EXPECTATION THAT FRONTLINE ALCOHOL AND OTHER DRUG STAFF BASE THEIR CLINICAL WORK ON THE BEST AVAILABLE EVIDENCE. BUT HOW DO THEY DECIDE WHICH EVIDENCE APPLIES TO THEIR CLIENTS? WHAT IF THEY ARE WORKING WITH TEENAGERS, BUT THE RESEARCH LITERATURE TALKS ABOUT WORK CARRIED OUT WITH SIMILARLY AFFECTED ADULTS? OR IF THEIR CLIENTS ARE COURT-MANDATED INTO TREATMENT, WHEREAS ALL THE PUBLISHED STUDIES TALK ABOUT PEOPLE WHO VOLUNTARILY SEEK HELP FOR THEIR SUBSTANCE USE?

LIKEWISE, HOW DO THEY DETERMINE THE QUALITY OF THE EVIDENCE, AND THEN TRANSLATE IT INTO THEIR PRACTICE?

What is evidence-based practice (EBP)?

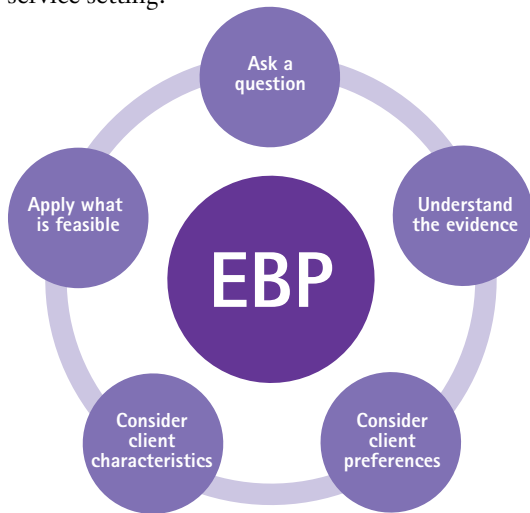
EBP means making decisions and acting according to what has been shown to be effective rather than relying exclusively on how things have 'always been done' or on clinical intuition alone. Part of this is the research evidence base but EBP is much broader than just research evidence.

EBP combines the following factors:

1. **Asking a focused clinical question** that allows you to search for the answers you are looking for. For example, 'Which psychological therapies are effective for reducing alcohol consumption in female adults with alcohol dependence?' Although it might seem like there are mountains of research findings available, there is often considerably less when your search is clear and focused.
2. **Understanding the research evidence** and having the ability to assess its quality. Evidence is never perfect but some studies are well conducted while other studies are less so. Understanding and interpreting the evidence is discussed in the next section.
3. **Considering the values and preferences of your client** to make sure the evidence matches your client's treatment goals. Pharmacotherapy might be the most effective treatment for some conditions but if a client objects to medication it won't be an option.
4. **Considering the clinical characteristics and circumstances of your client** to make sure your client's presentation matches that for which the treatment was found to be effective. For example a certain treatment may be effective for alcohol dependence, but what if the client also has an intellectual disability, or severe depression, or is a young person or an older person – will the treatment still be effective?
5. **Applying only what is practical and feasible** in relation to your skills and abilities and the setting in which you work. For example, even if the research suggests that long-term dynamic psychotherapy is effective, it would not be feasible to implement in most alcohol and other drug treatment settings or without extensive training and clinical supervision, however a six-session intervention might be.

A COMMON CRITICISM OF THE RESEARCH EVIDENCE IS THAT TREATMENTS ARE USUALLY TESTED IN TIGHTLY CONTROLLED RESEARCH SETTINGS, WHICH CAN DIFFER CONSIDERABLY FROM THE REAL WORLD.

Using this five-part model, EBP is the use of the best available evidence plus interpretation and application to your service setting.



How do I understand the evidence and assess its quality?

Qualitative versus quantitative research

These two broad types of research are not mutually exclusive but have a different use and focus. Qualitative and quantitative research is often undertaken together, and when this happens it is sometimes referred to as 'mixed methods research'.

Qualitative research generally involves the analysis of words, pictures or objects and the aim is a complete and detailed description of subject of investigation. It is useful when we might not know in advance exactly what we are looking for and it is often recommended in the early stages of a project. Because qualitative research is generally undertaken with very specific individuals or groups chosen for their ability to provide information about a particular issue or topic, it is subjective and rich in detail, so results are not usually easily applied to other settings or groups. Qualitative research is very useful for purposes like developing, evaluating and improving a specific service or program.

Quantitative research focuses on data that is numerical and researchers need to know in advance what they are looking for. Quantitative research is recommended when research questions are more fully developed, often in the mid to late stages of a project. It is generally viewed as more objective and seeks precise measurement through questionnaires and scales. Quantitative research tends to be less time consuming and more generalisable because it measures 'sameness' in a group of subjects, but may miss the subtle detail. It is very useful for measuring clinical outcomes or comparing services or programs.

Assessing strength of evidence

The National Health and Medical Research Council (NHMRC) has outlined criteria for assessing strength of evidence. The strength of evidence for (and sometimes against) the effectiveness of a particular approach depends on the quality of the studies that have investigated it. In assessing the quality of a study, consider the following:

- **What type of methods were used?** Within the NHMRC framework, systematic reviews and meta-analyses are considered the strongest evidence when examining outcomes of treatments, followed by randomised trials. Case studies are considered the weakest evidence upon which to make decisions about applying treatments to groups of patients.
- **Where are the results published?** Research that is published in a professional journal is subject to scrutiny (referred to as peer review) by other professionals prior to publication and in general is considered to be of higher quality and more reliable than a report that has been published only on the internet for example.
- **Does it address a sound and focused research question?** The question should follow logically from previous work in the area and the introduction section should provide context. Vague or irrelevant questions usually lead to vague or irrelevant results.
- **How were the study participants selected and managed?** Quality treatment studies select participants that are appropriate for the research question, have adequate numbers of participants so that outcomes can be measured, compare groups of participants that are as similar as possible at the start of the study so the only difference between them is the treatment being tested (the best method is random allocation to a group), have a reasonable follow-up period and allow for participant drop-out when analysing results. Attention to these things helps to minimise errors and bias.
- **How are changes measured?** Standard questionnaires or tools that are known to be reliable and valid measures of the outcome under investigation allow greater confidence in the results than a tool that is unknown, untested, or created specifically for the study.

Results of studies that ask similar questions, are similar in design, and report results in a similar way can be pooled and analysed as a group (meta-analysis) which is the strongest evidence available.

How do I decide whether the evidence is applicable to my practice?

A common criticism of the research evidence is that treatments are usually tested in tightly controlled research settings, which can differ considerably from the real world.

Initial studies often exclude clients with complex needs in order to see if a treatment works at all before testing it on participants that more closely resemble those we see in clinical settings. However, this is only a problem if you want to use a therapy strictly according to a manual and do exactly as they did in the study with the same type of clients, which is rarely the case.

The key to EBP is flexibility and the ability to adapt evidence to the clinical setting, which brings us back to the five-step EBP model. If evidence is applicable to your practice you should be able to answer 'yes' to the following questions:

1. Have I asked a focused, clinical question?
2. Have I found evidence that provides a suitable answer to my question?

3. Is the evidence of reasonable quality?
4. Does it match my client's preferences and treatment goals?
5. Does it fit reasonably with my client's clinical presentation and circumstances?
6. Do I have the necessary skills to conduct the intervention and/or to adjust it to better meet my client's needs?
7. Is my work setting suitable for this type of intervention?

What if the evidence is conflicting or there is little or no evidence that applies to my situation?

The application of evidence to practice is not always a perfect science; the important thing is to gather as many tools and as much information as you can to assist with decision-making.

A clinician's voice ...

Stefan Gruenert*

In the drug and alcohol sector, I often hear people say that our work is evidence based, or at least that our programs are evidence informed. And yet, how often do we actually look at the evidence in a systematic way to ensure that this is the case? At Odyssey House in Victoria, we have done this on occasions. Sometimes it has led to the introduction of a new treatment element or a new approach. For example, incorporating a trauma-informed module to assist clients with their emotional regulation.

However, examining the research literature has also thrown up some challenges. Sometimes, there is simply no available evidence for our questions. Other times, while the research has been conducted and seems to favour another approach, I feel the research was compromised by its quality or its design, the questions it asked, the country or context it was conducted in, or the people it excluded. Luckily, as a clinician who has dabbled in research, I feel confident to organise our own research when I can't find answers elsewhere. I hope the following examples will encourage others to do the same.

Example 1:

Unlike many other co-occurring mental health issues, the research literature seemed to suggest that people who experience social anxiety are difficult to retain in drug and alcohol treatment and that their social anxiety is likely to remain after treatment. To test this out at Odyssey, we first used a screening measure to determine how many people seeking our help actually had social anxiety and whether or not they were

more likely to drop out of treatment. We are now piloting a brief intervention to try and improve engagement and retention as part of an Australian Research Council Linkage grant.

Example 2:

A few years ago we realised that a significant number of clients who had completed residential treatment at our Therapeutic Community were starting to use alcohol in problematic ways as they reintegrated into work and family life. These were people who had never had a primary alcohol issue. In trying to understand this, we looked at international outcome studies and discovered that this was indeed a common problem. However, we couldn't find evidence of any programs designed to tackle this.

Several months later, we had formed a partnership with Windana (another treatment agency) and with Deakin and Washington Universities, and obtained a substantial grant from the AER Foundation. As a result, we were able to conduct a multi-agency, randomised controlled trial to develop and evaluate the effectiveness of a skills-based module to prevent problematic drinking post treatment. While the results haven't been published yet, they do indicate that alcohol was in fact a gateway to relapse, and that a brief module teaching mindfulness, challenging expectancies, and reflection on the role of alcohol in recovery can in fact reduce relapse rates. An added bonus is that both agencies also have long-term follow-up data on their programs' effectiveness.

* Dr Stefan Gruenert is the CEO of Odyssey House Victoria.

IF YOU CAN FIND NO RESEARCH EVIDENCE THAT ANSWERS YOUR QUESTION OR APPLIES TO THE SPECIFIC CLINICAL SITUATION, YOU NEED TO CREATE YOUR OWN EVIDENCE BASE.

It is rare that all research points in the same direction. Reasons for conflicting research findings include different outcome measures, different patient groups and different applications of an intervention. It will be necessary to weigh up the quality of the evidence and to look at the weight of the evidence. To do this, an understanding of what is a sound design and an ability to look at the whole body of evidence, rather than just one or two studies, is important.

Once you have made a decision to apply a particular intervention, service or program based on your assessment of the evidence, the measurement of client outcomes then becomes crucial, particularly when the evidence is conflicting or not clear.

A fundamental part of EBP is measuring your own clients' progress over time. Keeping appointments, being happy with treatment and appearing engaged are all important in treatment, especially when working with complex groups, but you cannot be certain that clinically meaningful change, including changes in drug or alcohol use or mental health symptoms, is occurring unless you measure that change. For example, if someone presents for treatment to reduce their alcohol consumption you need to measure their alcohol consumption in a meaningful way over the course of treatment to ensure that it is indeed reducing. Use structured assessments or tools at least at the beginning, middle and end of your intervention so you can adjust and adapt your approach collaboratively as therapy proceeds.

If you can find no research evidence that answers your question or applies to the specific clinical situation, you need to create your own evidence base. Sometimes this is referred to as 'Practice Based Evidence' – the use of evidence gathered from treatment implementation and practitioner knowledge. This is similar to a research project, in that you:

1. Choose what you believe to be a suitable intervention based on what you've learnt from the evidence that is available.
2. Identify the client's key issues and measure them at the beginning of the intervention as a baseline.
3. Measure the key issues throughout treatment and then at the end of treatment or at follow-up.
4. Tailor the intervention based on your assessment of the outcomes.

If the client is not improving you may need to try a different strategy but you may not be aware of this unless you keep a formal record. Clients also benefit from regular measurement and feedback of progress, particularly if they are at risk of relapse. Highlighting treatment gains at challenging periods in the client's life can strengthen engagement, improve self-efficacy and increase motivation to continue treatment.

Summary

An effective evidence-based practitioner:

- asks a clear and focused question
- finds, understands and interprets the evidence
- matches the evidence with their client's preferences and needs
- acts in accordance with their skills base and work setting
- creates evidence by measuring each client's progress throughout treatment when suitable evidence is lacking.

* *Linda Jenner and Nicole Lee write from LeeJenn Health Consultants (www.leejenn.com.au).*

RECOMMENDED EVIDENCE-BASED PRACTICE RESOURCES

Cochrane Collaboration

www.cochrane.org

The Cochrane Collaboration assists health care providers, policy makers and patients to make well-informed decisions about health care based on the best available research evidence. It publishes an extensive library of nearly 5000 systematic reviews with summaries for non-researchers and the public.

The National Health and Medical Research Council

www.nhmrc.gov.au

The NHMRC publish a number of documents designed to assist in the application of evidence-based practice including *How to put evidence into practice: Implementation and dissemination strategies* (2000); *How to present the evidence for consumers: Preparation of consumer publications* (2000); and *How to use the evidence: assessment and application of scientific evidence* (2000). The NHMRC also hosts the National Institute of Clinical Studies (NICS) which is designed to improve translation of research into health care practice.

Joanna Briggs Institute

www.joannabriggs.edu.au

The Joanna Briggs Institute focuses on the development and application of research into policy and practice. They produce and utilise similar processes and instruments to Cochrane Collaboration and NHMRC but offer a broader view.

National Drug Sector Information Service

<http://ndsis.adca.org.au>

NDSIS is a service of the AOD sector peak body, the Alcohol and other Drugs Council of Australia (ADCA). It holds a large database of drug and alcohol publications and staff can assist AOD workers to find research articles, guidelines, reports and other publications that will assist them to use evidence-based practices.

Achieving excellence

The Sydney Gay and Lesbian Choir perform on the night

THE NATIONAL DRUG AND ALCOHOL AWARDS WERE HELD IN SYDNEY 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, A NUMBER OF OUTSTANDING INDIVIDUALS ARE ALSO INDUCTED INTO THE DRUG AND ALCOHOL SECTOR'S HONOUR ROLL.

THIS YEAR'S AWARDS WERE SPONSORED BY THE FEDERAL DEPARTMENT OF HEALTH & AGEING, THE AUSTRALIAN SPORTS COMMISSION, NSW HEALTH, THE PHARMACY GUILD OF AUSTRALIA AND THE ACT DEPARTMENT OF EDUCATION AND TRAINING.

PRIME MINISTER'S AWARD

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 Judge Roger Dive, who is the Senior Judge of the NSW Drug Court. Judge Dive was responsible for the development and implementation of the NSW Youth Drug and Alcohol Court (YDAC) in 2000 and its success has been due in part to his passion and commitment to the program.

Judge Dive has championed the promotion of a humane and holistic response to offenders with alcohol and other drug problems. He is committed to the principles of 'therapeutic jurisprudence', and using the courts to reduce the impact and negative effects of drug and alcohol use on individuals and the community.

Judge Dive moved to the NSW Adult Drug Court in 2004 where he continues to lead a team from justice and health agencies who together manage and enforce long-term change in the lives of drug-dependent offenders.

In a statement released by the Prime Minister, Julia Gillard, to announce the award, she said, 'The innovative work of Judge Dive and his colleagues on the Drug Court is mirrored by a web of government and non-government services across all our states and territories—a partnership that succeeds through cooperation, goodwill and a shared belief that what we are doing really can make a difference.'



An interview with Judge Dive appeared in our last issue (July 2011, vol. 9, no. 2, pp. 22-23).

EXCELLENCE IN LAW ENFORCEMENT: The Bourke Alcohol Working Group



Members of the Bourke Alcohol Working Group

The Bourke Alcohol Working Group (BAWG), comprising representatives from the Police Service, Aboriginal Health, NSW Health and Bourke Shire Council, won the Excellence in Law Enforcement category.

BAWG is an outstanding example of how a multi-agency approach can have significant positive impacts on a community, particularly a rural community. Genuine consultation and participation by individuals from local agencies, working with the local community, has resulted in real solutions to local problems.

Bourke had a long history of alcohol-related crime and associated health issues, impacting on generations of local residents. Police Sgt Mick Williams developed the idea about bringing together committed people from multiple agencies in order to achieve positive outcomes with a lasting impact. A forum was conducted in July 2008 with over 80 subject experts in attendance. Arising from this, the Bourke five-year Alcohol Management Plan was developed and the BAWG was established, representing government and NGO groups, all working in a coordinated manner.

Bourke Specific Licensing Conditions were also introduced in February 2008 with the assistance and support of BAWG. A comparison of crime statistics for the 18 months before February 2008 compared to the 18 months after, ending August 2010, showed impressive reductions in intoxicated persons arrests, assaults and domestic-related assaults.

EXCELLENCE IN RESEARCH: The Range and Magnitude of Alcohol's Harm to Others study



Researchers from the Range and Magnitude of Alcohol's Harm to Others research study

The AER Centre for Alcohol Policy Research has won the Excellence in Research category for its Range and Magnitude of Alcohol's Harm to Others (RMAHO) research study. Support and assistance for the project was provided by its national collaborators: the National Drug and Alcohol Research Centre and the National Drug Research Institute.

The RMAHO research is the first comprehensive assessment anywhere of the extent to which alcohol misuse harms people other than the drinker. The research identified that alcohol's harm to others totals an economic cost of at least \$20 billion every year.

The study unveiled a new dimension in the national alcohol debate, and looked at the following critical questions:

- How are Australians affected by the drinking of others?
- What is the relationship between those affected and the drinker?
- What are the costs for others – in trouble, time and money?

The findings portray the tens of thousands of Australians who are affected by others' drinking and are hospitalised, assaulted, injured in road crashes, victims of child maltreatment and counselled. The survey numbers demonstrate that literally millions of people are affected by the public nuisance, noise and fear associated with others' drinking, and that an estimated 1.2 million people were affected by drinkers they live with or are related to.

HONOUR ROLL

This year, two people were inducted into the National Drug and Alcohol Awards Honour Roll: Mr David McDonald and Professor Robyn Richmond. The Honour Roll acknowledges individuals who have provided a significant contribution over the course of their careers to working to reduce harms from alcohol and other drug (AOD) use.

David McDonald is a social scientist who has worked tirelessly to improve

the health and well-being of people affected by AOD issues. His contributions to evidence-informed AOD public policy span decades. David has been awarded a huge range of AOD-related research grants and consultancies over the last 30 years, demonstrating his dedication to ensuring that the AOD sector's public health initiatives and policies are carefully designed, implemented and evaluated.

Professor Robyn Richmond was recognised for her exceptional and sustained contributions extending over 30 years to reducing the impacts and negative effects of alcohol and tobacco use in Australia.

Professor Richmond continues to have a stellar career in public health research, specifically focused on improving health outcomes through reducing risky alcohol consumption and smoking cessation.



David McDonald and Professor Robyn Richmond

EXCELLENCE IN PREVENTION AND COMMUNITY EDUCATION:

The WA Department of Health's Multi-Systemic Therapy Program

The Western Australian Department of Health's Multi-Systemic Therapy (MST) Program, which won the Excellence in Prevention and Community Education category, is an intensive family-based intervention for severe behavioural disorders in young people aged 10-16 years. Untreated disorders of this kind can be precursors of adult mental health problems, substance abuse, criminality, interpersonal violence, unemployment, incarceration and premature death.

The MST Program was introduced in 2005 after several years of research and investigation into various other national and international evidence-based programs. As a result of this study, the MST Program was located within a suite of hospital and clinic-based child and adolescent mental health services and programs, to increase its accessibility to, and coordination with, these services.

The MST Program is composed of two small teams of clinical psychologists, each including an Aboriginal mental health professional. Their family-based intervention programs run for approximately four to six months.

The program is the first mental health MST service in Australia and the judges were impressed by its robust longitudinal research component to measure the intervention's effectiveness.

EXCELLENCE IN SERVICES TO YOUNG PEOPLE:

Hello Sunday Morning

The Hello Sunday Morning (HSM) website – www.hellosundaymorning.com.au – has won the 2011 Excellence in Services for Young People category.

HSM began as a social experiment conducted by 23-year-old Chris Raine (CEO of HSM) who gave up alcohol entirely for a year to experience firsthand how Australia's alcohol dependence could be reduced. He documented his social experiment in a blog, which quickly gained traction and evolved into an organisation, Hello Sunday Morning.

Halfway through his year of sobriety, Chris began research with Fresh Advertising, who made up the original HSM team. The team conducted an extensive literature review on the motivators behind why young people binge drink; they then incorporated this knowledge into their own research through the HSM project.

HSM is now a non-denominational charity based in Australia which empowers individuals to contribute to, and

change, our cultural dependence on alcohol. HSM gives young Australians an opportunity to create a life without the cultural expectations around drinking, by sharing their experiences in a supportive online community.

As finalists in this same category last year, the HSM team was delighted to receive the top honour this year. 'Recognition such as this really helps validate the work we're aiming to achieve through our innovative program,' said Chris Raine.



Hello Sunday Morning: Chris Raine, Natalie Hertz and Laura Stokes

EXCELLENCE IN CREATING HEALTHY SPORTING COMMUNITIES:

Eastern Football League, Victoria

The Eastern Football League (EFL) of Victoria has been recognised for excellence in creating healthy sporting communities by winning this inaugural award at the 2011 Awards.

The new award, sponsored by the Australian Sports Commission, seeks to recognise best practice across the community sporting and recreation sector for the responsible management and prevention of harm relating to alcohol and other drugs.

The EFL operates in the eastern suburbs of Melbourne, with a combined membership of 48 Australian Football League clubs, and a total of 440 teams. Its 13 000 registered players range from age seven to veterans.

EFL football is more than a game; it is the biggest service club in many suburbs and communities. Football clubs provide a source of local pride, meaning and relevance. EFL secured the position of the first sporting body nationally to have 100 per cent membership of the Good Sports program – an alcohol management program for sporting clubs run by the Australian Drug Foundation – in 2010.

EFL has also conducted responsible service of alcohol training for clubs. They arranged for Victoria Police to attend finals matches and provide free voluntary breath testing to help to demonstrate the impact of various levels of alcohol intake. The EFL was also the first non-professional sporting body to implement an illicit drugs policy and a program that focused on helping club officials to identify and deal with matters largely unfamiliar to them, based on harm minimisation principles.

EXCELLENCE IN SCHOOL DRUG EDUCATION: Wollumbin High School, NSW

Wollumbin High School, in Murwillumbah NSW, has been judged the winner of the Excellence in School Drug Education category for its 'Life Without Drugs' initiative.

To get the initiative started, the NSW Department of Education and Training funded a pilot program, and also provided training and support throughout the process. This created a positive environment for the staff to experiment with drug education in a format that was unique to their school and student body.

The project focused on what works best for students. From the outset it became clear that social networking websites and mobile phones were the communication mediums most frequently used by the students.

As a result, the program utilised four key interactive components: creation of a website; interactive lessons using

Moodle (a web-based learning platform) and OneNote software; a Key Learning Area Task combining Art, English and Physical Development; and text messaging.

In accepting their award, the Wollumbin High School team thanked their whole school body for getting behind the program, and for the students who have made it a success.



Life without drugs: the Wollumbin High School team

EXCELLENCE IN MEDIA REPORTING: Jill Stark

A series of articles by Melbourne-based journalist Jill Stark in *The Sunday Age* has won her the Media Reporting award in 2011.

Ms Stark's articles initially investigated the relationship between Australian sporting codes, the alcohol industry and state and federal government alcohol policies, and attempts to change the nation's binge-drinking culture. Her article in April this year, titled 'Here's to me', shifted the focus onto her own drinking habits. Acknowledging publicly her own binge drinking, she embarked on a

period of abstinence from alcohol with the motivational aid of the website 'Hello Sunday Morning' (see the Excellence in Services to Young People award).

The judges considered that this insightful feature not only topped off Ms Stark's earlier coverage of alcohol and other drugs issues, but showed her journalistic professionalism and willingness to go that one step further to encourage her reading audience to consider their own habits.

The judges were also of the opinion that the content in Ms Stark's overall coverage had the potential to help change community attitudes towards the excessive consumption of alcohol, and the misuse of other drugs, including pharmaceuticals.

EXCELLENCE IN TREATMENT AND SUPPORT: Catalyst, UnitingCare Moreland Hall, Victoria

UnitingCare Moreland Hall's Catalyst Alcohol Community Rehabilitation Program is the winner of this year's Excellence in Treatment and Support category.

Catalyst is a post-withdrawal, community-based alcohol rehabilitation program designed to assist people in early recovery to make necessary lifestyle changes to alleviate alcohol-related problems in both the short and long term. It provides a flexible, holistic model designed to maximise the integration of participants' learning into their daily lives.

Catalyst was developed as a six-week program that allows people to participate in a rehabilitation program without having to enter a residential setting. By remaining in the community, they are able to maintain their family, work and social commitments and put the skills they learn into immediate practice.

The program has had an often profound impact on participants and their families, and evaluation findings have consistently demonstrated the positive changes that have occurred in participants' lives. The UnitingCare Moreland Hall team was delighted to receive their award, having been finalists in a number of categories in previous years.



UnitingCare Moreland Hall: Joanne Richardson, Ian Angus, Brandon Jones, Donna Ribton-Turner

upcoming events



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9-11 November

The 8th Australian & New Zealand Adolescent Health Conference: Youth Health 2011

Sydney Convention & Exhibition Centre,
Darling Harbour, Sydney, NSW
www.youthhealth2011.com.au

11-13 November

General Practitioner Conference & Exhibition (GPCE)

Melbourne, Vic
www.gpce.com.au

13-16 November

The Australasian Professional Society on Alcohol and other Drugs (APSAD) Conference

Hobart, Tasmania
www.apsadconference.com.au

24-25 November

2011 National Hepatitis Health Promotion Conference

Brisbane, Qld
[www.hepatitisaustralia.com/events/
hepatitis-health-promotion-conference](http://www.hepatitisaustralia.com/events/hepatitis-health-promotion-conference)

12-13 April 2012

12th Social Research Conference on HIV, Hepatitis C and Related Diseases

University of New South Wales, Sydney, NSW
nchsrconference2012.arts.unsw.edu.au

5-6 June 2012

Australian Winter School

Surfers Paradise, Qld
www.winterschool.info

6-8 June 2012

2nd National Indigenous Drug & Alcohol Committee Conference

Fremantle, WA
www.nidaconference.com.au

19-21 September 2012

2nd National Cannabis Conference

Brisbane, Qld
www.ncpic.org.au

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