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issuing **forth**

Socio-economic inequalities and drug use

ed**space**

One of NDARC's key priorities is to ensure that we disseminate the findings of our research as widely as possible in a timely manner. Although the centre is well known for it's high media profile there are limits to the quality of the information provided through media outlets. Accurate research findings need to be able to be accessed by alcohol and other drug workers and policy makers and over the years the NDARC Annual Symposium and *CentreLines* have become two of our main tools to achieve this goal.

Each year the NDARC Annual Symposium provides a forum for alcohol and other drug workers to hear about a wide range of research projects which are currently being undertaken at the Centre. Although publications are important to an academic institution it is vital that the information collected is fed back to the field as quickly as possible. Although the situation has improved greatly, there can still be a great delay between the collection of data, the identification of problems and the publication date of the report. Regular updates to the field are vital and the Annual Symposium has proven to be a great vehicle for getting important findings out to the field in an efficient way.

Last year our Annual Symposium proved to be more popular than ever with over 200 people registering for the day. The focus was on treatment, with a special emphasis on one of NDARC's major projects – The Australian Treatment Outcome Study (ATOS). A number of presentations at the Symposium addressed findings on treatment outcome at 3 months, and also a range of major clinical issues emerging from the study.

This year the NDARC Annual Symposium will be held on Thursday 29 July at the Masonic Centre, Sydney. Once again we have decided to focus on a number of key areas and highlight some of our major projects, either recently completed or currently in progress, that may be of interest to workers in the alcohol and other drug field. Those key areas are: alcohol, methamphetamine, and party drugs. Due to great demand we will also be re-examining ATOS, this time taking a close look at the NSW 12 month findings.

Unfortunately it is not always possible for people to attend the Symposium, due to either time or distance constraints. As a result we have been asked to investigate the possibility of videoing the proceedings and making this available, particularly for those who live interstate. We are currently looking at the costs involved in doing this.

For more information on the Annual Symposium and a registration form for the day please go the NDARC website at http://ndarc.med.unsw.edu.au/ndarc.nsf/website/News.symposium, or contact the NDARC Reception on (02) 9385 0333 to have a registration form faxed or mailed to you.

Paul Dillon, Editor

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headspace

Responding to drugs and alcohol: broadening our scope

Maree Teesson

A public health response to drug and alcohol problems has always been of crucial import. This is now even more vital with reducing health care dollars and increasing burden of disease, especially among young Australians. The National Drug and Alcohol Research Centre is embracing this challenge. In this edition of *CentreLines* we have asked Dr Catherine Spooner to outline some of her work in understanding socio-economic inequalities and drug use. This area is complex but if we are to reduce the burden of drug and alcohol problems on individuals and society a greater understanding is crucial.

As with physical disorders, health care in the drug and alcohol field has always been, and will continue to be rationed, and there will never be sufficient funds to provide the care that all individuals with problems with substance use need or would like. The UK spends 6.5%, Australia spends 8.5% and Canada spends 9.5% of their respective gross domestic products (GDPs) on health. Australia spends 5% of the health budget on mental health and substance use services[1]. Yet, the burden to society of mental disorders and substance use disorders is considerably more than would be implied by this allocation to care. The recent WHO Burden of Disease Report estimates that mental health and drug and alcohol contribute 20% to the burden of disease in society[2]. Mental disorders are the third leading causes of burden in developed countries after cardiovascular disease.

In all, 0.4% of the GDP is spent on mental health and drug and alcohol in Australia. This is half of what Canada, the UK and New Zealand spend. If there is not going to be a redistribution of funds it will be a matter of managing scarcity. We currently spend a considerable proportion of our health budget on people with chronic long-term disorders. While we have evidence that treatment can be effective, there are substantial numbers of people disabled by problems with drug and alcohol use who do not get treatment and who also may benefit. Importantly, these problems are often amenable to care.

The epidemiological data also demonstrate that problems with drug and alcohol use are of particular concern for young adults aged 15-24 years. The recent Australian Burden of Disease and Injury Study found that nine out of the ten leading causes of burden in young males and eight out of ten leading causes in young females were substance use disorders or mental disorders (Table 1). Thus, apart from the burden resulting from road traffic accidents (and asthma in females), the disease burden in this group is the result of alcohol dependence, suicide, bipolar affective disorder, heroin dependence, schizophrenia, depression, social phobia, borderline personality disorder, generalised anxiety disorder and eating disorders[3].

Table 1: Ten leading causes of burden of disease and injury in 15-24 years olds in Australia in rank order

MALES	FEMALES
1. Road traffic accidents	1. Depression
2. Alcohol dependence	2. Bipolar affective
3. Suicide	**3. Alcohol dependence**
4. Bipolar affective	4. Eating disorders
5. Heroin dependence	5. Social phobia
6. Schizophrenia	**6. Heroin dependence**
7. Depression	7. Asthma
8. Social phobia	8. Road traffic accidents
9. Borderline personality	9. Schizophrenia
10. Generalised anxiety disorder	10. Generalised anxiety disorder

This high concentration of mental illness in the young suggests that early intervention and prevention may assist to reduce the burden. Prevention is a crucial component in the breadth of interventions considered in the area. A report from the American Institute of Medicine noted that prevention of mental disorders has a low priority in the health care agendas of most countries. The report suggests that a greater effort should be placed on prevention. The authors argue that several factors make this possible. Firstly there has been a substantial growth in the knowledge about both environmental and genetic risk factors for substance use disorders. Secondly, a number of promising models for early intervention now exist[4].

It is one aspect of the first area, our greater understanding of the environmental risk factors which Dr Catherine Spooner will outline in *Issuing Forth*. **cl**

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issuing forth

Socio-economic inequalities and drug use

Catherine Spooner and Michael Gascoigne

Introduction

There has been substantial interest in the impact of individual-level socio-economic position (SEP) and population-level income inequality on health[1,2]. There is also good reason to believe that SEP influences drug use behaviours and drug consequences. This article discusses these relationships and considers the implications for policy and research. But first, the distinction between SEP and income inequality needs to be clarified.

SEP refers typically to an individual's or family's social situation as indicated by a variety of social and economic factors. Examples of these factors include occupation, education or income. SEP may indicate both absolute and relative social and economic circumstances. That is, a person with low SEP in a wealthy country could have a higher income than a high-SEP person from a poor country. Measures of SEP at the community level also exist. For example, the Australian Bureau of Statistics used data from the Census of Population and Housing to construct a number of indices to summarise the social and economic conditions of Australia by geographic area[3]. For example, the index of disadvantage focuses on low-income earners, relatively lower educational attainment and high unemployment. Professor Vinson has used data at the postcode level to rank NSW and Victorian postcode areas in terms of disadvantage[4].

Inequality refers to a condition in which separate groups differ in terms of a defined variable. The defined variable can relate to SEP (hence terms such as socio-economic inequality, economic inequality, and income inequality). The defined variable can relate to health status (hence the term 'health inequalities'). To avoid confusion, it is important to identify the type of inequality. **Income inequality** is often measured at the national level, but is also measured at the state and local levels. The **gini coefficient** is a common measure of income inequality. It can

be conceptualized as a measure of the average difference between all pairs of incomes in a population. The gini coefficient has a minimum value of 0 when everyone has the same income (complete equality) and it has a maximum value of 1 when a single individual or household receives all of the income in the population (complete inequality)[5].

In sum, SEP is usually used to reflect an individual or family's social and economic position in absolute terms as well as relative to others in the rest of their country. Geographic areas are also ranked in terms of their level of socio-economic advantage. Income inequality, on the other hand, refers to the size of the gap between rich and poor in an area, state or country.

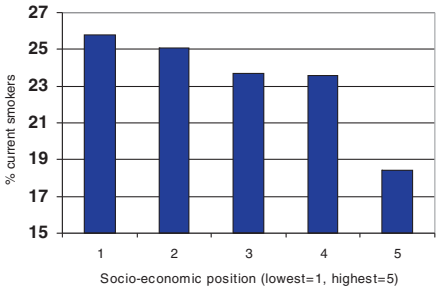
Socio-economic position

It is now widely accepted that higher SEP is associated with better health[6]. In summarising this literature, Lynch and colleagues noted that:

- The relationship has been found with many (but not all) disease and mortality outcomes
- The relationship between individual-level income and health is an incremental one. That is, with each increment in SEP, there is generally an increment in health status
- While poor health can have a negative impact upon SEP, the primary causal relationship is that SEP has a negative impact on health[5].

Conceptual models often see health behaviours such as drug use as a mediating factor in the relationship between SEP and health inequalities[7]. SEP differentials in drug use and drug problems add credibility to these conceptualizations. For example, many would be familiar with the higher rates of smoking among people from lower socio-economic backgrounds. The prevalence of smoking reported by five socio-economic groups of respondents in the 2001 National Drug Household Survey is presented in Figure 1, demonstrates a reduction in the rate of smoking from the lowest (26%) to the highest (18%) socio-economic groups. SEP has also been associated with drug-related harms such as foetal alcohol syndrome[8], alcohol and drug disorders[9], hospital discharges due to diagnoses related to alcoholism (alcohol psychosis, alcoholism, and alcohol intoxication)[10], alcohol-related deaths[11], lung cancer[12,13], and drug overdoses[14]. It has also been associated with social problems such as alcohol-related assault[15].

Figure 1: Socio-economic position and smoking rates in Australia



Source: **Australian Institute of Health and Welfare**. (2002). *2001 National Drug Strategy Household Survey. Detailed Findings.* Drug Statistics Series Number 11. Canberra.

However, the relationship is neither simple nor consistent. In a presentation at the NCETA Summer School on Addictions and Inequalities in February 2004, Robin Room (Director, Centre for Social Research on Alcohol and Drugs, Sweden) described how 'It is clear from the literature that the relationships are not simple and unidirectional; a simple model of poverty resulting in more substance use which in turn causes greater rates of illness will often not be sustained empirically'[16]. Professor Room demonstrated how:

1. Patterns of use or problems by SEP can vary with the measure of use or problems utilized. Indeed the SEP relation can be reversed.
2. Patterns of use or problems by SEP can vary with the measure of SEP utilized.
3. All else being equal, income tends to have the strongest positive relation of any inequality indicator to consumption variables, particularly to volume of consumption.
4. For serious substance-related consequences such as mortality, the effects of different components of SEP may be additive.
5. The relation between SEP and substance use pattern can vary within the same country and across gender and ethnic groups.

Income inequality

There is also some evidence that the extent of income inequality affects health outcomes over and above absolute disadvantage[5,17]. Given the increase in gaps between rich and poor in recent decades[18,19] there is concern about this relationship, which suggests that we need to pay attention not only to addressing poverty, but to addressing the size of the gap between rich and poor. However, a recent systematic review of the literature relating to inequality cast doubts on the extent of this relationship[5]. A fairly robust association between income inequality and health differences was found in the USA, but not in other countries. This could be related to particular characteristics of the USA, such as policies towards the poor. Whatever the reason, it appears that inequality might only contribute to some outcomes in some contexts. Lynch and colleagues concluded that 'there seems to be little support for the idea that income inequality is a major, generalizable determinant of population health differences within or between rich countries. Income inequality may, however, directly influence some health outcomes, such as homicide in some contexts.' It is important to note that there may be some health-related outcomes and behaviours that are sensitive to levels of income inequality such as drug use behaviours.

While the evidence for a link between income inequality and mortality and morbidity is weak outside the US, there is logic to considering whether the extent of inequality in a society could impact upon drug use behaviours. Given that drug use can be a form of coping with stress, it is not unreasonable to consider that areas or countries that have large gaps between rich and poor (and associated anomie, marginalisation[20], reduced social cohesion, reduced investment in social capital[21]) might be more subject to higher rates of drug use and related problems than more egalitarian societies. While a number of studies of inequality have included smoking and/or alcohol consumption as confounding variables[22,23,24,25,26] few studies have investigated drug use and related problems as outcome variables. Those that exist have reported mixed results (Table 1).

Table 1: Income inequality and drug use/outcomes

STUDY POPULATION	OUTCOME VARIABLE	ADJUSTMENT FOR	STUDY CONCLUSIONS
14,838 individuals in 15 industrialised countries	Smoking (never, former, light, heavy)	Individual age, marital status, individual socio-economic position, national cigarette diffusion	Income inequality associated with higher average levels of smoking,but this effect disappeared when Greece was excluded from the analyses. Higher income inequality associated with lower social disparities in smoking[27]
725 accidental overdose deaths (cases) and 453 accidental deaths due to other causes (controls) in 59 neighborhoods in New York City	Overdose deaths	Individual-level variables (age, race, and sex) and neighborhood-level variables (income, drug use, and racial composition)	Overdose deaths were more likely in neighborhoods with higher levels of drug use and with more unequal income distribution[28]
Cross-sectional US national probability sample	Alcohol dependence Symptoms of depression	Individual-level variables (family income, age, and race) State-level variables (alcohol tax policy)	'State income inequality does not increase the experience of alcohol dependence'[29]
81,557 individuals in 44 US states	CVD risk factors: BMI, history of hypertension, sedentarism, and smoking	State-level variables: Individual-level variables: income, gender, race/ ethnicity, age	'Inequality was positively associated with smoking, but associations were either stronger or only present at higher income levels. Associations of inequality with the outcomes were statistically significant in women but not in men'[30]

Adapted from Lynch, J., Smith, G.D., Harper, S., Hillemeier, M., Ross, N., Kaplan, G.A., et al. (2004). Is Income Inequality a Determinant of Population Health? Part 1. A Systematic Review. *The Milbank Quarterly* 82(1), 5-99.

Conclusions

In Australia, further research is needed to describe the relationships and (more importantly) to explain links between socio-economic disadvantage, absolute and relative deprivation and drug use. In the meantime, it is fair to say that SEP can impact upon drug use behaviours and problems of individuals, families and communities. This has implications for program and policy targeting, as well as adding urgency to the need to address the widening socio-economic disadvantage in our country. Whether inequality is an issue for the drugs field in Australia remains to be seen. In the meantime, it is an issue for consideration, debate and research.

Acknowledgements: Thanks to Associate Professor John Lynch for detailed comments on an earlier draft of this paper. **cl**

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project **notes**

Examining policy options for preventing cannabis users from driving under the influence of cannabis

Craig Jones, Don Weatherburn and Neil Donnelly (NSW Bureau of Crime Statistics and Research (BOCSAR)) and Wendy Swift

Funded by the NSW Office of Drug & Alcohol Policy, NSW Cabinet Office

Perhaps one of the most serious public health risks posed by cannabis use is the risk of fatal road trauma associated with driving under the influence of cannabis (DUIC). There is convincing evidence that driving-related psycho-motor performance is significantly impaired following recent consumption of intoxicating doses of cannabis. Furthermore, recent evidence suggests that fatally injured drivers who test positive for cannabis use may exhibit higher levels of accident culpability than drivers who do not test positive for any drug. Driving impairment and accident risk are increased if people drive after using cannabis in combination with alcohol, as they are known to have an approximately additive effect on driving-related impairment.

These findings are concerning, given the fact that DUIC appears to be quite common in Australia, particularly among young people who use cannabis frequently. One recent study found more than one-quarter of recent cannabis users, who were interviewed on the north coast of NSW, reported having driven within an hour of using cannabis in the previous year. These cannabis-intoxicated drivers also appear to commonly engage in driving under the influence of cannabis and alcohol together (DUICA), with one in four reporting the behaviour in the previous year. Little is known about the prevalence and effects of driving under the influence of cannabis and other illicit drugs.

In light of the relatively high prevalence of DUIC, and the potential for accident risk to increase after having used the drug, researchers and public policy makers around Australia have recently become interested in ways of reducing the prevalence and frequency of DUIC. There are two primary levers available to achieve this goal: educating users about the possible risks associated with DUIC and deterring users from driving under the influence of cannabis through law enforcement campaigns.

Police efforts to deter drug-driving have traditionally been constrained by an inability to test for recent drug use at the roadside in the same manner as they currently test for alcohol impairment. However, recent technological advances have provided police with the ability to test for the presence of a variety of drugs, including cannabis, through the analysis of saliva samples collected at the roadside. Changes in Victorian legislation will allow police in that State to trial random drug testing using this technology from mid-2004 and similar legislative changes have been proposed in other Australian States and Territories, including New South Wales. The potential deterrent value of such campaigns, though, is still very much an open question.

The first step in evaluating the potential benefits of any policy designed to reduce an unwanted behaviour should be to gain an appreciation of the factors associated with that behaviour, including an analysis of who is most likely to engage in the behaviour. At present, though, we know very little about the characteristics of cannabis-intoxicated drivers and other factors that are predictive of the likelihood of DUIC. It is particularly important for those responsible for educating cannabis users about the potential harms associated with DUIC to know why cannabis users engage or refrain from DUIC, how dangerous they believe DUIC to be, how likely they feel they are to be detected for driving under the influence of cannabis, and how severe they believe the penalties to be.

To date, the small number of Australian studies addressing these issues have involved either marginal, non-representative samples of injecting drug users, or very small samples of

long-term heavy cannabis users. In addition, only cursory attention has been paid to the relationship between the combined use of cannabis and other drugs (particularly alcohol). This is a conspicuous absence given the relatively high prevalence of DUICA among current cannabis users, and the potential for serious harm resulting from the combined use of cannabis and alcohol, and the combined use of cannabis and other illicit drugs.

This study, which employs accepted methodology from the criminological deterrence literature, will address these issues, in particular the potential benefits of intensifying law enforcement and education campaigns aimed at reducing DUIC. The two primary research questions are:

1. What factors are predictive of the prevalence and frequency of driving under the influence of cannabis (DUIC), driving under the influence of cannabis and alcohol together (DUICA) and driving under the influence of cannabis and other illicit drugs together?; and
2. Are there any likely deterrent benefits associated with (a) increasing the perceived certainty of being caught DUIC, (b) increasing the severity of sanctions if caught DUIC, and (c) providing factual information about the potential risks associated with DUIC?

Approximately 300 cannabis users will be recruited to participate in a confidential, anonymous interview on their behaviours and attitudes towards DUIC. Sampling methods will attempt to achieve a cross-section of younger (18-29) and older (30+) cannabis users, males and females and a wide range of cannabis use levels.

The study will incorporate a between-subjects factorial design to address the degree to which the certainty and severity of sanctions might reduce DUIC. Participants will be presented with one of four vignettes giving a hypothetical situation where they are presented with the opportunity to DUIC and asked to rate their likelihood of driving under those circumstances. We hypothesise that, if roadside testing and harsher penalties for DUIC would exhibit a deterrent effect, those subjects who are led to believe that the certainty and severity of punishment are high will indicate that they are less likely to DUIC than those in lower certainty/severity conditions.

Educating tertiary students in Sydney about what constitutes a standard drink

Fiona Shand, Jenny Stafford and Annie Bleeker

Funded by the Alcohol Education and Rehabilitation Foundation (AERF), this project aims to promote awareness amongst University and TAFE students in the Sydney region about what constitutes a 'standard drink'.

Essentially the objectives of the Standard Drinks Project are to:

- To educate tertiary students about what a standard alcoholic drink is for a range of alcoholic beverages.
- To provide a method for ongoing education of tertiary education students.

The methodology of the project includes:

- Liaising with Universities and TAFE colleges, their student associations and unions to promote what a standard drink is and safe levels of drinking.
- Set-up stalls in residential colleges, bar areas and other areas to ask people to pour a standard drink, provide posters, coasters and information booklets.
- Set-up stalls and provided resource packages at orientation weeks.
- Include articles about standard drinks and safe levels of drinking in student magazines.
- Liaise and work with medical services, counselling and career services within each of these organisations to provide information to health professionals and their clients.
- Distribute alcohol material/resources provided by the NHMRC (eg. booklets, posters, coasters, fact sheets, etc).

In January 2004, the project officer responsible for the AERF Standard Drinks project began to contact Universities and TAFE colleges in the Sydney area to ascertain their interest in participating in the project.

A Standard Drink Project Reference Group was established consisting of members from the University of Sydney, Department of Education and Training and NDARC personnel. The role of the reference group is to advise on the development, implementation and evaluation of the project.

The project has run in a number of universities and TAFEs across the Sydney area, with the greatest success being achieved with the University of Sydney. During O-week, eight student volunteers were recruited and trained by NDARC and the Health Education Unit at Sydney Uni. The aim of the training was to provide volunteers with information about alcohol and standard drinks, so that they could pass this information on to their peers. The training also included information about how to conduct and interpret the Alcohol Use Disorders Identification Test (AUDIT).

The training was evaluated by the volunteers with high levels of satisfaction recorded in both education sessions. Unfortunately training time was limited to 2 hours and ideally a 3-hour education session would have been more beneficial and allow time for questions and clarification. A 20-question pre-test on alcohol and standard drinks was administered to participants and the scores were very low (30%). Unfortunately the opportunity may not exist for NDARC to administer a post-test to participants.

Negotiations are also currently underway to conduct the standard drinks project in two Sydney University College residences.

The project will be able to document what is currently happening at Universities and TAFE's in the Sydney region with regard to alcohol and standard drinks information and provide a blue print of how to progress further with education tertiary students about standard drinks.

At this stage of the project there seems to be a great deal of interest from Universities and TAFE colleges to conduct alcohol education initiatives with students in tertiary settings. However without a budget or human resources to support it, the project is limited in scope and reach. **cl**

abstracts

Developing a global perspective on drug consumption patterns and trends – the challenge for drug epidemiology

Bulletin on Narcotics, Volume LV, Nos. 1 and 2, 2003 1-8

Paul Griffiths and Rebecca McKetin

The purpose of the present paper is to review progress made towards improving drug consumption information at a global level. The paper reviews methodological developments achieved through the collaboration of international experts and organizations in the field of drug use epidemiology at two global meetings. The first was held in January 2000 to develop a consensus on the principles, structures and indicators underpinning drug information systems, and the second in December 2001 to review methods used by regional epidemiological networks and identify opportunities for methodological development, future collaboration and improved working practices. Discussions at these meetings were successful in developing a framework for improved data collection practices at the global level, and showed considerable progress had been made in the coverage and quality of data collected. The use of drug information networks has played a key role in this developmental process by fostering the systematic collection and interpretation of data and providing a forum for the sharing of information and experiences across disciplines and geographic regions. Remaining challenges for data collection at the global level are the development of robust low-cost methods of collection that can be adapted to all regions of the world, as well as the need for ongoing interregional collaboration to foster this process.

Characteristics of Aboriginal Injecting Drug Users in Sydney, Australia: Prison history, hepatitis C status and drug treatment experiences

Journal of Ethnicity in Substance Abuse 2, 51-58

Carolyn Day, Joanne Ross and Kate Dolan

Australian Aboriginals are over-represented in prisons and tend to be over-represented in studies of injecting drug users (IDU). The aim of

this study was to examine differences between Aboriginal and non-Aboriginal IDUs in terms of gender, prison history and hepatitis C status and testing. Secondary analyses were conducted on data from three cross-sectional studies of IDUs. These studies employed similar methodologies, with recruitment being through needle and syringe programs, methadone clinics, snowballing and street intercepts. All studies were coordinated through the National Drug and Alcohol Research Centre. Aboriginal people were over-represented in all studies, were more likely to have been incarcerated and to report heroin as their drug of choice than non-Aboriginal IDUs. Females tended to be over-represented among Aboriginal IDUs, were more likely to have been incarcerated and had a longer period of time since their last hepatitis C test than non-Aboriginal female IDUs. Aboriginal people are over-represented among IDUs in Sydney. Given their greater risk of incarceration, particularly among females, Aboriginal IDUs were at greater risk of hepatitis C exposure than non-Aboriginal IDUs. The prison setting provides an opportunity to promote drug treatment and hepatitis C testing, though more needs to be done to reduce drug use and incarceration.

Attempted suicide among entrants to three treatment modalities for heroin dependence in the Australian Treatment Outcome Study (ATOS): prevalence and risk factors

Drug and Alcohol Dependence 73 1-10

Shane Darke, Joanne Ross, Michael Lynskey, and Maree Teesson

Aims: To determine the lifetime and recent histories of attempted suicide among entrants to treatment for heroin dependence in three treatment modalities and a non-treatment comparison group; and to ascertain factors associated with a recent history of attempted suicide.

Design: Cross-sectional structured interview.

Setting: Sydney, Australia.

Participants: Six hundred and fifteen current heroin users: 201 entering methadone/ buprenorphine maintenance (MT), 201 entering detoxification (DTX), 133 entering drug free residential rehabilitation (RR) and 80 not in treatment (NT).

Findings: A lifetime history of attempted suicide was reported by 34% of subjects, 13% had attempted suicide in the preceding year and 5% had done so in the preceding month. Females were more likely to have lifetime (44% versus 28%) and 12 month (21% versus 9%) suicide attempt histories. The 12 month prevalence of attempted suicide among treatment groups ranged between 11% (MT, NT) and 17% (RR). Factors associated with recent suicide attempts were: being an RR entrant, female gender, younger age, less education, more extensive polydrug use, benzodiazepine use, recent heroin overdose, Major Depression, current suicidal ideation, Borderline Personality Disorder (BPD) and Post-Traumatic Stress Disorder.

Conclusions: Recent suicidal behaviour is a major clinical problem for heroin users, and for females and RR entrants in particular. An essential adjunct to treatment for heroin dependence is routine screening for depression and suicidal ideation, with the provision of appropriate treatment where needed.

Adapting the Illicit Drug Reporting System (IDRS) to examine the feasibility of monitoring trends in the markets for 'party drugs'

Drug and Alcohol Dependence 73, 189-197

Libby Topp, Courtney Breen, Sharlene Kaye and Shane Darke

Since 1996, the Illicit Drug Reporting System (IDRS), Australia's strategic early warning system for illicit drug trends, has monitored annual trends in the markets for the four main illicit drug classes, cannabis, methamphetamine, cocaine and heroin. In 2000, a 2-year trial was implemented to examine the feasibility of using similar methodology to monitor trends in the markets for 'party drugs'. A triangulation of three data sources was sought: (1) quantitative interviews with a 'sentinel' population of drug users; (2) qualitative interviews with key informants (KIs), or those who have contact with drug users through their work; (3) extant indicator data sources such as the purity of illicit drugs seized by law enforcement agencies. The results suggested that the feasibility of collecting detailed, reliable and valid data about party drug markets is a direct function of the size of those markets. The trial demonstrated that the system would allow the successful monitoring of markets for party drugs that are relatively widely used, such as ecstasy, but would be less sensitive in monitoring markets for party drugs that are used by small proportions of the total population, such as gamma-hydroxy-butyrate (GHB) and ketamine. Methodological issues encountered during the conduct of this trial are discussed, including defining the appropriate sentinel population of drug users, identifying relevant key informants, and the relative absence of extant indicator data sources that could inform our understanding of party drug markets.

Drug driving among injecting drug users in Sydney, Australia: prevalence, risk factors and risk perceptions

Addiction 99, 177-185

Shane Darke, Erin Kelly and Joanne Ross

Aims: To examine the prevalence of drug driving, the prevalence of drug-related motor vehicle accidents, risk perceptions of drug driving, and factors associated with drug driving among injecting drug users (IDU)

Design: Cross-sectional survey

Setting: Sydney, Australia

Participants: 300 current IDU

Findings: 95% had driven a vehicle, 74% in the previous 12 months ("current drivers"). Eighty seven percent of lifetime drivers reported having drug driven, and 88% of current drivers had drug driven in the previous 12 months. There were no significant sex differences in lifetime or recent drug driving. The most common drugs used before driving in the preceding year were: cannabis, heroin, amphetamines and cocaine. A third of lifetime drivers reported having had a drug driving accident, with males more likely to have done so, and 9% of current drivers reported a drug driving accident in the previous year. The most common drugs that had been used before the most recent drug driving accident were heroin, cannabis and alcohol. Alcohol was perceived to be the most dangerous substance for driving performance and cannabis the least dangerous. Recent drug drivers perceived drug driving to be less dangerous than non-drug drivers. Recent drug drivers had driven more frequently over the preceding 12 months, had significantly higher levels of dependence, higher frequency of drug use, more extensive polydrug use, and were more likely to have used and/or injected a drug in a car in the previous 12 months.

Conclusions: Drug driving, and drug-related accidents are large scale public health problems among IDU. These behaviours pose serious risks to IDU themselves, and to the broader community.

Web-based interventions for substance use disorders: a qualitative review

Journal of Substance Abuse Treatment 26, 109-116.

Jan Copeland and Greg Martin

Background: Substance use disorders are one of the most common mental health problems in the Western world with a significant contribution to the global burden of disease and a high level of unmet treatment need.

Aims: To assess the use and effectiveness of web-based interventions for substance use disorders.

Method: A qualitative review of the published literature across databases Medline, EMBASE, PsychINFO, GrayLIT Network, and Web of Science using relevant key terms. A search of the worldwide web was also conducted using search engines such as Google.

Results: There were a number of computerised and internet based interventions for mental health disorders including substance use disorders located, however, they are largely descriptive with no large randomised controlled trials of internet delivered interventions for substance use disorders reported.

Conclusions: While the literature on internet based substance use interventions is sparse and flawed, the potential impact of effective intervention is considerable. On the basis of the limited research available it is reasonable to suggest that a demand for such interventions exists and there is a likelihood that they would be as effective as those delivered by therapists for the majority of less severely dependent clients. Further clinical outcome research, particularly in the area of brief interventions for alcohol use disorders and extension to other drugs such as cannabis and club drugs, is certainly justified. **cl**

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For more information on or copies of these publications, please contact the relevant researcher

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