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centre lines

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issuing **forth**

Guidelines on managing comorbidity in alcohol and other drug treatment settings

ed**space**

A recurring theme in the field that we often reflect on through *CentreLines* is the need for evidence-based research on alcohol and other drugs (AOD) to be communicated widely in order to meaningfully influence policy and increase public understanding and awareness of the issues. Communicating the results of research through the general media is a crucial tool in this process.

Media interest in illicit drugs *per se* is not the issue. A study being conducted by the Drug Policy Modelling Program (DPMP) at NDARC is currently examining the impact of media reporting on youth attitudes towards illicit drugs. The study has reviewed AOD coverage in major metropolitan newspapers in Sydney, Melbourne, Canberra, Brisbane and Perth, and in regional newspapers in Geelong and Newcastle. In total, 42,436 articles were identified from 1 January 2003 to 31 December 2008 referring to cannabis, amphetamines, ecstasy, cocaine and heroin.

This raw figure alone is enough to confirm the obvious: that the media's interest in illicit drugs is apparently insatiable. It is hardly surprising that the most frequent topic reported in connection with illicit drugs was criminal justice and arrest. Law enforcement figures were most frequently quoted as sources, while only a small proportion of articles referred to research in any form.

Contrary to common assumptions, the overall tone of the majority of a sample of articles selected for further analysis was neutral. Yet engaging the media in reporting the evidence, rather than giving oxygen to unsubstantiated opinion and reinforcing stereotypes remains the real challenge.

The featured article in this issue of *CentreLines* is a case in point. NDARC Senior lecturer Dr Katherine Mills writes about the groundbreaking work being conducted in Australia on co-occurring substance use disorder and mental health problems. An estimated 35 per cent of individuals with AOD use issues have at least one co-occurring mental health condition. This rises to as high as 84 per cent among individuals in AOD treatment programs.

As far back as 2002 the authors of a paper published in *Drug and Alcohol Review* concluded that comorbidity was the "single most important issue ... a matter akin to blood borne viruses in the 1980s." (Saunders B, Robinson S. Co-occurring mental health and drug dependency disorders: Workforce development challenges for the A&D field. *Drug and Alcohol Review.* 2002; 21:231-7).

Nearly a decade on, AOD workers are about to begin training in the implementation of new Federal Government guidelines on managing comorbidity in alcohol and other drug treatment settings. This is a tangible example of the potential for research influencing policy and clinical practice. However, engaging the media in this issue, encouraging broader discussion around issues facing not one, but two, marginalised groups, is a different challenge altogether. It should not be consigned to the "too hard basket".

Marion Downey, Communications and Media Manager, NDARC

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CentreLines is a joint publication from the National Drug and Alcohol Research Centre, Sydney and the National Drug Research Institute, Perth.

headspace

On being a research academic (or winning an Oscar)

Alison Ritter

At a time when many researchers around Australia are struggling with project grant applications, wading through the various online systems, responding to government tenders and applying for fellowships it would be easy to forget why we do what we do. Discovering a new treatment for comorbid conditions; investigating the link between socio-economic status and drug use; understanding how the media influences whether a young person will or will not commence or continue drug use; identifying specific genetic mechanisms associated with vulnerability to drug use; establishing the relationship between licensed venue density and alcohol-related assault … these are examples of generating new knowledge that will make a difference to alcohol and drug related use and harms.

Generating new knowledge can take many forms. One of the impressive features of the National Drug and Alcohol Research Centre (NDARC) is the diversity of ways in which knowledge is created. Clinical trials of new treatments; epidemiological studies of both the general population and targeted groups; analyses of policy regimes; evaluation of treatment services; computer simulations (modelling); qualitative field research; brain imaging and genetic studies; and cohort studies. This variety of methods all contribute in different ways to building a body of knowledge.

The location of NDARC within a University contributes subtly but importantly to knowledge generation. The academic freedom to pursue important topics plus the infrastructure and milieu encourages excellence in scholarship. Universities value and reward successful competitive grants because the grant process is aimed at ensuring the importance, significance and rigour of the research. Publications in international scholarly peer reviewed journals culminate the knowledge-generation cycle and increase the likelihood of success with future competitive grant applications.

Thus the sequence of grant writing, research, publication, grant writing and so on. Importantly many research centres, including NDARC, do not have tenured positions – all staff members are on time-limited contracts that rely upon success in gaining funding. This adds a level of stress to the cycle: a grant application is akin to a bid for employment.

Little wonder then that someone once likened being a research academic to being an actor. Applying for a grant or submitting a paper is like auditioning for an acting role. There may be frequent rejections and little certainty about the future. But in both cases there are peak experiences such as getting an Oscar or generating new knowledge. Some may take comfort in knowing that a research academic's career is not the only one with these features – or take up acting!

But there are two important counter-balances to the image I have portrayed thus far.

The first is the funding of the National Centres – they are not run entirely on competitive grants. We enjoy a long and successful relationship with the Commonwealth Government and receive a three-year grant to support our research. This provides a safety net, security for some staff, and funding for important infrastructure that is not available via the grants system. We would not be able to exist without the Commonwealth support. And for their investment, which amounts to approximately 20 per cent of the Centre's total funding, they receive back more than fourfold the amount of research directly funded, through research results and new knowledge generated by the entire Centre.

The second is that knowledge generation is only one part of the role that academic research plays. The translation of that research into meaningful information of use to practitioners and policy makers is critical. The recently published *Guidelines on the management of co-occurring mental health conditions in alcohol and other drug treatment settings* for the treatment of comorbidity is an excellent example of the importance of translation of research knowledge into practical and applied information.

So, the insecurity of highly competitive research funding is offset by government support for research centres. Scholarly academic publications are counter-balanced by writing other types of publications that translate our important new knowledge. We all deserve to win an Oscar. **cl**

issuing forth

Guidelines on managing comorbidity in alcohol and other drug treatment settings

Katherine Mills

A vast literature has accumulated over recent decades documenting the high prevalence of mental health disorders among individuals with alcohol and other drug (AOD) use disorders. Recent estimates from the 2007 National Survey of Mental Health and Wellbeing indicate that 35% of individuals with an AOD use disorder (31% of men and 44% of women) have at least one co-occurring affective or anxiety disorder[1]. The prevalence of comorbidity is even higher among individuals entering AOD treatment programs, as the presence of co-occurring disorders increases the likelihood of treatment seeking[2]. In their summary of the clinical literature Brems and Johnson[3] note that rates of mental illness among individuals in AOD treatment programs range from 51-84%. The most common comorbid disorders seen among those in AOD treatment settings are affective, anxiety and personality disorders[4, 5]. While the aforementioned disorders are the most commonly encountered by AOD workers, the number of potential combinations of disorders and symptoms is infinite. Additionally, there are a large number of people who present to AOD treatment who display *symptoms* of disorders while not meeting criteria for a *diagnosis* of a disorder[6].

The high prevalence of comorbidity means that AOD workers are frequently faced with the need to manage complex symptoms which may interfere with ability to treat AOD. A review in Victoria in 1993 reported that AOD workers felt overwhelmed and fearful when treating people with comorbid mental health disorders as their knowledge and the resources available to them were inadequate[7]. Consequently, they reported little confidence in their ability to manage clients with comorbid AOD and mental health disorders. Although this report was written more than a decade ago, the sentiments remain true today. Numerous reviews and policy documents have identified the need for educational resources for AOD workers as a priority[8-13]. This need has also been identified by AOD workers themselves[14]. In terms of AOD workforce development, the management of co-occurring mental health conditions has been described as "the single most important issue … a matter akin to blood-borne viruses in the 1980s"[15, p.234]. Despite this acknowledged need, there have been few resources available to the AOD sector to improve knowledge, skills and confidence in managing comorbidity.

In response, the Australian Government Department of Health and Ageing funded the National Drug and Alcohol Research Centre (NDARC) to develop *"Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings."*

What is the purpose of the Guidelines?

The purpose of the Guidelines is to provide AOD workers with up-to-date, evidence-based information on the management of comorbid mental health conditions in AOD treatment settings. They are based on the best available evidence and draw upon the experience and knowledge of clinicians, researchers, consumers and carers from around Australia.

The Guidelines aim to:

- Increase AOD workers' knowledge and awareness of mental health conditions.
- Improve the confidence and skills of AOD workers working with clients with comorbid mental health conditions.
- Provide guiding principles for working with clients with comorbid mental health conditions.
- Improve AOD workers' ability to identify mental health conditions.
- Provide practical information on the management of comorbid mental health conditions.
- Provide information regarding the treatment of comorbid mental health conditions.
- Provide information regarding referral processes.
- Provide resources that may be used to facilitate all of the above.

Who were the Guidelines developed for?

The Guidelines have been developed primarily for AOD workers working in both the government and non-government sector, including nurses, medical practitioners, psychiatrists, psychologists, counsellors, social workers, and other AOD workers. However, a range of other health professionals may also find them useful.

In writing the Guidelines it was recognised that those working in the AOD field differ greatly in terms of their roles, education, training and experience. As such, the Guidelines do not assume that all AOD workers will be able to address comorbidity to the same extent. At minimum, however, it is suggested that all AOD workers should be 'comorbidity informed'; that is, knowledgeable about symptoms of common mental health conditions and how to manage these symptoms if they arise.

How were the Guidelines developed?

The Guidelines were developed based on a comprehensive review of the best available evidence and the experience of an expert panel of academic researchers, clinicians, consumers and carers. In developing the Guidelines, we relied where possible on evidence from well-designed research studies. Where this evidence was not available, recommendations were based upon appropriate clinical experience. Prior to publication, the Guidelines were reviewed by a number of key stakeholders with expertise in the field and feedback was sought from AOD workers is non-government treatment services across Australia.

Are the Guidelines useful and relevant to clinical practice?

In May 2009, prior to the publication of the Guidelines, non-government organisation (NGO) AOD treatment services nationally were invited to provide feedback on a draft of the Guidelines. Copies of the Guidelines were sent to 77 services that expressed interest in participating in the study and 74 surveys were returned.

The feedback received was overwhelmingly positive, indicating that the Guidelines are acceptable to the AOD sector. Overall satisfaction with the Guidelines was high. The majority of respondents thought that the Guidelines would be useful and would assist with clinical decision making. In particular, respondents indicated that the Guidelines effectively illustrated links between the theory of responding to comorbidity and the practical aspects of responding (86%). The majority (84%) reported that the Guidelines would enable them to respond to comorbidity related issues with greater confidence and 93% indicated that they would use some of the things they learnt from the Guidelines in their work.

Dissemination of the Guidelines

The Guidelines were released in December 2009. A limited number of hard copies were printed and posted to all AOD treatment services across Australia and institutions providing tertiary education in AOD. The Guidelines, and other resources, may also be downloaded free of charge from http://ndarc.med.unsw.edu.au/comorbidity.

Free half-day seminars are also being conducted in all eight Australian states and territories during February and early March 2010. The seminars will provide an overview of the Guidelines with a focus on their implementation in clinical practice. The seminars will be of particular relevance to service managers, team leaders, educators, and comorbidity project officers from government and non-government AOD and related services.

Where to next?

These Guidelines go some way to assisting AOD workers in dealing with the complex needs of clients with comorbidity; by increasing the capacity of AOD workers to respond to comorbidity, it is anticipated that the outcomes for people with comorbid mental health conditions will be improved. However, research in this field is evolving at a rapid pace and consequently, it is imperative that the Guidelines be reviewed and revised in line with the growing evidence base. It is also important to gain an understanding of the AOD workforce's views regarding the usefulness of the Guidelines as a clinical tool. An online survey is available on the Guidelines website so that AOD workers may provide feedback on the utility of the Guidelines which may be used to inform future revisions.

Apart from Guidelines, a great deal more is needed to address the treatment needs of comorbid clients effectively. Of particular importance is the provision of improved education, training and supervision opportunities for the AOD workforce. In terms of research, further studies are needed to improve our understanding of the relationship between conditions, and the relative efficacy of varying treatment approaches and health service systems approaches. At a policy level, steps also need to be taken to reduce the physical, administrative, organisational, and financial barriers to the treatment of comorbidity. The fragmentation of service systems presents an enormous challenge to both the consumers of services and clinicians; as such, improved integration of service systems is essential. This does not pertain only to the integration of AOD and mental health systems, but to service systems across the health and social welfare sectors. Clients with comorbidity present to treatment with a variety of other medical, family and social problems (e.g., housing, employment, welfare and legal problems) which cannot possibly be addressed by one health professional or service alone. Thus, whilst the Guidelines represent an important step toward the provision of improved treatment for clients with comorbidity, there is much that remains to be done. **cl**

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project **notes**

A review of adolescent substance use and responses in WHO's Western Pacific Region

John Howard, Hammad Ali and Lisa Robins

This review was conducted to assist the WHO's Western Pacific Regional Office develop effective responses for young people who are, or who are at risk of becoming, problematic substance users. The region is home to a youthful population, experiencing the impact of globalisation, unemployment, demographic change, increased drug trafficking and production (eg opioids, amphetamines and cannabis).

Sexual behaviour while intoxicated increases the risk of STIs and unplanned pregnancies. Road traffic and other accidents, suicide and violence are associated with alcohol and other substance use. Young injectors are more likely to be involved in riskier behaviours than older injectors, increasing exposure to HIV, HCV and other blood-borne infections

Data came from peer- and non-reviewed, published and unpublished literature, websites and key informant interviews. Despite the limitations of the data, concerning trends emerged with regards to levels of alcohol, cannabis and amphetamine use, in addition to injecting drug use (IDU). Levels reported in many Pacific Island states far exceeded those for Australia and New Zealand.

The specific needs of young people are recognised, but remain largely unmet. As substance use is associated with many risky behaviours, broad and comprehensive interventions are required to deal with the range. There is a need to:

- Improve data collection via routine surveys to discern trends and emerging difficulties of young people, especially the most at risk adolescents.
- Develop a more collaborative approach from the UN system, governments and NGOs for the development of a facilitating policy and practice environment.
- Trial evidence-informed prevention and treatment, especially brief and non-residential interventions including those which involve families and the community.
- Build the capacity of both generalist and specific workforces to meet the multiple and complex needs of young substance users in youth friendly settings.
- Explore diverse sites for prevention and screening activities such as schools, dormitories and other out-of-home accommodation used by students, workplaces that employ young workers, and other sites such as seafarer/ marine colleges.
- Use coercion wisely and with regard to both human rights legislation and the Conventions on Rights of the Child (CRC).
- Trial police diversion and youth drug courts for those apprehended and charged with crimes.

Impact of Parental Substance Use on Infant Development and Family Functioning

Richard Mattick, Delyse Hutchinson, Lucy Burns, Wendy Swift, Marian Shanahan, Emma Black, Gabrielle Campbell and Erin Kelly

Community survey data show that half of all Australian women report some alcohol or other drug use in pregnancy. The limited available research also suggests that more than 1 in 4 men drink alcohol at risky levels during the prenatal period. The high incidence of substance use among Australian parents during this critical time is a major public health issue affecting over 100,000 babies each year.

Research suggests that parental substance use can have adverse impacts on birth outcomes and infant development, however the effects of such exposures are far from well understood. In fact, major gaps in current knowledge have led to uncertainty about appropriate public health recommendations to women and their partners about alcohol and other substance use in pregnancy. Well designed research studies examining these effects in greater detail are urgently needed.

A pilot study commenced in 2008. The current study, funded by an NHMRC grant, commenced in 2010 and will be the first large-scale Australian study to examine the effects of substance use among pregnant women and their partners during the prenatal period on infant development and family functioning. The impact of other factors such as social support, biological factors, income, parents' emotional well-being, exercise, nutrition and temperament will also be examined.

The research design involves a longitudinal birth cohort study, in which 2,000 pregnant women and their partners will be recruited during the prenatal period (conception to birth). Participants will be recruited though antenatal services attached to major hospitals in New South Wales and Western Australia. Participants will also be recruited through specialist drug and alcohol antenatal services. There will be five assessment waves in the study – three in the prenatal period and two postnatal – at eight weeks and 12 months.

This study aims to:

- identify substance use patterns in a cohort of pregnant women and their partners during the prenatal period and the characteristics associated with substance use.
- examine the relationship of maternal and paternal substance use with pregnancy outcomes for mothers and their infants.
- determine the extent to which substance use in pregnant women and their partners predict problems in (a) infant development (physical, cognitive, behavioural and emotional), and (b) family functioning (marital/intimate partner relationship quality, conflict and violence, parenting behaviour and parent-infant relationship quality).

Improved knowledge in these under-researched areas will provide evidence-based direction to the development of public health policy and community interventions that aim to improve the health and wellbeing of a large number of Australian children and families.

Using the EDRS to monitor "partying practice" of mixing energy drinks and ecstasy

Natasha Sindicich and Lucy Burns

The 'partying practice' of mixing energy drinks with alcohol and/ or other substances, such as ecstasy or prescribed medications such as stilnox or benzodiazepines, has been a recent issue of concern in the Australian community. The aim of this mixing practice by users is to enhance the "high" associated with these substances and to allow the users to continue using alcohol and other substances for longer periods of time.

Despite the negative consequences of consuming energy drinks in combination with other substances, there has to date been minimal research on the topic. As a result, the 2009 Ecstasy and Related Drugs Reporting System (EDRS) investigated this practice of consuming energy drinks while 'partying' and consumption patterns around mixing energy drinks with alcohol and ecstasy.

In the Regular Ecstasy User (REU) sample of 679 participants, 69% reported consuming energy drinks with alcohol in the previous six months to interview and 57% reported consuming energy drinks with ecstasy in the previous six months. Of those participants that had consumed energy drinks and alcohol and/or ecstasy (n=376), 74% had combined all three substances on their last occasion of consumption. Whilst males and females both reported consuming a national average of four drinks each (that combined alcohol and energy drinks) on their last occasion of use, females appeared to consume more combined drinks than did males,when data for each state was analysed.

Given the high proportions reporting this 'mixing practice' and beliefs held by consumers that energy drinks will reduce the fatigue, cognitive and motor impairments of alcohol, this issue is becoming increasingly concerning. It is of particular concern that consumers may be more likely to engage in risky behaviours, such as operating a car or a motorcycle, in the erroneous belief that they are alert (Ferreira et al., 2004a, 2004b). Further issues of concern that warrant study (included in the 2010 EDRS study) includes the exacerbation of acute 'up' and 'hangover' symptoms: the 'jolt and crash' episode involving headaches, heart palpitations, nausea and, after long-term use, tolerance and withdrawal. These findings suggest a strong role for consumer education around the effects of combining these substances, possible symptoms that may be experienced, and information around the recommended daily allowance of caffeine.

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Development of a cannabis withdrawal scale

David Allsop, Melissa Norberg and Jan Copeland

Cannabis dependence has a long history of controversy, and yet a growing body of research is unearthing a clinically significant withdrawal syndrome in some regular users. Given the dubious distinction of cannabis as the world's favorite illicit drug of abuse, with an estimated 160 million current users worldwide, learning more about cannabis dependence should be a major public health priority.

This study aims to find out more about the cannabis withdrawal syndrome, with the aim of developing a clinical measurement tool for assessing the severity of cannabis withdrawal. Cannabis withdrawal typically begins within 24 hours of last cannabis intake, and usually peaks within 1-2 days, and is thought to be largely over after 2 weeks. Cannabis withdrawal is characterized by several domains of physical and psychological discomfort, including anxiety, depression, sleep disturbance, digestive discomfort/problems (including reduced appetite/anorexia) and irritability/anger. Resumption of cannabis use alleviates withdrawal symptoms, thus cannabis withdrawal is believed to be a major contributor to the high rates of relapse observed clinically. Despite the discomforts associated with cannabis withdrawal and the role that withdrawal plays in relapse, there is currently no valid and reliable measure for quantifying the nature and severity of cannabis withdrawal during a quit attempt.

The creation of a psychometrically valid clinical tool for measuring cannabis withdrawal is an essential first step along the path towards developing interventions that can alleviate the discomfort (and relapse) caused by the cannabis withdrawal syndrome. Without a valid and reliable tool for measuring withdrawal, we would not be able to reliably quantify whether novel psychotherapies or pharmacotherapies are having the desired positive impact. To meet this gap in our current treatment efforts for cannabis use disorders we are currently running a pilot withdrawal study to gather cannabis withdrawal data with which to perform psychometric development of a measurement scale. The study is recruiting 50 non treatment seeking DSM-IV dependent cannabis smokers and measuring their withdrawal symptoms daily during a 2 week quit attempt, and a four week follow up compared with a one week "smoking as usual" baseline.

Data collection and analysis is well under way and we anticipate we will have a valid and reliable measurement scale by mid 2010. We feel that a deeper understanding of cannabis withdrawal and an easy and reliable way to measure it will open up novel therapeutic insights, and lead to better treatment outcomes. **cl**

abstracts

2007 National Survey of Mental Health and Wellbeing: methods and key findings

Australian and New Zealand Journal of Psychiatry, 49:635 -643

Tim Slade, Amy Johnston, Mark A. Oakley Browne, Gavin Andrews and Harvey Whiteford

Objective: To provide a description of the methods and key findings of the 2007 Australian National Survey of Mental Health and Wellbeing.

Method: A national face-to-face household survey of 8841 (60% response rate) community residents aged between 16 and 85 years was carried out using the World Mental Health Survey Initiative version of the Composite International Diagnostic Interview. Diagnoses were made according to ICD-10. Key findings include the prevalence of mental disorder, sex and age distributions of mental disorders, severity of mental disorders, comorbidity among mental disorders, and the extent of disability and health service use associated with mental disorders.

Results: The prevalence of any lifetime mental disorder was 45.5%. The prevalence of any 12 month mental disorder was 20.0%, with anxiety disorders (14.4%) the most common class of mental disorder followed by affective disorders (6.2%) and substance use disorders (5.1%). Mental disorders, particularly affective disorders, were disabling. One in four people (25.4%) with

12 month mental disorders had more than one class of mental disorder. One-third (34.9%) of people with a mental disorder used health services for mental health problems in the 12 months prior to the interview.

Conclusions: Mental disorders are common in Australia. Many people have more than one class of mental disorder. Mental disorders are associated with substantial disability, yet many people with mental disorders do not seek help for their mental health problems.

Opioid agonist pharmacotherapy in New South Wales from 1985 to 2006: patient characteristics and patterns and predictors of treatment retention

Addiction, 104, 1363–1372

Lucy Burns, Deborah Randall, Wayne D Hall, Matthew Law, Tony Butler, James Bell and Louisa Degenhardt

Aims: The aims of this study were to: examine the number and characteristics of patients entering and re-entering opioid replacement treatment between 1985 and 2006, to examine select demographic and treatment correlates of leaving treatment between 1985 and 2000, and to compare retention rates in methadone and buprenorphine maintenance treatment from 2001 to 2006.

Participant/design: A retrospective cohort study using register data from the Pharmaceutical Drugs of Addiction System. A total of n = 42 690 individuals prescribed opioid replacement treatment between 1985 and 2006 in NSW.

Measurements: Client characteristics over time, retention in days in first treatment episode, number of episodes of treatment and proportion switching medication.

Findings: Overall, younger individuals were significantly more likely to leave their first treatment episode than older individuals. In 2001–06, after controlling for age, sex and first administration point, the hazard of leaving treatment was 1.9 times for those on buprenorphine relative to those on methadone. Retention in treatment varied somewhat across historical time, with those entering during 1995–2000 more likely to leave at an earlier stage than those who entered before that time.

Conclusion: Retention in treatment appears to fluctuate in inverse proportion to the availability of heroin. Individuals in contemporary treatment are older users with a lengthy treatment history. This study has provided population-level evidence to suggest that retention in methadone and buprenorphine differ in routine clinical practice. Future work might investigate ways in which patient adherence and retention may be improved.

Predictors of social anxiety in an opioid dependent sample and a control sample

Journal of Anxiety Disorders, 24, 49–54

Fiona L. Shand, Louisa Degenhardt, Elliot C. Nelson and Richard P. Mattick

Abstract: Compared to other mental health problems, social anxiety is under-acknowledged amongst opioid dependent populations. This study aimed to assess levels of social anxiety and identify its predictors in an opioid dependent sample and a matched control group. Opioid dependent participants (n = 1385) and controls (n = 417) completed the Social Interaction Anxiety Scale (SIAS), the Social Phobia Scale (SPS) and a diagnostic interview. Regression analyses were used to test a range of predictors of social anxiety. Opioid dependent cases had higher mean scores on both scales compared to controls. Predictors of social anxiety centred on emotional rejection in childhood, either by parents or peers. For opioid dependent cases, but not controls, lifetime non-opioid substance dependence (cannabis, sedatives, and tobacco) was associated with higher levels of social anxiety. However, much of the variance in social anxiety remains unexplained for this population.

Can the Severity of Dependence Scale be usefully applied to 'ecstasy'?

Neuropsychobiology, 60, 137-147

Raimondo Bruno, Allison J. Matthews, Libby Topp, Louisa Degenhardt, Rapson Gomez and Matthew Dunn

Background/Aims: Although use of 'ecstasy' (drugs sold as containing 3,4-methylenedioxymethamphetamine) is prevalent, use is typically infrequent, and treatment presentations involving ecstasy as a principal problem drug are relatively rare. Human case reports and animal literature suggest dependence potential, although there may be some unique aspects to this syndrome for ecstasy in comparison to other substances. The Severity of Dependence Scale (SDS) was examined to determine whether this could usefully identify 'dependent' ecstasy consumers.

Methods: Cross-sectional survey of 1658 frequent (at least monthly) ecstasy consumers across Australia, assessing drug use, associated harms and risk behaviours. Dependence was assessed using the SDS, using a cut-off of four or more to identify potential 'dependence'.

Results: One-fifth of participants were screened as potentially 'dependent'. These individuals used ecstasy more frequently, in greater amounts, engaged more extensively in risk behaviours and reported greater role interference than other participants. These findings were independent of methamphetamine use or dependence. The underlying structure of the ecstasy SDS was bifactorial.

Conclusions: The SDS has demonstrated construct validity as a screening tool to identify ecstasy users at elevated risk of experiencing adverse consequences, including features of dependence. The underlying structure of dependence symptoms differs for ecstasy compared to other drug classes, and some 'dependent' consumers use the drug infrequently. The unique neurotoxic potential and entactogenic effects of ecstasy may require a distinct nosological classification for the experience of 'dependence' associated with the drug.

Capitalising upon political opportunities to reform drug policy: A case study into the development of the Australian "Tough on Drugs-Illicit Drug Diversion Initiative"

International Journal of Drug Policy, 20, 431- 437

Caitlin Elizabeth Hughes

Background: The introduction of political "war on drug" strategies and Prime Ministerial advisory groups increase opportunities for drug policy reform. Yet the strengths and limitations of capitalising upon political opportunities remain unclear. This paper provides a unique insight into the development of an Australian reform, the "Tough on Drugs-Illicit Drug Diversion Initiative." This reform was one of the major policies to emerge out of the Federal Coalition "Tough on Drugs" strategy. In spite of the rhetoric the Illicit Drug Diversion Initiative (IDDI) has diverted minor drug users away from the traditional criminal justice system.

Methods: This paper draws upon interviews with 16 expert policy makers involved in the advocacy and negotiations leading up to the adoption of the IDDI to examine what drove the reform and how and why a pragmatic reform emerged.

Results: The IDDI culminated from the presence of five main drivers: a crisis in relation to heroin and crime, antagonism towards the government, a weak but growing evidence-base on the merits of drug diversion, a shift in law enforcement attitudes and persuasive advocacy by a group of non-government experts. This paper contends that the Prime Minister's new "Tough on Drugs" strategy and expanded governance arrangements created new space for policy actors to intervene in the policy formulation process and to convert the governments proposed "zero tolerance" response into a more humane and potentially effective response.

Conclusion: This paper concludes that contrary to popular opinion political venues and politicisation may offer valuable opportunities for drug policy reform. The challenge for researchers and policy advocates is to see how they can best utilise political venues to obtain pragmatic reform. **cl**

recent **publications**

For more information or for copies of the report please go the NDARC website.

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