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issuing **forth**

Who is receiving treatment and to what effect? The development of treatment monitoring and outcome systems in Australia

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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. It is published bi-monthly and produced alternately by each Centre.

ed**space**

Welcome to the first *CentreLines* from NDARC's new premises. Over the past decade the Centre has seen many changes and much growth – so much so that we have completely outgrown our old premises in the grounds of the Prince of the Wales Hospital. Almost six months ago a number of NDARC staff volunteered to move to a temporary building to relieve some of the pressure that the increasing number of staff was causing on an already full building.

Dr Jan Copeland, Dr Michael Lynskey, Mr Peter Lawrinson, Ms Carolyn Day, Mr Mathew Warner-Smith and myself made the move to Botany Street. Ms Elizabeth Emrys from APSAD also joined us. This made way for large-scale projects, particularly ATOS to house new staff.

Over the past few months Dr Lynskey and Mr Warner-Smith have resigned from their positions and Ms Kate Pryce and Ms Kathryn Owler have moved into the 'cottage'.

The splitting-up of NDARC has set many challenges in the past few months and so all staff are extremely pleased to move into a building which will accommodate all and has been specifically designed for our purposes. To assist you with information regarding our new premises we have included an insert that lists all the details you need to contact NDARC.

Our new building has a great new conference room. Early next year we will distribute the list of our 2002 NDARC Outhouse Seminars - we hope that we will get to see many people attend these presentations, which are given by a range of national and international speakers from the drug and alcohol field.

We hope that you enjoy this issue of *CentreLines* and remember if there is anything that particularly interests you, please contact the relevant researcher.

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Paul Dillon
Editor

headspace

The National Drug and Alcohol Research Centre begins a new era as after almost eight years, Professor Wayne Hall has left the Centre. In addition, this issue of *CentreLines* comes from NDARC's new premises.

The Faculty of Medicine have recently advertised for a replacement for Professor Hall, and will hopefully appoint a new Executive Director before the end of 2001. Up to that time I will act in the role.

To maintain its research capacity, NDARC will continue to employ ten academic staff. Many of these positions are 'baseline' funded (Dr Jan Copeland, A/Professor Shane Darke, Dr Kate Dolan, A/Professor Richard Mattick and Dr Maree Teesson). Another position is the Illicit Drugs Statistics conjoint appointment which was previously filled by Dr Michael Lynskey. Since Dr Lynskey left the Centre to take up a position in the USA, Ms Louisa Degenhardt is now acting in this role. Three other academic staff are employed on specific externally funded research projects – Dr Erol Digiusto, Dr Joanne Ross and Dr Wendy Swift.

Some of the projects that will continue during 2002 are the Illicit Drug Reporting System (IDRS) and the write-up of the highly successful National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD). The Australian Treatment Outcome Study (ATOS), a study of the outcome of treatments for opioid dependence in 600 heroin users in methadone maintenance treatment, therapeutic communities, residential programs, and outpatient counselling will also continue throughout next year. Due to additional funding the study will also be extended into both South Australia and Victoria, bringing the sample to 1000 users.

In *Issuing Forth* this month, Dr Jan Copeland discusses a number of projects which she, together with other NDARC staff, are working on. The first of these is the Monitoring and Outcomes Project funded by the NSW Health Department.

To add to these we have plans to include the following projects in the coming year. Dr Chris Doran will bring his health economics expertise to conduct research into the cost effectiveness of pharmacotherapies for nicotine and alcohol dependence/abuse. This research will aim to investigate the efficacy and economic value of Zyban and nicotine replacement therapies in smoking cessation; and naltrexone and acamprosate in the management of alcohol dependence. Dr Kate Dolan will be investigating patterns of drug use and drug treatment utilisation among rural injecting drug users (IDUS). This study will aim to determine the prevalence of HIV and HCV infection, by way of finger prick blood samples, and risk behaviours. Patterns of migration from areas with low prevalence of blood-borne viruses to high prevalence areas will also be examined. Dr Anthony Shakeshaft will assess the impact of a computerised screening package for excessive alcohol consumption in general practice.

It is an exciting time for the Centre as the number of projects in progress continues to rise. We are continuing to build upon existing national and international collaborations. We hope to expand our national capacity through NDARC Collaborating Centres, as such the NSW Bureau of Crime Statistics and Research (BOCSAR) has been approached and Dr Don Weatherburn has agreed to BOCSAR becoming an NDARC Collaborating Centre. This will add to our already substantial relationships nationally. In addition we hope to also approach one or two health economics research units to form similar links.

As many of readers may be aware a major issue confronting the Centre and its ability to maintain and build capacity over the past few years has been the problem of accommodation. The buildings located in the grounds of the Prince of Wales Hospital have proven to be far too small to accommodate the almost 50 staff that are currently employed. For the past six months NDARC has been split over two locations as a number of major projects including NEPOD and ATOS have employed a number of new staff. Ten members of staff have been temporarily located at rented accommodation at Botany Street.

However, after a lengthy planning process we have finally moved into our new premises located at the Randwick Campus of the University of New South Wales. Newly-built, it is an air-conditioned building of 1000 square metres, fully fitted-out and linked to the UNSW. This new accommodation will allow NDARC to maintain its staffing of up to 55 staff, and to grow with new projects as there is room for at least 60 staff to be accommodated in the new premises.

The building has a large seminar room, as well as meeting and interview rooms suitable for counselling and interventions. Ms Eva Congreve, NDARC's archivist has now a much larger area in which to store our already extensive archive collection.

This accommodation is secure until the Faculty of Medicine builds new premises in the future, at which time NDARC is to join the Faculty in new purpose built buildings. As such, the future of NDARC in terms of accommodation seems to be secure.

I would like to take this opportunity to thank everybody who assisted in the development and organization of the new NDARC premises. Moving an organisation like NDARC was a huge task and even though the Centre staff already had huge workloads, we had a great deal of co-operation, making the move extremely successful and trouble-free. My personal thanks are extended to the Board of Management as well as the Dean, Professor Bruce Dowton and the University Facilities and Capital Works staff, as well as the NDARC staff who have taken on the responsibility of ensuring the planned premises meet our needs.

NDARC is at one of its strongest points in its almost thirteen year history. We currently have the largest staffing and some of the most exciting and challenging projects we have ever had, as well as brand new premises which have been purpose built for our needs. The year 2001 has been both a busy and productive one – I expect 2002 to be no different. The entire staff of NDARC looks forward to continuing to work cooperatively with our collaborating centres and others nationally and internationally. **cl**

Richard P. Mattick

issuing **forth**

Who is receiving treatment and to what effect? The development of treatment monitoring and outcome systems in Australia

While many important questions remain unanswered, we are reasonably confident that participation in treatment is more effective than non-participation for the majority of people in need; that treatment returns more to society in economic terms than it consumes; and that some interventions are more cost-effective than others, at least for large unselected groups of clients. Most of the knowledge we have gained about the treatment of substance use disorders has come from the evaluation of specific types of treatment activities (e.g., cognitive-behavioural therapy, pharmacotherapy), or treatment settings in which these interventions are delivered (e.g., inpatient versus outpatient). We have also learned, however, that a community needs a mix of interventions in order to meet the needs of a heterogeneous population, and that it is helpful to plan services along a 'continuum of care'[1]. This systems perspective to planning and delivering services has, in turn, increased the importance of evaluating the overall network of services that may be offered in a given jurisdiction.

Clinical treatment research addresses questions of treatment efficacy, outcome monitoring on the other hand is concerned with establishing whether the treatment experience of the client in the 'real world' is associated with change. These studies do not prove that outcomes were caused by the treatment experience. They do, however, establish that improvement has occurred following treatment, and give much more attention to the heterogeneity of the client population, the multiplicity of potential outcomes and the complexity of the client's experience across many different services in which they participate. In short, outcome monitoring addresses questions related to the effectiveness of treatment as it is routinely delivered, and as it is experienced by the client.

Outcome monitoring is recommended as a complementary strategy to enhance and extend knowledge gained from experimental and quasi-experimental clinical treatment research[1]. Outcome monitoring has also emerged as a meeting ground for health services researchers, funders, planners and managed care providers, program administrators and staff, and clients involved in the planning and delivery of their services. It can, however, be a very uneasy meeting place and many of the issues that arise in planning and implementing an outcome monitoring system reflect the competing needs and perspectives of these various stakeholders.

The ongoing monitoring of client outcomes is itself a cost to the service delivery system. This begs the important question of accountability and the overall cost-benefit of the monitoring system itself. In assessing the accountability of the outcome monitoring system, it is necessary to examine and prioritise the different expectations of the various stakeholders involved in system development. A monitoring system may fulfil the needs of one or more stakeholders very well (e.g., the funder), but fail to meet the needs of others (e.g., the treatment system administrator or individual service provider). Deciding whose information needs are most important will have a major impact on system design and overall cost. The rationale for implementing an outcome monitoring system is grounded on four overlapping, but sometimes competing, perspectives:

- quality of care;
- program and treatment system accountability and resource allocation;
- internal program and treatment system quality improvement; and
- health services research.

In summary, the 'effectiveness' of treatment for substance use disorders from an accountability perspective must be measured not only in terms of reduced alcohol and drug use, but its impact on a wide range of other personal, public health and safety concerns. A monitoring system must, however, go beyond the basic description of such outcomes achieved, and focus also on the use of this information for planning and resource allocation.

The outcome monitoring system must also recognize and measure the complex array of problems that often exist concomitantly with substance abuse problems. Beyond the basic design of the monitoring system there are other methodological details to be decided when planning and implementing an outcome monitoring system. These include:

- self report;
- selecting cases for follow-up;
- sample size;
- timing and frequency of follow-up;
- obtaining informed consent and locating clients;
- conduct of follow-up interviews; and
- selection and training of interviewers. See Copeland et al.[2], for a discussion of these and related issues

In summary, the final selection of outcome measures should be guided by:

- program and system objectives;
- the client population served;
- the total time to be invested in the clinical assessment process for the collection of baseline data;
- the potential use of the computer to assist in collection of the information (i.e., self-administered questions);
- the time period over which clients will report substance use, consequences, etc.;
- established reliability and validity data;
- cost to use the instrument if it is not in the public domain;
- the follow-up data collection strategy (i.e. telephone versus face-to-face interviews); and
- the resources available for data collection, analysis and preparation of reports.

The Australian National Minimum Data Set of Clients of Alcohol and Other Drug Treatment Services

A National Minimum Data Set (NMDS) is a minimum set of data elements agreed by the National Health Information Management Group for mandatory collection and reporting at a national level. A National Minimum Data Set is contingent upon a national agreement to collect uniform data and supply it as part of the national collection, but does not preclude agencies and service providers from collecting additional data to meet their own specific needs.

In Australia, an ongoing data collection system commenced on the first of July 2000 as agreed by all States and Territories. A slightly expanded number of items began collection from July 2001. This project was borne out of a national forum conducted in 1995 by the Alcohol and Other Drugs Council of Australia that examined barriers between research and practice within the alcohol and other drug (AOD) field. The aim of the project was to design a national framework for collection of consistent data across all treatment services. This collection is known as the National Minimum Data Set on Clients of Alcohol and Other Drug Treatment Services (NMDS:AODTS)[3].

In 1998 the National Drug and Alcohol Research Centre (NDARC) developed and piloted, in consultation with treatment agencies, a set of data items for national collection[4]. The NMDS:AODTS became a joint project with the IGCD Working Group consisting of representatives from all jurisdictions, the Australian Institute of Health and Welfare (AIHW), NDARC, the Australian Bureau of Statistics (ABS), and the Commonwealth Department of Health and Aged Care. Development of the data elements for the National Minimum Data Set continued throughout 1999. In December 1999, the Commonwealth, and State and Territory Governments endorsed the first version of the NMDS:AODTS. The specialist alcohol and other drug definitions developed for the NMDS-AODTS are included in the National Health Data Dictionary for use by other data collections[5].

The NSW Monitoring and Outcomes Project

Within New South Wales, NDARC has been

involved in a partnership with the NSW Health Department – the Monitoring and Outcomes Project (MOP). This is supervised at the Centre by Dr Jan Copeland working with Mr Peter Lawrinson and Ms Kate Pryce. The monitoring aspect of the project involved the collaborative development of the NSW MDS:AODTS which is an expanded version of the national data set that includes additional items to describe the treatment services being provided. Definitions of these data items are available in the Data Dictionary for Alcohol and Other Drug Treatment Services in New South Wales which is soon to be revised[6]. The first years' collection is now being analysed and demonstrates that the potential value of the data for service planning and development has been realised. This includes the growing trend of heroin as the principal drug of concern despite maintenance pharmacotherapies not being included in the collection, the age, gender and ethnicity differences in patterns of service utilisation, and high proportions of clients having a history of injecting drug use. The completed report will shortly be available from the NSW Health Department and peer-review publications will follow for wider dissemination.

The next phase of the MOP project was the addition of an outcomes module to complement the data collection. The process of development included a review of available measures of treatment outcome[7] and a review of treatment outcome monitoring and predictors of treatment outcome[2]. In addition to these reviews there was extensive consultation with government and service providers.

General considerations were that the instrument be brief (15-20 minutes); generic; multi-dimensional; useful for ongoing assessment or case management; easy to administer and interpret; be acceptable to staff and clients; and have good psychometric properties. As no existing instrument met these criteria the Brief Treatment Outcome Measure (BTOM) was developed which includes the NSW MDS:AODTS and a range of drug use, health, psych-social and legal items. There are also 5 identified sub-scales of the BTOM: the Severity of Dependence Scale (SDS)[8]; Blood Borne Virus Exposure Risk (this includes measures of sharing needle/syringe, spoon, water, filter, tourniquet, drug/solution mix and swab); Polydrug use; an 8 point Psychological Functioning sub-scale; and a 5 item Social Functioning sub-scale. The appropriate psychometric testing of the BTOM is currently being conducted including development of scoring guidelines for the SDS for heroin and alcohol. The BTOM also includes a treatment specific module that was first developed for opioid maintenance pharmacotherapies.

The BTOM has commenced clinical trials in methadone units across New South Wales and will be used as the measure of methadone effectiveness for the NSW Drug Summit initiatives. We have now developed the additional treatment specific modules in the assessment of treatment outcome for detoxification, counselling and rehabilitation services and they will soon commence clinical trials. These trials will not only assess the performance of the measure itself but just as importantly the viability and logistically resource implications of telephone follow-up of treatment clients three months after treatment entry.

In conclusion, while progress is likely to be made on standardisation of a core set of measures and 'best practices' for outcome monitoring internationally, progress is likely to be slow. The slower the progress in this crucial area, the more likely it is that the information systems for the substance abuse field will be eclipsed by larger health information systems and inappropriate, largely institutional models applied to this sector.

Finally, the ultimate test of these outcome monitoring systems will be their contribution to decision-making regarding accountability issues, resource allocation, and improvements to service delivery and system functioning. We know that evaluative data are but one element in the decision-making process and there are many barriers to effective use of evaluation findings. It will be important to have reasonable expectations of these monitoring systems, especially in this early stage of their development.

In the Australian context, particularly in New South Wales, the ground is very fertile for the development of routine outcome monitoring. There have been significant increases in funding of alcohol and other drug services with a greater emphasis on accountability. Concurrently, there has been the introduction of the NSW MDS:AODTS that has standardised the collection of descriptive and process data on clients. This has paved the way ideologically and logistically for the pragmatic collection of treatment outcome data as long as it is brief, valid and appropriate. **cl**

Jan Copeland

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project **notes**

National Drug Law Enforcement Research Funded Project: the role of police in preventing and minimising illicit drug use and its harms

Catherine Spooner

Dr Catherine Spooner (a private consultant and Visiting Fellow with NDARC), Mr Mark McPherson (Team Leader, NSW Police Drug Programs Coordination Team) and Prof Wayne Hall (former Executive Director, NDARC) have been commissioned by the National Drug Law Enforcement Research Fund (NDLERF) to conduct research into the role of police in preventing and minimising illicit drug use and its harms. The objective of this research project is to increase the understanding of Australian police, at the policy, planning and operational levels, of ways in which they can contribute to the outcomes sought by the National Drug Strategy in the following areas.

- Preventing and minimising the impact of drug overdoses
- Encouraging entry into drug treatment programs
- Encouraging safer illicit drug use practices and
- Reducing the demand for illicit drugs (including those strategies aimed at reducing the uptake of illicit drugs).

The questions to be asked, in relation to the above objective, are:

- Upon what frameworks or philosophies are police policies and actions based?
- What roles do police play, in both day-to-day activities and in specific illicit drug prevention projects/initiatives, which impact on the illicit drug use and its harms?
- What are the positive and negative consequences of current police activity in this area?
- What other legitimate roles could police play?
- What are the barriers to police participation in illicit drug prevention activities?
- What are the barriers to best police practice in illicit drug prevention activities?
- How can legitimate police participation and effectiveness in illicit drug prevention activities be facilitated?
- What recommendations can be made for future police policy and operations in the prevention of illicit drug use and its harms?

In short, the project involves a literature review, consultations with police, and consultations with health, user groups and others on research and practice relating to the role of police in preventing and minimising illicit drug use and its harms. Outcomes will be a strategic paper for police policy makers, a manual for front-line police, and a project report for a wider audience.

The project commenced in mid 2001 and is scheduled for completion in October 2002.

Computerised detection and treatment of alcohol problems among general practice patients

Anthony Shakeshaft, Richard Mattick (NDARC), Mark Harris (Dept of GP, UNSW), Alex Wodak (St Vincents), and Enrico Coiera (Medical Informatics, UNSW)

Substantial illness, premature death and economic costs continue to occur in Australia as a result of problem drinking. Problems related to the misuse of alcohol have been shown to be under detected by health care professionals, despite the wide spread use of alcohol in the general community. As a result, the provision of appropriate and effective interventions has also been less than optimal. It is most likely that the greatest overall impact on problem drinking would be achieved by the provision of a number of interventions, ranging from prevention strategies in the general community to treatment services in health care settings. Examples of prevention strategies in the general community include educational media campaigns and legislative based approaches, such as the enforcement of drink driving and liquor licensing laws. Examples of settings in which treatment services are or could be provided include workplaces, general practice, community-based health care centres and hospitals.

Of these various settings, greater utilisation of general practice is likely to be an effective means of improving detection and treatment: approximately 80% of Australian adults consult a general practitioner in a given year; both general practitioners and patients see early intervention as an appropriate role for them; successful early intervention may lessen the burden on specialist drug and alcohol and mental health care services; general practitioners already provide the majority of health care for mental health disorders; and greater utilisation of general practitioners would require less reallocation of costs between levels of government and fewer changes to the Medicare Benefits Schedule.

Despite these potential advantages, there are significant barriers that may prevent greater utilisation of general practitioners in reducing the occurrence of problem drinking. Although the nature of these barriers is most likely to be multi-faceted and complex, a factor that has been clearly identified is the lack of time that general practitioners have to detect and address problem drinking. One possible solution is to make greater use of patient-driven computer technology. This solution is promising as computer assessments have been shown to be accurate and acceptable to patients, including those in general practice settings. In addition, preliminary data from the UK suggest computer-delivered interventions that do not involve medication can be as effective as usual care provided by general practitioners.

This study has been designed to address two main aims:

- To identify the proportion of general practice patients who report problem drinking using computerised screening.
- To evaluate the cost-effectiveness of a computerised intervention for problem drinkers.

This study is funded by the NHMRC of Australia.

The role of commercial drug injecting rooms (shooting galleries) in the regulation of public injecting and amenity in Kings Cross

Jo Kimber, Kate Dolan, Erica Southgate, Linette Collins, Michael Lynskey and Margaret MacDonald

Commercial Drug Injecting Rooms (CDIRs) or 'shooting galleries' have operated in Kings Cross since the early 1990s and came to public attention during the Royal Commission into the NSW Police Service. In 1994 at least 10 CDIRs were operating and were estimated to be catering in total for up to 40,000 injections per month.

Little information is available on CDIRs, however, at least two are known to be currently operating (February 2001), and the Police have indicated they will be closed down with the opening of the Medically Supervised Injecting Centre (MSIC) in May 2001. Based on the previous estimate of injections occurring in 10 venues and no change in the number of injections occurring in Kings Cross in the last 6 years, the two remaining venues could account for approximately 8,000 injections per month, an average of 265 injections per day. The MSIC will be opened 8 hours a day, 7 days a week, and is estimated that 100 - 200 injections will be supervised per day. This means that even if every person who injected in CDIRs were to attend the MSIC, there would still be at least 65 displaced injections per day.

This study aims to investigate the of use of CDIRs in Kings Cross and their role in the regulation of public injecting and amenity in Kings Cross before and after the opening of the MSIC. The study aims to collect current information on the use and characteristics of CDIRs. The study will use quantitative and qualitative methods including IDU questionnaires and in-depth interviews, key informant interviews, syringe counts and police operations data.

This forms part of Jo Kimber's PhD research. **cl**

ab**stracts**

The validity of an Australian modification of the AUDIT questionnaire

Drug and Alcohol Review, 20, 143-154

Louisa Degenhardt, Katherine Conigrave, Sonia Wutzke and John Saunders

The Alcohol Use Disorders Identification Test (AUDIT) has been used widely and is reported to be superior to conventional questionnaires in detection of current hazardous and harmful alcohol use. We assessed the validity of an Australian modification of the AUDIT (the AusAUDIT), which has been employed widely in Australian and New Zealand early intervention programmes. We used a cross-sectional study of 370 subjects from the follow-up phase of a randomised controlled trial of early intervention to reduce hazardous alcohol consumption. Scores on the AusAUDIT were compared against 12-month ICD-10 diagnoses of harmful alcohol use and dependence, as determined by the Composite International Diagnostic Interview, and against self-report of alcohol consumption exceeding Australian National Health and Medical Research Council (NH&MRC) recommended limits. AusAUDIT had good internal consistency and discriminated significantly between persons meeting criteria for ICD-10 alcohol use disorders, and drinkers who did not. At currently recommended cut-off scores, AusAUDIT detected more than 85% of people meeting criteria for ICD-10 alcohol use disorders, or drinking over NH&MRC recommended limits, but its specificity was limited (29% in men, and 58% in women for drinking over NH&MRC limits). No subset of questions performed as well as the full AusAUDIT in detection of drinking problems, but the alcohol consumption items provided a reasonable screen for drinking over NH&MRC limits. We conclude that AusAUDIT is effective in detecting problematic drinking, but positive cases should be confirmed by clinical assessment. The findings illustrate the need for validation of questionnaire modifications, and the difficulty in increasing test sensitivity without reducing specificity.

Physical injecting sites among injecting drug users in Sydney, Australia

Drug and Alcohol Dependence, 62, 77-82

Shane Darke, Joanne Ross and Sharlene Kaye

A sample of 200 injecting drug users were interviewed about their bodily injection sites. The mean number of injection sites ever used by subjects was 3.1, with a mean of 2.0 sites used in the previous 6 months. Sixteen percent of subjects had injected in five or more sites. Almost all (99%) had injected in the cubital fossa (crook of the arm). The next most popular site was the forearm (71%).

Other sites included the hand (53%), foot (19%), leg (18%) and groin (6%). There was a clear progression in sites used, from the cubital fossa at initial injection to the use of such sites as the groin after 10 years of injecting. Females had used significantly more injection sites than males and reported more injection-related problems. The use of more injection sites was independently associated with a greater number of injection-related problems and a greater number of drug classes ever injected.

A randomised controlled trial of brief interventions for cannabis problems among young offenders

Drug and Alcohol Dependence, 63(s1), s32

Jan Copeland, Wendy Swift, John Howard, Roger Roffman, Robert Stephens and James Berghuis

There is a well-identified association between early age of initiation and heavy cannabis use and involvement in crime among adolescents. However, there is a serious gap in the development of effective service provision to this group of young people. This paper describes the methodology and latest progress of a randomised controlled trial of the Cannabis Check-up and the more intensive Cannabis Check-up Plus among 460 young offenders in Sydney, Australia. The Cannabis Check-up is a one session intervention that provides personalised feedback on aspects of cannabis use. The Check-up Plus includes the young person's family and incorporates two additional sessions of skills based cognitive-behaviour therapy. Subject recruitment will be via a range of strategies such as Children's Court magistrates, youth justice conferencing and formal police cautions. Participants are re-interviewed for six months following the check-up for cannabis-related and criminal re-offending outcomes. Recent cannabis consumption will be validated at Vaseline and follow-up by urinalysis.

This project is jointly funded through the Commonwealth and NSW State Attorney's-General Departments.

The association between psychosis and problematical drug use among Australian adults: findings from the National Survey of Mental Health and Well-Being

Psychological Medicine, 31, 659-668

Louisa Degenhardt and Wayne Hall

Background. The present paper aimed to (a) provide Australian estimates of the population-level association between psychotic 'caseness' and substance use; (b) examine liability to problematical substance use according to 'caseness' via the conditional prevalence (prevalence among users); and (c) examine associations between problematical substance use and the number of psychotic symptoms using ordinal logistic regression.

Method. Data were from the National Survey of Mental Health and Well-Being (NSMHWB), a stratified multi-stage probability sample of Australian adults, using a subset of persons under the age of 50 years (n = 6722). A screener assessed the presence of characteristic psychotic symptoms. Associations between 'case' status and DSM-IV alcohol, cannabis and other drug use disorders were examined. Ordinal logistic regressions predicting psychosis scores were carried out, including demographic, mental health and drug use variables.

Results. Ninety-nine persons (1.2%) screened positively for psychosis. Regular tobacco, alcohol and cannabis use were much more common among persons screening positively, as were alcohol, cannabis and other drug disorders. Among alcohol and cannabis users, psychosis 'cases' were much more likely to be dependent. Ordinal logisitic regressions revealed that regular tobacco use, cannabis and alcohol dependence, and opiate abuse were predictors of psychosis scores.

Conclusions. The mental health risks of problematical substance use need to be disseminated to persons at risk of, or suffering from, psychotic illness, and to heavy substance users.

Work is needed to develop effective treatment approaches for problematical substance use among persons with psychosis.

Outcomes of a comprehensive treatment program for adolescents with a substance-use disorder

Journal of Substance Abuse Treatment, 20, 205-213

Catherine Spooner, Richard Mattick and Wesley Noffs

Outcomes of a multimodal residential treatment program for adolescents were compared with usual care. The quasiexperiemntal design included pretest, 3-month posttest, and 6-month follow-up of program referrals (mean age 16; 53% male). The intervention group (IG) comprised referrals who entered the program (n = 61) and the comparison group (CG) comprised referrals who did not enter the program (n = 60). The six outcomes (substance use, criminal behavior, social functioning, psychological distress, physical health, and HIV risk-taking behaviour) were assessed using the Opiate Treatment Index and the Symptom Checklist-90-Revisited. The study groups demonstrated equivalent improvement on all six outcomes. Multiple factors are likely to have influenced these results, including inadequate program implementation and differential drop-out. There was, however, a higher prevalence of multiple improvements among the IG than the CG. It is concluded that adolescents with a PSUD can improve, however, a superior means of achieving this improvement has yet to be demonstrated.

The relationship between cannabis use, depression and anxiety among Australian adults: findings from the National Survey of Mental Health and Well-Being

Social Psychiatry and Psychiatric Epidemiology, 36, 219-227

Louisa Degenhardt, Wayne Hall and Michael Lynskey

Background. This study aimed to examine the patterns of association between cannabis use, and anxiety and affective disorders, in the general population.

Method. Data from the Australian National Survey of Mental Health and Well-Being, a representative survey of Australians aged 18 years and over, were analysed to address the following questions: (1) is there an association between cannabis use, DSM-IV abuse and dependence, and DSM-IV affective and anxiety disorders; (2) if so, is it explained by: demographic characteristics, levels of neuroticism, or other drug use; and (3) does the presence of a comorbid affective or anxiety disorder affect the likelihood of treatment seeking among cannabis users?

Results. There was a moderate univariate association between involvement with cannabis use in the past 12 months and the prevalence of affective and anxiety disorders. Among those with DSM-IV cannabis dependence, 14% met criteria for an affective disorder, compared to 6% of non-users; while 17% met criteria for an anxiety disorder, compared to 5% of non-users. These associations did not remain significant after including demographics, neuroticism and other drug use in multiple regressions.

Conclusions. Cannabis use did not appear to be directly related to depression or anxiety when account was taken of other drug use. However, the association between heavier involvement with cannabis use and affective and anxiety disorders has implications for the treatment of persons with problematic cannabis use.

A randomised controlled trial of brief cognitive-behavioral interventions for cannabis use disorder

Journal of Substance Abuse Treatment, 21, 55-64

Jan Copeland, Wendy Swift, Roger Roffman and Robert Stephens

The increasing demand for treatment for cannabis dependence in Australia and internationally has led to the identification of significant gaps in knowledge of effective interventions. A randomised controlled trial of brief cognitive-behavioral interventions (CBT) for cannabis dependence was undertaken to address this issue. A total of 229 participants were assessed and randomly assigned to either a six-session CBT program (6CBT), a single-session CBT intervention (1CBT), or a delayed-treatment control (DTC) group. Participants were assisted in acquiring skills to promote cannabis cessation and maintenance of abstinence.

Participants were followed up a median of 237 days after last attendance. Participants in the treatment groups reported better treatment outcomes that the DTC group. They were more likely to report abstinence, were significantly less concerned about their control over cannabis use, and reported significantly fewer cannabis-related problems than those in the DTC group. Those in the 6CBT group also reported more significantly reduced levels of cannabis consumption than the DTC group. While the therapist variable had no effect on any outcome, a secondary analysis of the 6CBT and 1CBT groups showed that treatment compliance was significantly associated with decreased dependence and cannabis-related problems. This study supports the attractiveness and effectiveness of individual CBT interventions for cannabis use disorders and the need for multisite replication trials. **cl**

recent publications

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

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