



June 08

Are we locked-in to lockouts?

High Dose NSAID Toxicity

Where's the Justice in Alcohol and Drugs

Fieldwork Placements for Post-graduate Psychology Students

Forum - From Hospital to the Community

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ISSN: 1835-8292

Are we locked-in to lockouts?

Alcohol-related violence in and around licensed premises is an issue of growing community concern. But how to address this complex issue remains the subject of considerable debate. This article looks at recent government action to address alcohol-related violence and anti-social behaviour and asks, what else can be done?

On June 3 2008 the Victorian Government introduced a 3-month trial of late hour entry restrictions (known commonly as lockouts) in the local government areas of Melbourne, Yarra, Port Phillip and Stonnington. Curiously, the gaming floor of Crown Casino is exempt from the lockout declaration. For the duration of the trial, patrons will not be allowed to enter city bars, pubs and clubs after 2am and if they leave a venue for any reason they will not be permitted re-entry. Patrons who leave a venue for a cigarette, to access an ATM or to chaperone friends to a taxi will not be allowed back in.

The 2am lockout has been introduced as one of 'a number of immediate measures [including a freeze on issuing late-night liquor licences] to address public safety and amenity in entertainment precincts' (VAAP 2008, p.34). In support of the trial, the Government notes that a high proportion of alcohol-related violence and anti-social behaviour occurs after 2am and as people move between late-night venues. The success of lockouts in regional Victoria has also driven the decision to trial a lockout in Melbourne.

But the introduction of the lockout has not been without controversy. Licensees have actively challenged the decision with more than a quarter of inner-city venues granted an exemption from the trial. Large numbers of young people, who feel they are the target of the move, have been vocal in their opposition. Practical issues have also been raised including the need to improve access to safe, reliable public transport and taxis so people can get home safely. While some degree of resistance may have been expected, what does the evidence say about lockouts?

Criminologist Ross Homel believes lockouts are not likely to make much difference and refers to these kinds of interventions as 'symbolic politics rather than serious intervention'. He points to evaluations of the lockout in Brisbane, saying 'the jury is still out' on the long-term impact of lockouts.

Professor Homel's research over the last several decades has led him to believe that much more fundamental issues related to the management of venues and amenity need to be addressed. What is needed, he says, is a 'community mobilisation approach' which brings together police, regulatory agencies, industry and the community to address the issues in an integrated way.

There are some promising examples to draw from, according to Professor Homel. The Alcohol-Linking Program in the Hunter Valley may be one example. The program was a collaborative project between NSW Police, Hunter Valley New England Population

Health and the University of New Castle under taken over a decade to improve community safety by enhancing collection and recording by police of alcohol intelligence information and applying the information to reduce alcohol-related harm (Wiggers 2007). The project results revealed the need for a 'whole of community' response directed at reducing alcohol-related harm.

The VAAP indicates that the trial will be evaluated but what will be the measure of success? The Government is yet to release details of the evaluation process and the targets by which success will be measured but it seems likely that police statistics will be a key measure of success as they have been in other jurisdictions.

While police statistics are one useful measure, a more rigorous and multi-dimensional evaluation that recognises that there are a large number of individual and environmental factors that contribute to alcohol-related harm is needed.

What has been the impact regarding displacement – are problems shifting to other areas or occurring at different times of the day. What about seasonal variations? Does the lack of public transport in the early hours create other problems? Professor Homel believes an examination of temporal and spatial displacement should form part of a sophisticated evaluation but he also believes that longer-term evaluations are needed to draw any meaningful conclusions about the effects of lockouts.

High Dose NSAID Toxicity Secondary To Codeine Dependence

Misuse of over-the-counter (OTC) pharmaceutical drugs containing codeine has been recognised for many years. Cough mixtures and analgesics like paracetamol that are compounded with codeine, such as Panadeine® or Mersyndol®, have been previously identified as a source of misuse. Recent media attention highlighting concerns from pharmacy and the medical profession suggest that misuse of ibuprofen/codeine combinations is currently problematic.

The drug - Ibuprofen 200mg/codeine phosphate 12.8mg is available as Nurofen Plus® or Panafen Plus® OTC from pharmacies.

It may be the relatively high codeine content per tablet and per packet that makes these products desirable for misuse. Ibuprofen/codeine products contain a substantially higher dose of codeine per tablet in comparison to other compounded analgesics available OTC.¹ They are available in pack sizes as large as 75, which offer 50% more codeine per packet than a packet of Panadeine Forte which is only available with prescription.

Nurofen Plus® and Panafen Plus® combine codeine phosphate, a drug with potential for dependence, with ibuprofen, a non-steroidal anti-inflammatory drug (NSAID) with widely recognised toxic properties.

NSAIDs are amongst the leading causes of drug-related morbidity and mortality in Australia and worldwide.^{2,3} Therapeutic use of NSAIDs is associated with an increased risk of injury to the lining of the gastrointestinal (GI) tract including erosion, ulceration, haemorrhage and perforation.⁴ Risk of GI complications caused by NSAIDs is dose-dependent (with risk increasing parallel to increasing dose); and increases with duration of treatment over months and years with no development of tolerance.⁵

When codeine is combined with a fixed dose of another analgesic the user is unable to adjust the dose of each drug independently. 30mg of codeine is accepted by authoritative sources as the lowest dose necessary to produce an analgesic effect.⁶ The 12.8mg of codeine phosphate per tablet offers questionable additional therapeutic benefit to the mild analgesic effect of ibuprofen.⁷ Increased consumption of the combined product to achieve a therapeutic level of codeine for pain relief or to achieve an intoxicating effect leads to secondary ingestion of ibuprofen at high and potentially toxic levels.

Cases of harm- In January 2008, two cases of perforated gastric ulcers associated with excessive misuse of Nurofen Plus were published in the MJA, sparking media attention and responses from the medical, pharmaceutical and manufacturing industries.⁸

The cases attended the same community hospital emergency department within a six month period, both with a remarkably similar clinical presentation. The first case was a 39 year old female, with a history of alcohol and codeine misuse, who reported that she had been taking 16-24 Nurofen Plus tablets daily for 3 weeks prior to her presentation. The second case, a 41 year old male, admitted to recreational use of a packet of Nurofen Plus a day for one year. The maximum recommended daily dose of Nurofen Plus is 6 tablets a day.

Both cases presented with acute and severe abdominal pain. Investigations demonstrated the need for urgent surgical attention. In both cases surgery revealed a perforated gastric ulcer and gross contamination in the abdomen; a condition that is life-threatening without prompt specialist medical intervention.

A search of the published literature reveals that other serious complications, such as low potassium levels and renal failure have also been caused by excessive use of ibuprofen/codeine products.^{9,10,11} The death of a young mother from renal failure, caused by a two year addiction to Nurofen Plus sparked outrage in the United Kingdom last year. The country's All Party Parliamentary Group on Drug Misuse has launched an enquiry into the problems associated with over-the-counter drug misuse.

Responses - Arguments for maintaining the status quo are based on accessibility and cost. Some believe that easy access to these products should not be restricted because of the harms suffered by a few. It is also argued that restricting these drugs to prescription only may place a burden and additional cost on the health care system.

The counter argument which advocates tighter controls, suggests that there is a need for further effort to prevent these serious and life-threatening injuries. These injuries result in considerable suffering and cause life-long disability and possibly death. The cost to the health care system to treat these harms may be substantial. It is suggested that a large proportion of Australian adults may be at risk of misusing these products, because in any one year 1 in 5 people are affected by mental illness and 1 in 13 adult Australians have substance use disorders. These conditions may limit the ability of some people to use these products safely, particularly as they include a drug of dependence (codeine).

What you can do - People working in the Drug and Alcohol field should be mindful that these products can be misused and ask about OTC drug use when taking a patient history. If misuse of ibuprofen/codeine products is suspected, please warn of the potential associated injuries.

1 Panadeine 15 offers a higher dose of codeine per tablet but is only available in packets of 12.

2 ACSQHC, Second National Report on Patient Safety: Improving Medication Safety, July 2002.

3 Hawkey CJ, NSAIDs toxicity: where are we and how do we go forward? *Journal of Rheumatology* 2002;29:650-1.

4 Tarone RE et al. Nonselective Nonaspirin Nonsteroidal Anti-Inflammatory Drugs and Gastrointestinal Bleeding: Relative and Absolute Risk Estimates From Recent Epidemiologic Studies. *Am J Therapeutics*. 2004;11:17-25.

5 Hawkey CJ, NSAIDs toxicity: where are we and how do we go forward? *Journal of Rheumatology* 2002;29:650-1.

6 Therapeutic Guidelines Ltd. *Therapeutic Guidelines: Analgesics*. 2007.

7 Rossi S (Ed.). *Australian Medicines Handbook 2008*. Adelaide: Australian Medicines Handbook, 2008.

8 Dutch, MJ, Nurofen Plus misuse: an emerging cause of perforated gastric ulcer, *MJA* 2008; 188:56-57.

9 Lambert PA, Close C. Life-threatening hypokalaemia from abuse of Nurofen Plus. *J R Soc Med* 2005;98:21.

10 Chetty R et al. Case report: severe hypokalaemia and weakness due to Nurofen Misuse. *Ann Clin Biochem* 2003;30:422-3.

11 Dyer BT, Martin JL, Mitchell JL, et al. Hypokalaemia in ibuprofen and codeine phosphate abuse, *Int J Clin Pract*, 2004

Where's the Justice in Alcohol and Drugs

In last month's newsletter we briefly touched on the State Governments allocation of \$591M for 244 extra prison beds and a 355 bed upgrade at the Ararat prison. Given reader feedback and the obvious intersections between the alcohol and drug sector and the criminal justice system, VAADA thought readers might be interested in a better insight into some facts and figures as they relate to our mutual areas.

Firstly, over 2008/09 Victoria will record it's highest ever police budget of \$1.75B. The Prison/Corrections budget allocation while difficult to assess is estimated at \$1.1B and the state budget allocation for Alcohol and Drug Services over this time is set at \$123.9M

Interestingly despite the considerable 'Law and Order' focus over many years we note that since 1999 the state's crime rate has dropped by 23.5%¹. In fact in 2007, Victoria's overall crime rate was the lowest of all Australian States and Territories – consistently 20% below the national average. However, over the 10 year period between 1997 and 2007 the number of prisoners in Victoria's increased by close to 58%.

The Council of Australian Governments (COAG) confirm that each prisoner costs around \$80,000 per year and that that around 53% of the prison population have been in prison before². Staggeringly 44% of Victorian Prisoners returning to corrective services within 2 years of release³. We also know that in 2002, an unreleased survey by the Burnet Institute found a lifetime prevalence of injecting drug use in 65 per cent of a random sample of prisoners.⁴ It is estimated that 50-80% of prisoners have a drug or alcohol dependence.⁵ In a more recent Victorian survey of prisoner health it was noted that the prevalence of Hepatitis C amongst Victorian Prisoners was 60% for women and some 52% for men and considerably higher indigenous prisoners (older aboriginal males -78% and young aboriginal females -77%⁶). Most importantly we also know that Drug treatment in prisons does not yet replicate the range of treatment available in the community.

The fact that prison numbers continue to increase in the face of all the evidence of the harms done seriously confronts current rhetoric around evidence based practice in our sector. There is a dramatic disconnect between the facts and the solutions which could improve both individual and community outcomes. It is vital to commence a renewed community dialogue about what works and what doesn't. New and innovative policy and program initiatives seeking to redress the harms done by ineffective and wasteful law and order spending must be re-assessed. The crucible that is our prison and justice system must be re-assessed both in terms of the treatment and its rehabilitative focus but also in light of the irretrievable damage it does to individuals and the longer term impact this has for the whole of the community.

Hugh de Kretser, Federation of Community Legal Centres Victoria, Media Release 8 May 2008

(Endnotes)

1 Statement by Victorian Treasurer Lenders

2 Victorian Department of Justice (2005) Statistical profile of the Victorian prison system 2000-01 to 2004-05

3 Office of the correctional services commissioner, Building a responsive corrections system long term management strategies, July 2002, Department of Justice Victoria

4 Hellard, M., Crofts, N. and Hocking, J. (2002). Hepatitis C Virus among Inmates in Victorian Correctional Facilities: a report of the prevalence of hepatitis C and the risk behaviours associated with the transmission of hepatitis C virus in Victorian correctional facilities. September. Melbourne: Burnet Institute.

5 Ombudsman Victoria / OPI, Conditions for persons in custody, July 2006

6 Victorian Prisoner Health Study - Department of Justice, Melbourne 2003

Fieldwork Placements for Postgraduate Psychology Students by The Australian Psychological Society AOD Student Supervision Scheme

The Clinical Supervision of Postgraduate Psychologist Trainees Undertaking Placements in Alcohol and Other Drugs (AOD) Services Project aims to improve treatment outcomes for clients with substance use and mental health problems and the development of services to better address comorbidity issues.

This initiative offers supervised psychological services to clients in non-Government organisations who present with comorbid mental health problems. It presents an opportunity for AOD services to provide fieldwork placements for postgraduate student psychologists. Additionally, the initiative will increase opportunities for AOD services staff to consult with a psychologist who will be organised under the initiative to provide weekly supervision for the postgraduate psychology student's work with clients with comorbid mental health problems.

The Australian Psychological Society (APS) is administering this scheme on behalf of the Commonwealth Government and is responsible for recruitment of AOD services and consultant psychologists to provide the necessary supervision. The scheme has begun successfully throughout Australia and the APS is now seeking expressions of interest from AOD services in Victoria where there are students awaiting placement opportunities. Why participate in this scheme? If you provide a placement opportunity for a postgraduate psychology student your clients will have access to a range of psychological services that might include:

1. Assessments designed to identify comorbid mental health problems i.e problems other than those associated with alcohol and other drugs
2. Counselling to support clients with a range of issues including:
 - Mental health problems including depression, anxiety, psychosis
 - Adherence to treatment
 - Adjustments to lifestyle change
 - Family and relationship problems
 - Relapse prevention skills

PTO

DATE	EVENT
July 4	Stories of Barcelona: Australian Perspectives on the 19th International Conference on the Reduction of Drug Related Harms – “Towards a global approach” 9.00am – 12.30pm ANEX Conference Room Level 2 Suite 1 600 Nicholson St North Fitzroy. Speakers Danny Jeffcote, Peter Higgs and Meredith Kratzmann. To register email r.flett@anex.org.au or 03 9486 6399.
July 9	Women, Motherhood & Drugs Forum (FREE) Anex invites you to a free one-day forum to improve knowledge and awareness of the issues and challenges relating to parenthood, pregnancy and illicit drug use. To be held at the Anex Conference Room, Suite 1, Level 2, 600 Nicholson St, Fitzroy North Vic Time: 10.00am - 12.30pm, Contact Anex, Ph: (03) 9486 6399, Email: info@anex.org.au
July 15 -16	Practice Research Network Workshop This free two-day workshop is to establish a Practice Research Network in Victoria and to develop a stronger working partnership between researchers and clinicians. Time: 9:30am - 4:30pm Venue: Metropole Hotel and Conference Centre, 44 Brunswick Street, Fitzroy. More information & Enquiries: Email Lisa Johns at lisa.johns@turningpoint.org.au or 0425 757 307
July 16	Alcohol and young people: the role of parents – This free DrugInfo Clearinghouse will explore some of the issues raised in the recently released publication suite ‘The role of parents in preventing alcohol-related harms among young people’. Time: 10am to 12.30pm (registration and refreshments from 9.30am). For more information, or to book your place, telephone 1300 85 85 84 or send your name, organisation and contact phone number to druginfo@adf.org.au .
July 25	Leadership in the Community (Linc) forum This Eastern Region Alcohol and Drug Strategy Group forum aims to provide an opportunity for members of the alcohol and drug community and from other areas of health, welfare, education and law, to be energized and inspired by speakers noted for their leadership ability. Cost to attend the forum is \$25.00 and includes morning and afternoon tea and lunch. More information can be accessed online at www.emrlinc-forum.com . RSVP’s by COB Friday 11 July 2008
July 27	From Hospital to the Community Presented by VAADA & VAILA. For more information go to www.vaada.info or contact Chris on 9416 0899 or cmcdonnell@vaada.org.au

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What is required of AOD services?

Types of Activities

A postgraduate psychology student is equipped to provide your AOD service or clients with activities that include:

1. Individual counselling sessions
2. Group based behavior change programs
3. Development of material for use within the AOD service
4. Staff training

Your AOD service would also be expected to nominate an on-site coordinator to oversee the student’s day to day activities and ensure an appropriate caseload. You must also ensure that the student has appropriate working conditions and facilities for client contact, as you would for any other employee.

Expenditure (up to \$2000) incurred in support of the placement will be reimbursed by the APS. This might include the purchase of testing materials for psychological assessments.

Are there additional benefits for AOD services?

The project also allows for consultant psychologists to be employed for additional hours on supervision days to conduct staff training in the area of comorbidity.

Forum - From Hospital to the Community

The Victorian Alcohol and Drug Association (VAADA) and the Victorian Alcohol and other drugs Inter-hospital Liaison Association (VAILA), present From Hospital to the Community at the Northcote Town Hall on 25 July 2008.

This seminar will provide three moderated case studies examining hypothetical clinical presentations that clinicians may encounter when working with clients who have substance misuse issues.

Each case study will be presented to a panel of clinicians from a major Melbourne hospital who will tease out the complexities of the issues clinicians may confront in such situations and what a best practice response may be. Case studies will be moderated and the audience encouraged to contribute their practical experience and knowledge, as well as having an opportunity to question panellists over their responses to the scenarios.

Case Studies

Case Study 1 ‘Opioid Substitution Pharmacotherapy’

Case Study Two: ‘Alcohol Withdrawal and Delirium Management’.

Case Study Three: ‘How Do We Manage Smoking in Non-Smoking/Smoking Environments?’

For more information visit: www.vaada.info