Estimates - QoN No. E12-581

QON-12/92

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Caroline Le Couteur: To ask the Minister for the Arts

[Ref: Cultural Facilities Corporation, Statement of Intent, Page 5]

In relation to: Accountability Indicators

1. I note the following:

   a) Number of education and community programs at facilities managed by Cultural Facilities Corporation (CFC) - (discontinued measure) – Estimated Outcome in 2011-12 is 570;
   b) Number of education and community programs provided by CFC – (new indicator) – target for 2012-13 is 480.

   Could you please advise:

   i. Whether facilities managed by CFC are hired out to the public and whether there will be lower facility hiring in 2012-13?
   ii. Why there appears to be a reduction in the services provided or offered by CFC in 2012-13?

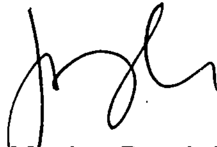
Minister Burch: The answer to the Member's question is as follows:–

i. Facilities managed by the Cultural Facilities Corporation (CFC) are generally hired out to the public with certain exceptions e.g. Calthorpes' House is considered too fragile for hiring out in this way. It is not expected that there will be lower hiring of CFC facilities in 2012-13. It should be noted that hires of CFC facilities by the public are not counted in the number of education and public programs recorded.

ii. The difference between the 2011-12 Estimated Outcome for education and community programs at facilities managed by the CFC and the 2012-13 target for education and community programs provided by the CFC relates to two main factors:
   - the fact that there was an intensive provision of education programs in 2011-12 in association with two children's picture book exhibitions at the Canberra Museum and Gallery – this intensive provision is not expected to happen during 2012-13 as there will not be similar exhibitions in that year; and

E12-581

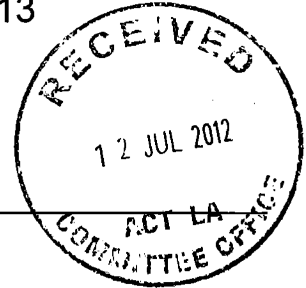
- the fact that, in terms of programs associated with the Centenary of Canberra in 2013, the timing of these is expected to focus more on the second half of 2013 than the first half, which impacts on the 2012-13 target.

Approved for circulation to the Select Committee on Estimates 2012-2013
Signature:  13.7.12 Date:
By the Minister for the Arts, Ms Joy Burch MLA

Estimates - QoN No. E12-582

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013



ANSWER TO QUESTION ON NOTICE

Caroline Le Couteur: To ask the Minister for the Arts

[Ref: Budget paper 4, page number 359, Output 3.3]

In relation to: Capital Works

1. What assurances can be provided that the capital works activities listed for completion in June 2013 will be completed on time and on budget?

2. The Glassworks and other Arts Facilities are receiving improvements to fire systems. What other Arts Facilities does this include?

Minister Burch: The answer to the Member's question is as follows:–

1. Several mechanisms have been put in place to ensure that capital works projects will be delivered on time and on budget. Procurement Officers from Shared Services provide expert input into budget and construction timelines. Engaging quantity surveyors to work closely with architects at the design stage of capital works projects emphasizes the importance of budget from the first step. Projects are reviewed throughout the design stages prior to tendering. The transfer of the Capital Works Team from artsACT to Community Services Directorate, Asset Management Branch, means that the arts capital works projects benefit from targeted design and construction expertise and resources.

2. There are a number of projects being delivered through the "Glassworks and other Arts Facilities Fire Improvements". The Canberra Glassworks has undergone an extensive upgrade to improve the fire safety and detection systems in the arts centre. Other facilities include: Strathnairn Homestead, the design and implementation of a bush fire management plan and a significant upgrade to the hydrant services on the property; Gorman House Arts Centre, replacement of an aging fire panel and improvements to fire installations; Tuggeranong Arts Centre, replacement of an aging fire panel. There are also several smaller projects such as updating fire evacuation plans at Strathnairn, Tuggeranong and Street Theatre and replacements of fire hydrants.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: 12-7-12 Date:

By the Minister for the Arts, Ms Joy Burch MLA

Estimates - QoN No. E12-583

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Caroline Le Couteur: To ask the Minister for the Arts

[Ref: Budget paper 4, page number 353, Output 3.3]

In relation to: Accountability Indicators

1. I note that the accountability indicators for Arts have reduced from 11 to 3:

   a) Why have the accountability indicators been reduced?
   b) What steps has the Directorate put in place to ensure that this loss of detail will not lead to reduced accountability?
   c) How were the new indicators chosen?
   d) How do the new indicators compare to accountability indicators used by Arts Directorates/Departments in other jurisdictions?

Minister Burch: The answer to the Member's question is as follows:–

a) The accountability indicators were reduced to improve performance monitoring and to reflect changes in program delivery. The changes include that the Cultural Ministers Council has ceased (indicator c), artsACT now only administers the Cultural Facilities Corporation's board appointments (indicator d), and the Public Art program has ceased (indicators i and j). All arts funding has been condensed into one broad indicator (indicators e to h). There is now one indicator for each of artsACT 's three main areas of reporting namely, policy (indicator l), funding (indicator m), and facilities (indicator n).
b) artsACT is accountable for all its activities and there remains detail in the key area of arts funding, policy and facilities.
c) The new indicators were chosen in discussions with artsACT and Finance and Budget division of the Community Services Directorate.
d) It is difficult to compare the ACT to other jurisdictions given the diversity in reporting regimes. However, the ACT has some similar indicators to other jurisdictions.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: 23·7·12 Date:

By the Minister for the Arts, Ms Joy Burch MLA

Estimates - QoN No. E12-584

QON-12/96

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Meredith Hunter: To ask the Minister for Community Services

[Ref: Budget paper 4, page number 346, Care and Protection Services - Output 4.2]

In relation to: Reception Centre

1. With respect to the ACT Public Advocate, "Review of the Emergency Response Strategy for Children in Crisis in the ACT", May 2012 – Improve Emergency Response Processes – Recommendation for Future Possible Action (Page 12):

   a) When will the inclusive review of the framework, provision and tendering process and the current practices in the non-government sector in relation to the current standards for Out of Home Care, be finalised?
   b) When will the investigation into the number and type of reception and other Out of Home Care facilities, and other options for "places of care" for children who don't fit into foster care, such as "residential" and other family group home placements so that inappropriate properties are never used in future, be finalised?

Minister Burch: The answer to the Member's question is as follows:–

1. a) - b) These recommendations were identified by the Public Advocate in the Stage 1 Report. The government response *agreed in part* at that time and indicated that:

   The Government agrees that this work should take place.

   Given the scope of the work proposed and its urgency, part should be conducted by the Public Advocate and part by the Auditor-General, who is already scheduled to review Care and Protection Services during 2012.

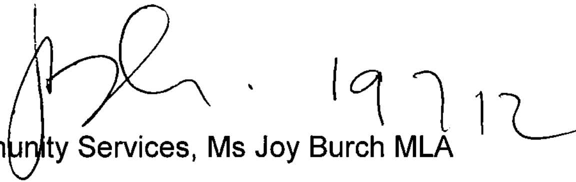
   The Public Advocate has now completed the second part of the review and the Auditor General is currently conducting her review, which it is anticipated will be completed before the end of this calendar year. These recommendations were considered by the Public Advocate and Auditor General when the terms of reference were developed for the reviews.

   In addition, a review of the Out of Home Care framework including provision and tendering processes is underway in the Community Services Directorate. It is expected a new model that has been codesigned with the sector, will be completed ready for public consultation in 2013, and finalised in readiness for a tender process in 2014. The renewal of funding agreements is due in 2015.

Agencies providing Out of Home Care in the ACT are currently subject to a comprehensive set of standards as a condition of their Service Funding Agreement. The current work to develop a new Out of Home Care 5 Year Plan for the delivery of Out of Home Care in the ACT will include consultation on these standards.
Any amendments in response to this consultation, and to ensure alignment with national standards, will be undertaken over the next 12 months.

The development of models of care for children in Out of Home Care across a range of settings is ongoing. Individual responses have been developed in relation to specific children and young people. The Directorate has established a reception centre for children and young people, including sibling groups, which is managed by Care and Protection Services. This centre allows Care and Protection Services to have additional places available at short notice. Current work with community sector agencies, including Anglicare and the Australian Childhood Foundation, seeks to address the range of current future needs in the Out of Home Care population.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature:  Date:

By the Minister for Community Services, Ms Joy Burch MLA

Estimates - QoN No. E12-585

QON-12/97

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Meredith Hunter: To ask the Minister for Community Services

[Ref: Budget paper 4, page number 355, Care and Protection Services - Output 4.2]

In relation to: Accountability Indicators

1. Indicator (b) – The 2011-12 Estimated Outcome and 2012-13 target are the same, yet Note 2 indicates that there is a continuing increase in need. Why is the 2012-13 target therefore the same as the 2011-12 Estimated Outcome?

2. Indicator (e) and (h) – Given that there is a target of 50,000 out of home care days being used in 2012-13 and 300 Indigenous children and young people receiving support, it is assumed that there are 137 children or young people in foster care, residential care, kinship care or refuges.

   a) Is this correct?
   b) What is the level of unmet need for foster care, residential care, kinship care or refuges?

3. Indicator (d) – Given that there is a target in 2012-13 of 220,500 total out of home care days being used and 1200 children and young people receiving care and protection services, it is assumed that 604 children and young people are in foster care, residential care, kinship care or refuges.

   a) Is this correct?
   b) What is the level of unmet need for foster care, residential care, kinship care or refuges?
   c) Does this indicator exclude indigenous children and young people?

Minister Burch: The answer to the Member's question is as follows:–

1. The target for 2012-13 is an increase on the previous year's target. The indication of a continuing increase in need was referring to the increase from the previous year's target of 1700.

2. a) This is not correct. The calculation provided in the question is a simple calculation of average occupancy.

   In fact, the measure of out of home care days utilised provided in the budget papers is a measure of the number of days for which the Office for Children Youth and Family Support made a payment for overnight care for Aboriginal and Torres Strait Islander children and young people. This figure does not equate to the number of individual children who access the service nor their individual length of stay.

E12- S85

The 300 children referred to in indicator (h) is the expected number of Aboriginal and Torres Strait Islander children who were receiving any support on the day of measurement, including family support directly from the Aboriginal and Torres Strait Islander Services and/or support from Child Protection Services where the child or young person is living at home as well as those children in out of home care.

b) There is no unmet need in terms of a place of safety for any child when required. When a child or young person is assessed as being at risk they are placed in temporary out of home care pending a decision on their long term care requirements.

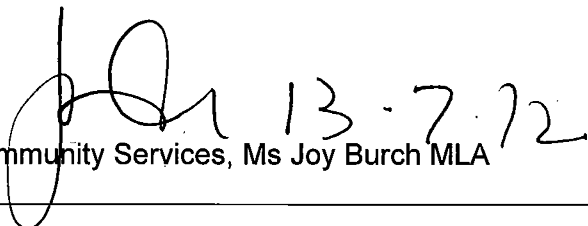
3. a) This is not correct. The measure of out of home care days utilised provided in the budget papers at indicator d) is a measure of the number of days for which the Office for Children Youth and Family Support made a payment for overnight care for all children and young people. This figure does not equate to the number of individual children who access the service nor their individual length of stay.

   The 1200 children referred to in Indicator (i) is the expected number of children and young people who were receiving any support on the day of measurement, including appraisal or short to longer term support where the child or young person is living at home as well as those children in out of home care.

   b) Please refer to answer 2) b

   c) The indicator includes Aboriginal and Torres Strait Islander children and young people.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature:  Date: 13.7.12

By the Minister for Community Services, Ms Joy Burch MLA

Salvaneschi, Sam

From: Burrows, Sarah
Sent: Thursday, 12 July 2012 7:47 AM
To: Salvaneschi, Sam
Cc: Pitts, Julia
Subject: FW: Questions on Notice

Authorised for publication
30/07/12

Hi Sam,
As requested
S

From: Robert Neil [mailto:rwneil@hotmail.com]
Sent: Wednesday, 11 July 2012 5:58 PM
To: Burrows, Sarah; Pitts, Julia
Subject: Questions on Notice

Sarah/Julia please forward the message below to the relevant Assembly people

The response to Questions Taken On Notice
E12-493
E12 -494
E12 -495
E12 -496
E12 -497
E12 -498
E12-499
E12 -500
E12 -501

And
Questions on Notice
E12 -586
E12-587
E12-588

Are answers from me

Mr Robert Neil
Commissioner for Sustainability and the Environment
11 July 2012

Burrows, Sarah

From:	Robert Neil [rwneil@hotmail.com]
Sent:	Sunday, 8 July 2012 8:01 PM
To:	Burrows, Sarah; Pitts, Julia; Fitzgerald, Bruce
Subject:	QoN 587A
Attachments:	QoN 587 Answer Estimates 2012.docx

The answers to Questions taken on notice (Question 587A) are answers provided by me.

Robert Neil
Commissioner for Sustaiability and the Environment

Burrows, Sarah

From: Robert Neil [rwneil@hotmail.com]
Sent: Sunday, 8 July 2012 8:54 PM
To: Burrows, Sarah; Pitts, Julia
Subject: QoN 586 and 588
Attachments: QoN 586 Answer Estimates 2012-2.docx; QoN 588 Answer Estimates 2012.docx

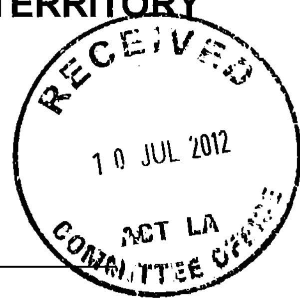
The answers to Questions on Notice 586 and 588 have been answered by me.

Robert Neil
Commissioner for Environment

Estimates - QoN No. E12-588

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013



ANSWER TO QUESTION ON NOTICE

MR RATTENBURY : To ask the Commissioner for Sustainability and the Environment [Minister for Environment and Sustainable Development)

[Environment and Sustainable Development Office of the Commissioner for Sustainability and the Environment (pp313 &317,BP4)

[from Estimates 28 June 2012 P1151]
MS HUNTER: Are there any delegations in place when the commissioner is away? Are there other delegations?

Ms Burrows: Yes there are. Delegations are in place to continue the current operations of the office while the commissioner is away.

In relation to

- What are these delegations? When were they put in place? Under what Act do these delegations occur?
- Can you please provide written copies of these delegations?
- Noting the independence of the Office of the Commissioner, who will authorise responses to Questions on Notice while the Commissioner is away?

COMMISSIONER NEIL: The answer to the Member's question is as follows:–

- Delegations were made under The Commissioner for Sustainability and Environment Act 1993 and the Legislation Act 2001 Part 19.4 on the 7th June 2012. I delegated my powers to both of my senior manager positions in relation to sections 15(5), 16(1),16(2),17(1)17(2)(b), 17(3) these delegated powers were limited to cover existing ongoing investigations. The section 18 delegation with regard to State of Environment reports was not limited.
- A copy of the delegation, drafted by the Government Solicitor's Office and based on their advice, is attached.

- I will authorise the Commissioner's responses to questions on notice. Prior to leave I ensured that systems were in place so that the office could contact me with regard to the Estimates hearing or other matters the Senior Managers may wish to discuss with me. I have been in contact with my staff through email to answers and sign off to the questions from the Committee. My Office has also liaised the secretariat for the Select Committee on Estimates regarding these arrangements.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: Date: 9/7/12

By Ms Sarah Burrows for the Commissioner for Sustainability and the Environment

E12-588

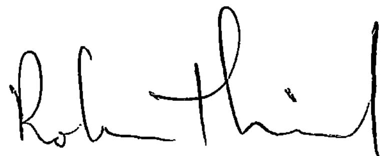
Australian Capital Territory

Commissioner for Sustainability and Environment Act Delegation 2012 (No 1)

made under the

Commissioner for Sustainability and Environment Act 1993 **and** ***Legislation Act 2001 Part 19.4***

I delegate my powers specified in column 2 of the attached Schedule to each person holding or performing the duties of an office in the ACT Public Service specified in column 4 of the Schedule, subject to the limitation specified in column 5 of the Schedule.



Robert Neil
Commissioner for Sustainability and the Environment.

Date: 7 June 2012

This is page 1 of the Schedule to the Instrument of Delegation for the *Commissioner for Sustainability and Environment Act 1993* being the *Commissioner for Sustainability and Environment Act Delegation 2012 (No 1)*

column 1 item	column 2 section	column 3 Power	Column 4 Delegate	Column 5 Limitation
1	15(5)	In relation to an investigation: obtain information from any person, and make any enquiries, as the delegate decides	Position Number 10970; Position Number 13797	Limited to an existing, ongoing investigation
2	16(1)	In relation to an investigation: enter any place occupied by an agency and carry on the investigation at that place.	Position Number 10970; Position Number 13797	Limited to an existing, ongoing investigation
3	16(2)	In relation to an investigation: inspect any documents relevant to an investigation that are kept at premises entered under s. 16(1)	Position Number 10970; Position Number 13797	Limited to an existing, ongoing investigation
4	17(1)	In relation to an investigation: issue written notice to the head of an agency to provide information in writing or produce documents or other records	Position Number 10970; Position Number 13797	Limited to an existing, ongoing investigation
6	17 (2)(b)	In relation to an investigation: issue written notice to the principal officer of an agency or person nominated by the principal officer to produce documents or other records	Position Number 10970; Position Number 13797	Limited to an existing, ongoing investigation

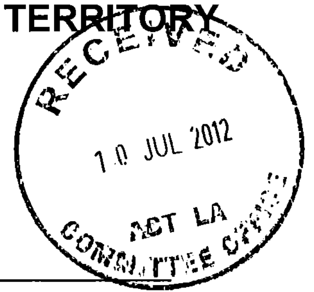
This is page 2 of the Schedule to the Instrument of Delegation for the *Commissioner for Sustainability and Environment Act 1993* being the *Commissioner for Sustainability and Environment Act Delegation 2012 (No 1)*

column 1 item	column 2 section	column 3 Power	Column 4 Delegate	Column 5 Limitation
7	17 (3)	In relation to an investigation: take possession of, make copies of, or takes extracts from and keep for any period necessary, any documents or records produced under subsection 17(1) or 17(2)(b) issue written notice to the principal officer of an agency or person nominated by the principal officer to produce documents or other records	Position Number 10970; Position Number 13797	Limited to an existing, ongoing investigation

Estimates - QoN No. E12-587

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013



ANSWER TO QUESTION ON NOTICE

ZED SESELJA MLA : To ask the Commissioner for Sustainability and the Environment

[Ref: ESD, Budget paper 4, page number 313]

In relation to : Annual Budget

1. Please provide a breakdown of the 2012-13 budget allocation including:

    a. The Commissioners wage and associated costs

    b. The wages and associated costs for employed staff

    c. Any provisions for consultancy, contractors, advertising and travel

Mr Robert Neil : The answer to the Member's question is as follows:–

The anticipated breakdown of the 2012-13 budget is as follows:

a. The Commissioners wages and associated costs are at the SES 2.5 Level with a Salary of $240,000.

b. Similar to previous years, our 2012-13 budget allocated to salaries and associated costs of employed staff are $535,000.

c. Approximately fifteen percent of the 2012-13 budget will be spent on professional services that will inform investigations, complaints and special reports. Five percent of our budget is allocated to variable Office costs which includes stationary, travel, education and training and advertising for vacant positions.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: [signature] Date: 9-7-12

By Ms Sarah Burrows for the Commissioner for Sustainability and the Environment

Estimates - QoN No. E12-586

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

RECEIVED 10 JUL 2012 ACT LA COMMITTEE OFFICE

ANSWER TO QUESTION ON NOTICE

MR RATTENBURY : To ask the Commissioner for Sustainability and the Environment [Minister for Environment and Sustainable Development)

[Environment and Sustainable Development office of the commissioner for Sustainability and the Environment (pp313 &317,BP4)

- In relation to : Given the notifiable instrument for appointment of the Acting Commissioner expires 5 September 2012, and the Acting Commissioner returns from leave on 10 August, what arrangements are in place for a handover in the three-week period following the Acting Commissioner's return?
- Has the Commissioner been involved in contract extension discussions?
- Given that the Commissioner took over finalisation of the latest State of the Environment report based on an existing structure what would the Commissioner do differently if starting from scratch?
- Does the Commissioner get adequate and timely cooperation from all directorates in the handling of complaints?
- Which were the directorates on which complaints were lodged and how many were there?
- What are the main challenges to the independence of the role of the Commissioner?
- Who will authorise the Commissioner's responses to questions on notice given that the Commissioner is away?

COMMISSIONER NEIL: The answer to the Member's question is as follows:–

- The appointment for my position as Acting Commissioner expires on 6 September 2012. I will ensure an appropriate handover is undertaken by myself and my staff to any new Commissioner, should it be required.
- I have had preliminary discussions, over the Commissioner Position, with the Director General, Environment and Sustainable Development Directorate and have been involved with contract extension discussions with the Director General.
- The format of the 2011 State of Environment Report was determined after extensive consultation with subject matter experts, representatives from community groups and academics. I think it provided, and can continue to provide, a good framework for State of Environment Reporting. In assessing progress and making recommendations in the 2011 State of Environment Report I looked at

recommendations from previous State of Environment Reports and other reports by previous Commissioners, the Government progress on those Report recommendations and high lighted the continuing need for action in some areas. With that minor change there would be little change to the structure if I had started from scratch.

Noting the above it is still important to ensure the State of Environment Report is relevant and contemporary. A review of the 2011 ACT State of Environment Report is currently under way. This review will evaluate both process and content of the State of the Environment Report with a focus on continuous improvement.

- In general, adequate and timely cooperation is received from the Directorates with regard to the handling of the complaints.

- Two new complaints were lodged for the year 2011-12. They involved ESDD and TAMS Directorates. Several complaints from the 2010-11 financial year were also concluded during 2011-12.

- The Independence of the Commissioner is supported by its own legislation, the separate recognition through the administrative arrangements and our own budget papers. Keeping this in place will maintain the independence of the Commissioner.

- I will authorise the Commissioner's responses to questions on notice. Prior to leave I ensured that systems were in place so that the office could contact me with regard to the Estimates hearing. I have been in contact with my staff through email to answers and sign off to the questions from the Committee. My Office has also liaised the secretariat for the Select Committee on Estimates regarding these arrangements.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: Date: 9/7/12

By Ms Sarah Burrows for the Commissioner for Sustainability and the Environment

Estimates - QoN No. E12-589

QON-12/98

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Meredith Hunter : To ask the Minister for Community Services
[Ref: Care and Protection]

In relation to : The provision of transport and supervised care services.

1. How many organisations have been contracted to provide transport and supervised contact services over the last financial year and how many of those organisations have been audited or assessed for compliance with the minimum service delivery requirements for the provision of transport and supervised contact services?

2. Have all current providers been consulted in the development of the tender specifications for contracting these services?

3. When do you anticipate putting out the tender and in what timeframe will the process be completed?

Minister Burch: The answer to the Member's question is as follows:–

1. Five authorised foster care and residential care service providers are funded under existing Service Funding Agreements to provide transport and contact (supervised and non-supervised) between a child or young person and their family. In addition, one other provider in the ACT is engaged on a fee for service basis to provide transport and supervised contact for children and young people in kinship care and other care arrangements.

   In the last financial year the Office for Children Youth and Family Support has reviewed two of these providers for compliance against the minimum service delivery requirements for the provision of contact and supervised standards. Providers of Out of Home Care Services have also participated in self-audits against a number of the out of home care standards and it is intended that all agencies will be progressively audited against all the standards over the next financial year.

2. The Office for Children Youth and Family Support is currently undertaking a project to develop a model for the future delivery of transport and contact services. The details of the model will form the basis of any future procurement process. All providers were invited to an Out of Home Care roundtable held in December 2011, where initial discussion occurred about progressing work on an improved transport and supervision model.

   The Office for Children Youth and Family Support will consult over coming months with providers of transport and contact services in the development of the model.

3. The timeframe for any procurement process for transport and contact services is dependent on the development of the model, including consultation with service providers and other stakeholders. It is expected that the consultation process and model would be finalised by the end of the calendar year and that the new model and procurement process would be implemented in 2013.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: 19-7-12 Date:

By the Minister for Community Services, Ms Joy Burch MLA

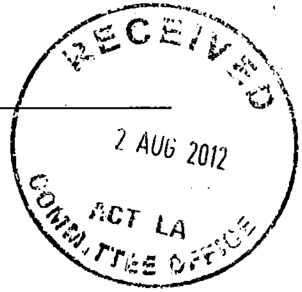
QON - 12/99

Estimates - QoN No. E12-590

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE



Steve Doszpot : To ask the Minister for Multicultural Affairs

Ref: BP4 p 345 Output 3.2 Community Affairs

In relation to: Register of Multicultural Advisers

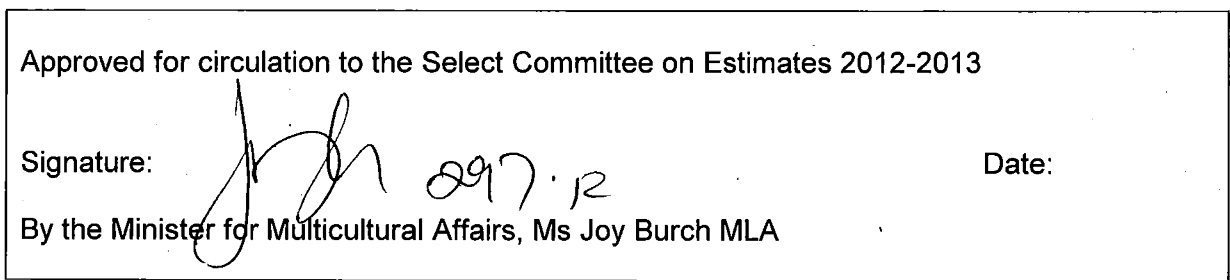
a) What is the annual cost of maintaining this register?
b) How often is the ROMA reviewed and updated and by whom?
c) Who uses this register and is there any assessment of how useful it is?

Minister Burch: The answer to the Member's question is as follows:–

a) The Office of Multicultural Affairs maintains the Register of Multicultural Advisors as part of its core functions and its allocated operational budget.

b) The register is reviewed and updated on an ongoing basis by the Office of Multicultural Affairs when new applications are received from candidates or requests received from Directorates for appointment of suitably qualified candidates to ACT Government boards and committees. Candidates on the Register are encouraged to update their details on annual basis.

c) The Office of Multicultural Affairs receives requests from ACT Government Directorates seeking nominations positions on boards and committees. The Office analyses applications held on the Register to ensure that proposed nominees have relevant skills and experience to effectively contribute to the work of the ACT Government board or committee in question.



Approved for circulation to the Select Committee on Estimates 2012-2013

Signature:

Date:

By the Minister for Multicultural Affairs, Ms Joy Burch MLA

Estimates - QoN No. E12-591

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Steve Doszpot : To ask the Minister for Multicultural Affairs

Ref: BP4 p 345 Output 3.2 Community Affairs

In relation to: Interpreter Services

a) What is the annual cost of this service?

b) What is the current usage?

Minister Burch: The answer to the Member's question is as follows:–

a) Business units within ACT Government directorates meet the costs of interpreter services on a case by case basis from their respective administrative budgets. Therefore an annual total expenditure amount for the ACT Government is not readily available.

b) Data in relation to the use of interpreter services is not collected from ACT Government directorates to give a consolidated number of interpreter occasions each year.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: Date: 31.7.12

By the Minister for Multicultural Affairs, Ms Joy Burch MLA

Estimates - QoN No. E12-592

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Steve Doszpot : To ask the Minister for Multicultural Affairs

Ref:BP4 p 345 Output 3.2 Community Affairs

In relation to: Theo Notaras Multicultural Centre

a) What is the annual running cost of this centre?

b) How many FTE are employed?

c) How many visitors does it attract per year?

d) How many functions per year are held in the centre?

e) Are there any restrictions on who can book this centre for a function?

f) Do the rates vary, or are there standard charges irrespective of client?

g) What are the hire rates?

Minister Burch: The answer to the Member's question is as follows:–

a) The annual running cost of the Theo Notaras Multicultural Centre for the 2011-12 financial year is $852,000, including rental payments.

b) One.

c) A visitors register is not maintained for the Theo Notaras Multicultural Centre as this is not considered feasible.

However it is estimated that approximately 42,600 visitors attended formal functions held at the Theo Notaras Multicultural Centre last financial year (based on an average of 100 people per function).

It is estimated that a further 100 people visited to the Centre on average each day for 250 days each year. These visitors to the Centre either attended activities in the Multicultural Youth Centre, had their overseas qualifications assessed, attended meetings and activities with the five peak multicultural groups and the 35 multicultural community organisations accommodated in the Centre, attended English classes hosted by the Migrant and Refugee Settlement Services Inc, or participated in meetings and activities with staff from the ACT Office of Multicultural Affairs.

This brings the total estimated number of visitors to the Theo Notaras Multicultural Centre to 67,600 last financial year.

E12-592

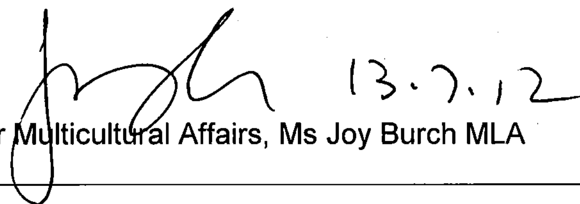
d) 426 functions were held in the Theo Notaras Multicultural Centre during the 2011-2012 financial year. This does not include other activities, such as exhibitions, meetings in the various meeting rooms and general programs undertaken by the tenants in the Centre in their respective leased space.

e) The priority for the use of the Theo Notaras Multicultural Centre is for non profit community organisations and government agencies that host community functions and conduct meetings. Businesses may use the centre only where the function room is not required for community or government functions.

f) The rates are dependent on the number of rooms booked, the hours required and are applied at a community, business or government rate.

g) Please refer to **Attachment A** for the rates for the use of the Theo Notaras Multicultural Centre.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature:  13.7.12 Date:

By the Minister for Multicultural Affairs, Ms Joy Burch MLA

E12-592

Theo Notaras Multicultural Centre Hiring Rates

Level 2, North Building, 180 London Circuit Canberra City ACT 2601

Session timings

08:00am-12:00noon
01:00pm-05:00pm
6:00pm-10:00pm

Community Rates

Function Room	Meeting Room	Kitchen
$180 for 1 session $270 for 2 sessions $405 for 3 sessions	$20 per hour	$50 (Flat Rate) for as many sessions as required.

Business Rates

Function Room	Meeting Room	Kitchen
$200 for 1 session $360 for 2 sessions $540 for 3 sessions	$40 per hour	$50 for 1 session $100 for 2 sessions $150 for 3 sessions

Government Rates

Function Room	Meeting Room	Kitchen
$50 per hour up to four hours $360 for 2 sessions $540 for 3 sessions	$40 per hour	$50 for 1 session $100 for 2 sessions $150 for 3 sessions

Note: All Amounts are inclusive of GST. Some Centre bookings on public holidays may be subject to additional charges. All private bookings will be subject to business rates. Community rates apply to all non-profit activities.

Estimates - QoN No. E12-593

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Steve Doszpot : To ask the Minister for Multicultural Affairs

Ref:BP4 p 345 Output 3.2 Community Affairs

In relation to: ACT Tibetan Buddhist Society in Canberra

a) What discussions has the government had with the Tibetan Buddhist Society to find a suitable site for the Society's headquarters?

b) Have any options been presented to the Society?

Minister Burch: The answer to the Member's question is as follows:–

a) The Tibetan Buddhist Society of Canberra (the Society) was found eligible for a direct sale in late 2010. The Society was advised at the time that a site would be offered when a suitable block of land was identified.

b) No, as suitable land has not been identified.

In the meantime, the Society has been offered the use of the facilities in the Theo Notaras Multicultural Centre.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: 19/7/12 Date:

By the Minister for Multicultural Affairs, Ms Joy Burch MLA

Estimates - QToN No. E12- 594

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Alistair Coe MLA on 28 June 2012 : Ms Kathy Leigh, Director-General, took on notice the following question(s):

Ref: Hansard Transcript 28 June 2012 PAGE 1139

In relation to : RFID hardware

The hardware that has been purchased as part of that $1 million—is all of that hardware being utilised?

Dr Bourke MLA : The answer to the Member's question is as follows:–

The RFID hardware includes:
- cabling
- signal receivers
- staff, visitor and detainee devices or 'tags' (for detainees these were bracelets)
- tag re-chargers, and
- the monitoring equipment housed in the AMC's Master Control Room.

The cabling, signal receivers, staff and visitor tags, staff tag re-chargers and the monitoring equipment is all used to support the duress alarm component of the system.

The detainee tags and tag rechargers are no longer used.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: [signature] Date: 9/7/12

By the Minister for Corrections, Dr Chris Bourke MLA

Estimates - QToN No. E12-595

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Ms Amanda Bresnan MLA on 20 June 2012: The Attorney-General took on notice the following question(s):

Ref: Hansard Transcript 20 June 2012 PAGE 341

In relation to: Disaggregation of Court Fees for FY 2012-13

Has that been broken down by ACAT, Magistrates Court and Supreme Court? (Provide a breakdown or disaggregation by ACAT, Supreme Court and Magistrates Court of the expected revenue of $227,000 from Court fees for 2012-13)

Mr Corbell MLA: The answer to the Member's question is as follows:–

The estimate of increased revenue of $227,000 is based on three factors:

- Shift in the distribution of cases before the courts;
- The impact of the fee changes in the Supreme Court; and
- The impact of the fee changes in the Magistrates Court.

The fee changes are designed to change behaviours and estimates have been calculated assuming this.

Shift in the distribution of cases before the courts

In 2011, the Assembly increased the civil jurisdiction of the Magistrates Court to $250,000 (s257, *Magistrates Court Act 1930*).

The effect of changes to jurisdiction and other measures is expected to discourage lower value civil proceedings (<$250,000) from commencing in the Supreme Court. Cases which would have been commenced in the Supreme Court may instead be commenced in the Magistrates Court.

The effect of these changes (together with ordinary increases in general court fees) is expected to be a **net reduction of $169,000** in revenue across the courts – resulting from more cases commencing in the lower cost Magistrates Court.

E12 - 595

Supreme Court
The previous flat fee structure applying to probate matters had a negative effect on low value estates, in some cases, substantially eroding the value of the estate. Estates valued at <$50,000 will no longer pay fees – with a graduated fee structure for higher valued estates. The effect of new court fees and the introduction of graded probate fees is expected to result in an **increase in revenue ($391,000)** to the Supreme Court.

Magistrates Court
Lower value cases<$50,000
The effect of new court fees (particularly the reduction in court fees in relation to lower value cases <$50,000) is expected to result in a decrease in revenue ($173,000).

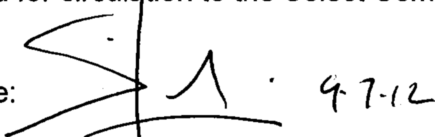
Higher value cases>$50,000
A shift in the commencement of higher value cases ($50,000 - $250,000) from the Supreme Court to the Magistrates Court will see more cases commence in the Magistrates Court. The expected effect of new court fees is an increase in revenue ($178,000). Note that the costs associated with commencement and hearing in the Magistrates Court are lower than the Supreme Court.

Net effect
The combined effect of new fees in the Magistrates Court, is estimated to slightly **increase revenue ($5,000)** to the Magistrates Court.

ACAT
ACAT fees are statutory revenue of the ACAT Trust, and fee changes in that jurisdiction have no impact on consolidated revenue.

Combined impact
The anticipated combined impact of the above estimates is an estimated **increase in revenue ($227,000)**. This combines estimates about the shift of cases within the courts (-$169,000), the increase of revenue in the Supreme Court ($391,000) and the increase of revenue in the Magistrates Court ($5,000).

Approved for circulation to the Select Committee on Estimates 2012-2013



Signature: 9.7.12 Date:

By the Attorney-General, Mr Simon Corbell MLA

Estimates - QToN No. E12- 596

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Alistair Coe MLA on 20 June 2012: The Attorney-General, took on notice the following question(s):

Ref: Hansard Transcript 20 June 2012 PAGE 351-352

In relation to: Costs for appointment of a judge

Would you please take on notice a request for the costs of the appointment of a judge, the yearly costs of a judge, the yearly costs of a pension for a judge and also the time for an average appointment a judge would serve or would be drawing that cost.

Mr Corbell MLA: The answer to the Member's question is as follows:–

Judges Recruitment

The appointment process for a judge in the ACT is estimated to cost approximately $20,000.

This estimate includes:
- advertising the position locally and interstate;
- transport costs for interstate travel if the circumstances require this; and
- cost of a scribe and report if needed.

This cost does not include staff costs.

Cost of Salary and Pension

The Remuneration Tribunal Determines the salary of judges annually.

Judges – Salary and On Costs (excluding the Chief Justice)

The current determination provides a base salary for a judge (with effect from 1 July 2011) of $391,140.

Other expenses and entitlements relating to a judge's tenure cost approximately $100,000pa. This includes travel, car and FBT.

Provision of two support staff costs approximately $185,000 (assuming 1 ASO5 and 1 ASO4 positions).

Costs for the provision of additional court staff to run an additional court room, transcripts, legislation and IT resources have not been included.

E12-596

Payment in lieu of long service leave entitlement

Up to one year's salary is payable on retirement in lieu of long service leave entitlement.

Pension entitlement

After reaching the age of 60 and 10 years service the pension is paid at a rate of 60% of the current salary (as it changes throughout the period the pension is paid) for a serving judge.

For judges who exit at the maximum age (70 years) with at least 6 years but less than 10 years judicial service the pension is paid at a rate of 6% of current judicial salary for each of the years of judicial service.

Judges who exit on invalidity are eligible for 60% of a current judge salary.

The domestic partner of a judge who dies in service is eligible for 62.5% of a judicial pension.

When a retired judge dies and they have a domestic partner, a pension will be paid to the domestic partner at a rate of 37.5% of a current judge's salary until the death of the domestic partner (note 62.5% of 60% is 37.5%).

In either case if there are dependent children the amount of the pension will be adjusted to provide an additional amount of support for the children. There is also provision for orphaned dependent children.

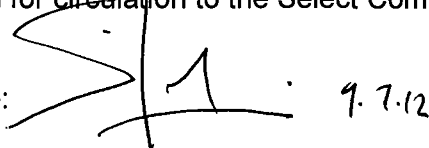
The length of time a pension is payable depends on how long the judge and their domestic partner live and the age of dependent children.

The most recent report of the Australian Government Actuary on the Long Term Costs of the Judges Pension Scheme 2008 calculates a notional rate of employer contribution of 61.4%. The ACT supreme Court scheme is the same as the Commonwealth judge's pension scheme

Average time of tenure

The ACT has had ten (10) judges appointed to the ACT Supreme Court since 1980. The current Chief Justice, will have served approximately 21 years of service when he retires in 2013. The former Chief Justice, Justice Miles served 17 years. Justice Gallop served 18 years. Justice Kelly, Crispin and Gray each served approximately ten years. Justice Connolly died in office after 3 years and nine months. Three (3) are currently serving judges, Justices Penfold, Refshauge and Burns.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature:  9.7.12 Date:

By the Attorney-General, Mr Simon Corbell MLA

Estimates - QoN No. E12-597

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Mr Smyth MLA : To ask the Minister for Health

Ref: Health – Mental Health, BP4, page number 65, output class 1.2

In relation to the Adult Mental Health Inpatient Unit:

1. What was the total budget for furniture and fittings for this Unit.

2. What were the budgets for the different categories of goods within furniture and within fittings for this Unit.

3. Were any items of furniture or fittings valued between $10,000 and $20,000 and, if so, what were these goods and what were the unit costs.

4. Were any items of furniture or fittings valued between $20,000 and $50,000 and, if so, what were these goods and what were the unit costs.

Ms Gallagher MLA : The answer to the Member's question is as follows:–

1. I can advise that the budget for furniture and fittings of the Adult Mental Health Unit was $457,709 ex GST.

2. I can advise that the budget comprised of two categories known as Group 2 and Group 3 items.

   Group 2 - Items supplied by the client and fixed by the contractor. These include items that are transferred but require installation by the contractor, or where the client chooses to buy a piece of equipment and give it to the contractor for installation.

   Group 3 – Items supplied and installed by the client. These include all moveable items that can easily be transferred or installed by staff and major items of electromedical equipment that are purchased from the project budget, but are installed and commissioned by a third party.

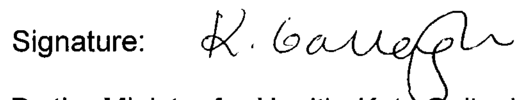
   The budget for the Group 2 Furniture Fittings and Equipment (FF&E) was $34,308 ex GST and Group 3 FF&E was $423,401 ex GST.

E12-597

3. I can advise that no individual item of furniture or fittings purchased was valued between $10,000 and $20,000.

4. Additionally, I can advise that no item of furniture or fittings purchased was valued between $20,000 and $50,000.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature:  Date: 26.7.12

By the Minister for Health, Katy Gallagher MLA

Estimates - QoN No. E12-598

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Mr Hanson MLA : To ask the Minister for Health

Ref: Budget paper 4, page number 63, output class 1.1

In relation to : EDIS passwords

1. Can EDIS be accessed via CITRIX?

Ms Gallagher MLA : The answer to the Member's question is as follows:–

1. No.

Approved for circulation to the Standing Committee on Estimates 2012-2013

Signature: K. Gallagher Date: 26.7.12

By the Minister for Health, Katy Gallagher MLA

Estimates - QoN No. E12-599

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Mr Hanson MLA : To ask the Minister for Health

Ref: Budget paper 4, page number 63, output class 1.1

In relation to : EDIS passwords

1. Have the passwords for the following EDIS usernames been changed since the release of the Auditor General's Report;
   - (i) DOCTOR
   - (ii) NURSE
   - (iii) BEDMAN
   - (iv) CLERK

2. If they have been changed, on what date were they changed?

Ms Gallagher MLA : The answer to the Member's question is as follows:–

1 & 2. DOCTOR – Changed 6 July 2012
NURSE – Changed 6 July 2012
BEDMAN/CLERK – For operational reasons, BEDMAN and CLERK were not changed until 20 July 2012. The Health Directorate continues to monitor to ensure there is no inappropriate use.

These changes were undertaken following the completion of the PWC Audit process and review of the possible impact on the operational requirements of the system as a working tool in the ED. This required notification to all users prior to any changes.

Approved for circulation to the Standing Committee on Estimates 2012-2013

Signature: Katy Gallagher Date: 9.8.12

By the Minister for Health, Katy Gallagher MLA

Estimates - QoN No. E12-600

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Mr Hanson MLA : To ask the Minister for Health

Ref: Budget paper 4, page number 63, output class 1.1

In relation to : Emergency Department cost

1. What is the median cost per patient for the treatment they receive within the Emergency Department?

2. What is the median cost per patient for the treatment they receive within the Emergency Department for the following triage categories;
   (i) Category One
   (ii) Category Two
   (iii) Category Three
   (iv) Category Four
   (v) Category Five

Mr Barr MLA : The answer to the Member's question is as follows:

1. $766

2.
   (i) $927
   (ii) $904
   (iii) $781
   (iv) $620
   (v) $414

Approved for circulation to the Standing Committee on Estimates 2012-2013

Signature: Andrew Barr

Date: 19.7.12

By Acting Minister for Health, Andrew Barr MLA

Estimates - QoN No. E12-601

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Mr Hanson MLA : To ask the Minister for Health

Ref: Budget paper 4, page number 63, output class 1.1

In relation to : EDIS levels

1. What are the different levels of access to EDIS?

2. What capabilities do each of these levels of access have?

3. How many people have access to each level within ACT Health?

Ms Gallagher MLA : The answer to the Member's question is as follows:–

1. From limited read only screens, to specific role based access and full administrator access. Within each level of access, different configurations can be made to change the level of capability within that level of access.

2. The system is configured in a number of ways to match access to different screens based on individual roles. For example, an ED physician may have access to the clinical screen and have the capacity to edit and make changes, however a triage nurse may have more limited access based on their role.

3. As per previous responses to QONs and as indicated in the PwC and Auditor General's Reports there are multiple users of generic logons such as DOCTOR, NURSE etc. Persons wishing to access EDIS must be using a PC that is configured with the EDIS application and EDIS is part of their user profile.

Approved for circulation to the Standing Committee on Estimates 2012-2013

Signature: K. Gallagher   Date: 26.7.12

By the Minister for Health, Katy Gallagher MLA

Estimates - QoN No. E12-602

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Mr Hanson MLA : To ask the Minister for Health

Ref: Budget paper 4, page number 63, output class 1.1

In relation to : Use of emergency department data

1. Please list all people, positions and organisations that are provided with information from EDIS (including internal positions such as specialists).

Ms Gallagher MLA : The answer to the Member's question is as follows:–

1. Multiple reports are sent to Emergency Department Executive staff, Canberra Hospital & Health Services Executive and Health Directorate Health Performance Unit. Individual Emergency Department clinicians have access for research purposes.

In addition, further reports are sent to the Admissions and Accounts Department, Ward Clerk and Emergency Clerk Supervisors, Trauma Data Managers.

Data is also sent to the Australian Institute of Health and Welfare, who provide aspects of the information to other agencies such as the Productivity Commission, National Health Performance Authority and the Department of Health and Ageing. It is also provided to myself as the Minister for Health.

Approved for circulation to the Standing Committee on Estimates 2012-2013

Signature: K. Gallagher Date: 26.7.12

By the Minister for Health, Katy Gallagher MLA

Estimates - QoN No. E12-603

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

RECEIVED 20 JUL 2012 ACT LA COMMITTEE OFFICE

ANSWER T0 QUESTION ON NOTICE

Mr Hanson MLA : To ask the Minister for Health

Ref: Budget paper 4, page number 63, output class 1.1

In relation to : Staff Culture Survey

1. When was the most recent staff culture study carried out in ACT Health (that included the Division of Critical Care)?

Mr Barr MLA: The answer to the Member's question is as follows;-

The most recent workplace culture survey in the Health Directorate was conducted over the period 19 March – 11 April 2012. This included all areas of the Directorate, including the Division of Critical Care.

Approved for circulation to the Standing Committee on Estimates 2012-2013

Signature: Andrew Barr Date: 19.7.12

By Acting Minister for Health, Andrew Barr MLA

Estimates - QoN No. E12-604

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Mr Hanson MLA : To ask the Minister for Health

Ref: Budget paper 4, page number 63, output class 1.1

In relation to : Review of Governance by Professor Mick Reid

1. What will be the total cost of this review?
2. When will this Review begin?
3. When will this Review be completed?
4. Will the Review be made publicly available?

Mr Barr MLA : The answer to the Member's question is as follows:–

The Health Directorate is currently in the process of finalising the Terms of Reference for this review and are still in negotiation with Professor Mick Reid. Once this information is finalised and the Terms of Reference agreed, I am willing to provide a copy of the Terms of Reference to the Committee.

Approved for circulation to the Standing Committee on Estimates 2012-2013

Signature: [signature] Date: 19.7.12

By the Acting Minister for Health, Andrew Barr MLA

Estimates - QoN No. E12-605

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

QUESTION ON NOTICE

Mr Hanson.MLA : To ask the Minister for Health

Ref: Budget paper 4, page number 63, output class 1.1

In relation to : Director of Data Integrity

1. What is the total cost of establishing this position, including;
   (i) Salary of Director
   (ii) Staff (other than Director) salaries
   (iii) Administration and management?

2. Will additional staff be provided to support this Director?

3. When will this Director be appointed?

4. What is the job description of this Director?

5. At what frequency and how will this Director report to the Director General of the Health Directorate?

6. Will the reports of the Director be made publicly available?

Mr Barr MLA: - The answer to the Member's question is as follows: -

1. The documentation for the role of Director of Data Integrity is currently under development. Full details in relation to the responsibilities of the role and level of staff to be provided for, and salary of, the Director will be established as part of this process. This process will be completed by the end of July 2012.

2. See answer "1" above.

3. It is planned to advertise for the position of Director of Data Integrity in August 2012.

4. See answer "1" above.

5. See answer "1" above.

6. See answer "1" above.

Approved for circulation to the Standing Committee on Estimates 2012-2013

Signature: Date: 19.7.12

By Acting Minister for Health, Andrew Barr MLA

Estimates - QoN No. E12-606

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Mr Hanson MLA : To ask the Minister for Health

Ref: Budget paper 4, page number 63, output class 1.1

In relation to : Name disclosure

1. Was any legislation breached when Ms Jackson's name was disclosed on 3rd July 2012, if so what were they?

2. Were any internal ACT Health policies and/or breached when Ms Jackson's name was disclosed on 3rd July 2012, if so what were they?

3. Were any ACT Government policies and/or procedures breached with Ms Jackson's name was disclosed on 3rd July 2012, if so what were they?

Mr Barr MLA : The answer to the Member's question is as follows:–

1. The disclosure of Ms Jackson's name would have engaged the *Privacy Act 1988* (Commonwealth). The disclosure was inadvertent. The question as to whether the law was breached asks for a legal opinion which I am not required to give.

2. It is the policy of ACT Government Health Directorate to comply with the *Public Sector Management Act 1994* and the *Privacy Act 1988* (Commonwealth). The disclosure of Ms Jackson's name would have engaged the *Privacy Act 1988* (Commonwealth). The disclosure was inadvertent. The question as to whether the policy was breached asks for a legal opinion which I am not required to give.

3. It is government policy to comply with the *Public Sector Management Act 1994* and the *Privacy Act 1988* (Commonwealth). The disclosure of Ms Jackson's name would have engaged the *Privacy Act 1988* (Commonwealth). The disclosure was inadvertent. The question as to whether the policy was breached asks for a legal opinion which I am not required to give.

Approved for circulation to the Standing Committee on Estimates 2012-2013

Signature: Date: 19.7.12

By Acting Minister for Health, Andrew Barr MLA

Estimates - QoN No. E12-607

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Mr Hanson MLA: To ask the Minister for Health

[Ref: Health, Budget paper 4, page number 55 – 98]

In relation to : Health Funding Envelope

1. Given that the Health Portfolio is now split into the Health Directorate and the ACT Local Hospital Network Directorate, what is the formula used to calculate the health funding envelope?

2. What is the estimated envelope for the 2013-14 budget?

Mr Barr MLA : The answer to the Member's question is as follows:–

1. The creation of the LHN Directorate has no impact on the formula used to calculate the Health Funding Envelope.

2. The estimated envelope for 2013-14 is $72.8m.

Approved for circulation to the Standing Committee on Estimates 2012-2013

Signature: Andrew Barr Date: 19.7.12

By the Acting Minister for Health, Andrew Barr MLA

Estimates - QoN No. E12-608

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Mr Hanson MLA : To ask the Minister for Health

Ref: Budget paper 4, page number 63, output class 1.1

In relation to : Emergency Department Funding

1. In relation to the reward funding, the National Performance Agreement (NPA) states that performance will be assessed against a baseline of 2009-10 data.
   i. Is this baseline now incorrect?
   ii. Will this baseline be recalculated and the NPA changed accordingly?

2. Clause 36 of the NPA states:

   "Consistent with Clause C14 of the Intergovernmental Agreement on Federal Financial Relations, States and Territories agree to provide data under this Schedule which is of the highest accuracy and quality, as well as being provided in a timely manner"

   Has the ACT Government breached this clause and the Intergovernmental Agreement on Federal Financial Relations by submitting inaccurate data more than once?

3. Clause 45 of the NPA states:

   "States and Territories will submit accurate and verifiable data within one month of the end of each quarter"

   Has the ACT Government breached this clause?

4. In relation to the NPA Emergency Department Capital Funding to enhance ED capacity in public hospitals. The ACT Government was given $1.7 million in 2009-10, $3.4 million in 2010-11 and $1.7 million in 2011-12
   i. What was this funding spent on?
   ii. What other project have been noted as worthy but have not been funded?

E12-608

Ms Gallagher MLA : - The answer to the Member's question is as follows:–

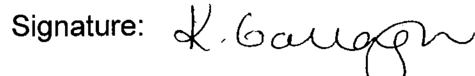
1.
   i. Yes.
   ii. Revised data will be provided to the Commonwealth. The Commonwealth will assess the results and make any necessary changes to the baseline and annual targets.

2. No. The ACT provided data to the Australian Institute of Health and Welfare in line with validation processes provided by the Institute. The data provided met the requirements of Institute.

3. The ACT met the timeframe for provision of data in line with validation processes established by the Australian Institute of Health and Welfare. No reward funding has been accessed by the ACT under the National Partnership Agreement arrangements. The first allocation of reward funding relates to the 2012 calendar year with funding to be provided in line with results by June 2013.

4.
   i. The total funding has been allocated to both public hospitals (on an equal share basis) to fund capital works associated with initiatives developed by each hospital to improve patient flow through the emergency department.
   ii. None. The Health Directorate advised both public hospitals of the level of funding available. Each hospital developed initiatives based on their service redesign models in line with available funding.

Approved for circulation to the Standing Committee on Estimates 2012-2013

Signature:  Date: 26.7.12

By the Minister for Health, Katy Gallagher MLA

Estimates - QoN No. E12-609

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

QUESTION ON NOTICE

Mr Hanson MLA : To ask the Minister for Health

Ref: Budget paper 4, page number 63, output class 1.1

In relation to : Fast Track

1. What is the total number of Fast Track Patients that did not wait per month from January 2009 – May 2011?

2. What is the total number of Fast Track Patients returned to the Emergency Department within 72 hours of discharge from Fast Track per month from January 2009 – May 2012?

Mr Barr MLA : The answer to the Member's question is as follows:

1. The total number of Fast Track patients that did not wait per month from January 2009 to May 2011 is as follows:

Jan-09	132
Feb-09	91
Mar-09	164
Apr-09	102
May-09	121
Jun-09	152
Jul-09	180
Aug-09	138
Sep-09	107
Oct-09	132
Nov-09	150
Dec-09	126
Jan-10	133
Feb-10	131
Mar-10	176
Apr-10	131
May-10	151
Jun-10	170
Jul-10	141
Aug-10	178
Sep-10	141
Oct-10	186
Nov-10	165
Dec-10	121
Jan-11	221
Feb-11	186

E12-609

Mar-11	159
Apr-11	153
May-11	164

2. The total number of Fast Track Patients returned to the Emergency Department within 72 hours of discharge from Fast Track per month from January 2009 – May 2012 is as follows:

Jan-09	97
Feb-09	76
Mar-09	100
Apr-09	78
May-09	55
Jun-09	68
Jul-09	54
Aug-09	77
Sep-09	60
Oct-09	72
Nov-09	86
Dec-09	69
Jan-10	83
Feb-10	68
Mar-10	73
Apr-10	78
May-10	76
Jun-10	64
Jul-10	69
Aug-10	91
Sep-10	67
Oct-10	77
Nov-10	58
Dec-10	75
Jan-11	95
Feb-11	76
Mar-11	91
Apr-11	74
May-11	82
Jun-11	62
Jul-11	59
Aug-11	53
Sep-11	68
Oct-11	65
Nov-11	77
Dec-11	81
Jan-12	83
Feb-12	73
Mar-12	82
Apr-12	84
May-12	61

Approved for circulation to the Standing Committee on Estimates 2012-2013

Signature: Date: 19.7.12

By the Acting Minister for Health, Mr Andrew Barr MLA

Estimates - QToN No. E12- 610

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Alistair Coe MLA on 28 June 2012: Dr Chris Bourke MLA, Minister for Corrective Services, took on notice the following question(s):

Ref: Hansard Transcript 28 June 2012 PAGE 1141

In relation to: Purchasing a stand-alone duress alarm system

What would be the cost of purchasing a duress system as a stand-alone procurement?

Dr Bourke MLA: The answer to the Member's question is as follows:–

The Territory has not yet gone to the market in regard to the procurement of a stand-alone system and the Government is therefore unable to specify what the cost of the system would be.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: [signature] Date: 10/7/12

By the Minister for Corrections, Dr Chris Bourke MLA

Estimates - QToN No. E12- 611

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Jeremy Hanson MLA on 28 June 2012 : Ms Bernadette Mitcherson, ACT Corrective Services Executive Director, took on notice the following question(s):

Ref: Hansard Transcript 28 June 2012 1134

In relation to : Assaults by sentenced prisoners against remandees

So how many assaults have there been on remandees by sentenced prisoners?

Dr Bourke MLA : The answer to the Member's question is as follows:–

In the financial year 2011-12 there have been two recorded assaults of a remand detainee by a sentenced detainee.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: [signature] Date: 10/7/12

By the Minister for Corrections, Dr Chris Bourke MLA

Estimates - QToN No. E12- 612

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Brendan Smyth MLA on 28 June 2012 : Ms Bernadette Mitcherson, ACT Corrective Services Executive Director, took on notice the following question(s):

Ref: Hansard Transcript 28 June 2012 PAGE 1137

In relation to : Threats against officers' families

Have there been any threats against officers' families? If so, what action is taken?

Dr Bourke MLA : The answer to the Member's question is as follows:–

ACT Corrective Services is not able to provide a definitive figure of threats to officers' families. I am advised there has only been one incident since the AMC began accepting detainees where such a threat has been referred to police. That incident involved the former Acting Superintendent.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: Date: 10/7/12

By the Minister for Corrections, Dr Chris Bourke MLA

Estimates - QToN No. E12- 613

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Brendan Smyth MLA on 28 June 2012 : Ms Bernadette Mitcherson, ACT Corrective Services Executive Director, took on notice the following question(s):

Ref: Hansard Transcript 28 June 2012 PAGE 1135

In relation to : Assaults against officers in the first 6 months of 2012

So how many instances of assault have there been on officers? That is to December last year. How many in the first six months of this year?

Dr Bourke MLA : The answer to the Member's question is as follows:–

There was one assault by a detainee on a corrections officer in the first six months of 2012 at the AMC.

Approved for circulation to the Select Committee on Estimates 2012-2013	
Signature:	Date: 10/7/12
By the Minister for Corrections, Dr Chris Bourke MLA	

Estimates - QoN No. E12-614

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Mr Smyth MLA: To ask the Minister for Health:

[Ref: Health – Acute Services, BP4, page number 65, output class 1.1]

In relation to acute services:

1. How is the funding, which is provided to acute services, allocated to the Canberra Hospital and to Calvary Hospital and what amounts are provided to each Hospital.

2. In relation to the funding which is provided from acute services for the Canberra Hospital, how are these funds allocated to the various functions, such as Surgery & Oral Health and Cancer Service and Pathology.

3. If the funds for acute care are not allocated according on a functional basis, how are these funds divided across various programs or other activities and what funds are provided to each program or activity.

Mr Barr MLA : The answer to the Member's question is as follows:–

1. The Territory budgets on an incremental basis with adjustments made through the annual budget process. The Health Directorate follows a similar methodology when setting the budgets for the Canberra Hospital and Health Services and Calvary Public Hospital.

   The budgets for 2012-13 have not been finalised. We are in the process of analysing the final results for 2011-12, distributing savings targets and agreeing activity targets. .

2. The functions, surgery and oral health, cancer service, pathology etc., are also funded on an incremental basis. The Deputy Director-General, Canberra Hospital & Health Services is responsible for finalising these budgets.

3. Funding is allocated on a functional basis. The 2012-13 budgets have not been finalised.

Approved for circulation to the Standing Committee on Estimates 2012-2013

Signature: [signature] Date: 19.7.12

By the Acting Minister for Health, Andrew Barr MLA

Estimates - QoN No. E12-615

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION ON NOTICE

Mr Smyth MLA: To ask the Minister for Health:

[Ref: Health – Acute Services, BP4, page number 63, Strategic Objective 17]

In relation to the emergency department:

1. How many visits were made to the emergency department during the financial year 2011-12.

2. What is the average cost separation for a person who attends the Canberra Hospital.

3. What is the average cost separation for a person who attends the emergency department at the Canberra Hospital.

4. What proportion of people, who attend the emergency department, are suffering from a chronic condition.

5. How many of the people, who are suffering from a chronic condition, have made repeat attendances to the emergency department.

Mr Barr : The answer to the Member's question is as follows:

1 64,656.

2 $5,532.

3 $766.

4 This information is not captured within the emergency department information system. The primary diagnosis on arrival is recorded, but this will not, in many cases, record underlying chronic illnesses.

The latest national data reported on hospitalisation of people with chronic conditions (2009-10) shows that the ACT rate is 34% below the national average at 1.04 per 1,000 population (COAG Reform Council Report on the National Healthcare Agreement, June 2012).

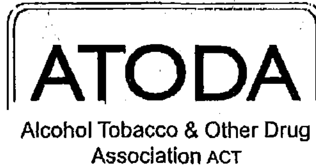
5 See answer to question 4 above.

Approved for circulation to the Standing Committee on Estimates 2012-2013

Signature: Andrew Barr   Date: 19.7.2012

By Acting Minister for Health, Andrew Barr MLA

QTON No. E12-616



Ms Sam Salvaneschi
Secretary
Select Committee on Estimates 2012-2013
Committee Office, ACT Legislative Assembly
sam.salvaneschi@parliament.act.gov.au

Follow up information and responses to questions on notice to the evidence given by Ms Carrie Fowlie, Executive Officer, Alcohol Tobacco and Other Drug Association ACT (ATODA) to the Estimates Committee 2012–13 on 15 June 2012

Dear Ms Salvaneschi,

Please see attached follow up information and my responses to questions on notice to the evidence given by me to the Estimates Committee 2012 - 13 on 15 June 2012 at the ACT Legislative Assembly.

I have also provided two corrections to the data cited in my evidence, this is provided in a second document.

I am more then happy to provide any additional information or support the Committee may like.

Kind regards,

Carrie Fowlie
Executive Officer
Alcohol Tobacco and Other Drug Association ACT (ATODA)

email: carrie@atoda.org.au
post: PO BOX 7187 Watson ACT 2602
visit: 350 Antill St., Watson ACT
mobile: 0406 585 020
phone: (02) 6255 4070
fax: (02) 6255 4649
web: www.atoda.org.au

4 July 2012

Follow up information and responses to questions on notice to evidence given by Carrie Fowlie, Executive Officer, Alcohol Tobacco and Other Drug Association ACT (ATODA) to the Estimates Committee 2012 – 13 on 15 June 2012

1. **"THE CHAIR: It would be great if we could have that data too, please." (Proof of Transcript Evidence, p. 65)**

In response to the request from the Chair for data on the return on investment from drug treatment and support programs including needle and syringe programs (NSP), I provide the following adapted excerpt from the Australian Government Department of Health and Ageing commissioned report *Return on Investment 2: Evaluating the cost-effectiveness of Needles and Syringe Programs in Australia 2009:*[1]

"Effectiveness of NSPs

It was estimated that over the last decade (2000-2009) NSPs have directly averted:

- 32,050 new HIV infections
- 96,667 new HCV infections

When secondary transmissions (sexual or mother-to-child transmission from infected injecting drug users (IDUs) are considered, the epidemiological benefits are even greater. The cumulative benefits of NSPs are further pronounced if long-term projections are considered, as the preventative effects of NSPs flow through to influence the incidence of long-term clinical complications.

Economic analysis of NSPs during 2000-2009

During 2000-2009, gross funding for NSP services was $243m. This investment yielded:

- Healthcare costs saved of $1.28 billion ($1.12bn-$1.45bn, IQR).
- Approximately 140,000 daily adjusted life years (DALYs) gained.
- Net financial cost-saving of $1.03 billion ($876m-$1.98bn, IQR).
- The net present value of NSPs (in 2000) is $896m (disc 3%)(Table c) and $817m (disc 5%).

It was estimated that:

- For every one dollar invested in NSPs, more than four dollars were returned
- (additional to the investment) in healthcare cost-savings in the short-term (ten years) if only direct costs are included; greater returns are expected over longer time horizons.

---

[1] Adapted excerpt from Wilson, D. (2009). *Return on investment 2: Evaluating the cost-effectiveness of needle and syringe programs in Australia.* Canberra: Australian Government Department of Health and Ageing. Available from: http://www.med.unsw.edu.au/nchecrweb.nsf/resources/Reports/$file/RO-2ReportLQ.pdf

- NSPs were found to be cost-saving over 2000-2009 in seven of eight jurisdictions and cost-effective in the other jurisdiction. Over the longer term, NSPs are highly cost saving in all jurisdictions.
- The majority of the cost savings were found to be associated with hepatitis C virus (HCV) related outcomes. However, when only HIV-related outcomes were considered in the analysis, it cost $4,500 per DALY gained associated with HIV infection.
- If patient/client costs and productivity gains and losses are included in the analysis, then the net present value of NSPs is $5.85bn; that is, for every one dollar invested in NSPs (2000-2009), $27 is returned in cost savings. This return increases considerably over a longer time horizon.
- NSPs are very cost-effective compared to other common public health interventions, such as vaccinations (median cost per QALY of $58,000), allied health, lifestyle, and in-patient interventions (median cost of $9,000 per DALY gained), and interventions addressing diabetes and impaired glucose tolerance or alcohol and drug dependence (median cost of $3,700 per DALY gained).

<u>Results about future NSPs</u>

If NSPs were to decrease in size or number, then relatively large increases in both HIV and HCV could be expected with associated losses of health and life and reduced returns on investment. Significant public health benefits can be attained with further expansion of sterile injecting equipment distribution.

Investment in NSPs was cost-saving for current NSP funding when analysed for all time periods. Cost savings were:
- $782m (2010-2019)
- $3.23bn (2010-2029)
- $17.75bn (2010-2059)
- $28.71bn (2010-2079)

The net present value of current NSP investment at 2010 (discounted 3%):
- $641m (2010-2019)
- $2.27bn (2010-2029)
- $8.41bn (2010-2079)

Increased funding and provision of NSPs would be associated with greater cost-savings. The maximum return would be achieved at 125% to 200% of current levels; this is when the total net savings (NPV) is maximal. Expansion of NSPs in all jurisdictions would be cost- saving. There is potential for expansion, considering that only approximately 50% of all injections are currently with a sterile syringe."

Upon request from the Committee, I am also happy to provide further information in regards to the investment benefits of other types of drug treatment and support.

2. **THE CHAIR: "If you cannot fund the specific drug programs in the budget, do you think there is a need for that separation or that that joint policy work is a good thing?" (Proof of Transcript Evidence, p. 64-65)**

In response to the Chair's question, which from what I understand was referring to the relationship between mental health and alcohol, tobacco and other drugs (ATOD), I provide the following response.
It is in everyone's interest to support joint, evidence-based policy and practice responses wherever possible. Although ATOD and mental health have much in common, they also differ in many ways. ATOD has much in common with many areas including chronic disease, public health, law enforcement, education, etc. and it is sometimes forgotten that strengthening the physical health and wellbeing is a significant area of need for many people with ATOD problems. Therefore collaboration across these key areas is essential, however drug treatment and support services and policies warrant specific attention in their own right.

Both the ACT and Australia's drug policies are based on harm minimisation and the 'three pillars'. This approach is quite distinct from mental health, for example I provide below an adapted excerpt from the National Drug Strategy 2010 – 2015:[2]

"The overarching approach of harm minimisation, which has guided the National Drug Strategy since its inception in 1985, will continue through 2010–2015. This encompasses the three pillars of:

1. **Demand reduction** to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community

2. **Supply reduction** to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs

3. **Harm reduction** to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs.

The three pillars apply across all drug types but in different ways, for example, depending on whether the drugs being used are legal or illegal. The approaches in the three pillars will be applied with sensitivity to age and stage of life, disadvantaged populations, and setting. In the *National Drug Strategy 2010– 2015*, the three pillars are underpinned by strong commitments to:
- Building workforce capacity
- Evidence-based and evidence- informed practice, innovation and evaluation
- Performance measurement
- Building partnerships across sectors.

Specific objectives have been identified under each pillar as follows:

Demand reduction
- Prevent uptake and delay onset of drug use
- Reduce use of drugs in the community
- Support people to recover from dependence and reconnect with the community

[2] Excerpt from the National Drug Strategy 2010 – 2015, available from:
http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/DB4076D49F13309FCA257854007BAF30/$File/nds2015.pdf

- Support efforts to promote social inclusion and resilient individuals, families and communities.

Supply reduction
- Reduce the supply of illegal drugs (both current and emerging)
- Control and manage the supply of alcohol, tobacco and other legal drugs.

Harm reduction
- Reduce harms to community safety and amenity
- Reduce harms to families
- Reduce harms to individuals."

The *ACT Alcohol, Tobacco and Other Drug Strategy* 2010 – 2014 mirrors this approach and is available from:
www.health.act.gov.au/c/health?a=dlpubpoldoc&document=1967

3. MS FOWLIE: "I am happy to send that to you. It is from a needle and syringe program, a review of the evidence that was funded by the Department of Health and Ageing." (Proof of Transcript Evidence, p. 66)

As a follow up to Mr Hargreaves questions (Proof of Transcript Evidence, p. 65) about prisons and drug treatment services, I have attached and provide the following adapted excerpt from the Australian Government's Department of Health and Ageing report *Needle and syringe programs: A review of the evidence*:[3]

"Since reporting began, HIV incidence and prevalence among injecting drug users in Australia has been relatively low compared to many other countries. In 1999-2003, HIV prevalence among people attending Needle and Syringe Programs in Australia remained around 1% and less than 0.5% among men and women seen at metropolitan sexual health centres who identified themselves as injecting drug users.

In the United States, access to sterile needles and syringes is restricted by laws prohibiting the possession of needles and syringes and a Congressional ban on the use of federal funds to operate Needle and Syringe Programs. There are approximately 140 Needle and Syringe Programs in the United States. By comparison, more than 3,000 Programs operate across Australia. Among the estimated one to one and a half million injecting drug users in the United States, approximately 19,000 HIV infections occur annually. The Centers for Disease Control and Prevention in the United States estimate that between 1994 and 2000 injecting drug users and their sexual partners represented approximately one third of all people infected with HIV. In Australia between 1994 and 2003, approximately 8% of HIV diagnoses were in people with a history of injecting drug use.

Professor Penny and Dr Wodak, leading Australian HIV experts, commented:

> *The risk of HIV in injecting drug users is not limited to themselves but to their sexual partners and, tragically to their children. In New York City, which has a*

[3] Adapted excerpt from: Dolan, K. MacDonald, M., Silins, E. & Topp, L. 2005. Needle and syringe programs: A review of the evidence. Canberra: Australian Government Department of Health and Ageing. p. 13 – 14.
http://www.health.gov.au/internet/main/publishing.nsf/content/BF779AA5E45815C6CA25712400081717/$File/review.pdf

population about the same size as New South Wales but rampant HIV among IDUs [injecting drug users], more than 17,000 paediatric cases of AIDS have been reported, compared to 42 in New South Wales. These paediatric cases in New York City were in almost all cases the direct result of one or other parent being an IDU. There is a serious risk to Australian children of HIV infection acquired from their parents should an uncontrolled epidemic erupt among IDUs, if present programs are curtailed.

In sharp contrast to HIV infection, the prevalence and incidence of hepatitis C is high among injecting drug users in Australia. Hepatitis C has been more difficult to contain because the virus is spread more easily through blood to blood contact than HIV and was already well established among injecting drug users before the introduction of Needle and Syringe Programs. An injecting drug user sharing an unclean needle used by another injecting drug user of unknown infection status is at between 150 and 800 times higher risk of infection with hepatitis C than HIV.

Many people in the community, including some injecting drug users, are unaware of the risk factors for contracting hepatitis C and unknowingly engage in behaviours that put them at risk. Injecting drug use is the leading risk behaviour for transmission of hepatitis C in Australia. It is estimated that 81% of existing hepatitis C infections are due to unsafe injecting practices.12 The prevalence of hepatitis C infection is likely to have been even higher in Australia if Needle and Syringe Programs had not been introduced.

The Australian National Council on Drugs (ANCD) recommended the following to help control hepatitis C:

The ANCD believes that the hepatitis C epidemic requires a greater concentration of effort in regard to education and information through existing Needle and Syringe Program services in order to decrease its incidence within the injecting drug user population, particularly among those injecting stimulants and among young injectors.

Over the past 15 years Needle and Syringe Programs have been the subject of extensive scientific evaluation. These studies have confirmed that Needle and Syringe Programs substantially reduce the number of HIV infections. Studies in the United States have found that providing needles and syringes can decrease HIV-risk injecting behaviour by up to 74%. Almost all studies of risk behaviour of people attending Needle and Syringe Programs have found a decrease or at least no increase in risky practices."

5. **MR SMYTH: "Do we have any detail as to the number of prisoners at the AMC who have actually got themselves off drugs while they are in the AMC, or do we have a similar number as to how many have taken up drug use in the AMC?" (Proof of Transcript Evidence, p. 67)**

As a follow up to the response I gave to Mr Smyth's question, I provide the following information:

- The first ACT Inmate Health Survey – Summary report was released in November 2011 (data collected in May 2010). The report is available from: http://health.act.gov.au/health-services/population-health/epidemiology-

branch/epidemiology-publications-health-series/inmate-health-survey-summary-results

- Below is a snapshot of the ATOD findings taken from the report:[4]

Table 9: Tobacco smoking, alcohol and other drugs use by inmates, ACT, 2010.

	Number	%
Tobacco use		
Current smokers	110	85
Over 20 smokes per day(1)	35	32
Commenced smoking while in prison(1)	22	20
Attempted to quit smoking(1)	86	78
Would like to quit smoking(1)	88	80
Share accommodation with a smoker in prison	83	61
Thought tobacco smoking should be allowed in prison	119	88
Alcohol		
Consumed 6 or more drinks on one occasion daily or almost daily(2)	41	33
Ever injured as a result of drinking(2)	58	47
Consumed alcohol while in prison(2)	20	16
Illicit drugs		
Ever used illicit drugs	122	91
Ever injected drugs(3)	81	67
Ever accessed community-based needle/syringe programs(4)	60	74
Currently on methadone maintenance program(4)	40	53
Under the influence of alcohol/other drugs at time of committing offence that led to imprisonment(5)	97	79

Source: ACT Inmate Health Survey 2010.

Note:
(1) denominator is the total number of current smokers (N=129).
(2) denominator is the total number of persons reporting drinking (N=124).
(3) denominator is the number of people who responded YES to ever used illicit drugs (N=121).
(4) denominator is the total number reported YES to ever injected drugs (N=80).
(5) denominator is the number of people who responded (123).

- Please see attached the *ACT Inmate Health Survey: Alcohol Tobacco and Other Drug Research Project Proposal.*

6. MR SMYTH: "And alcohol abuse? "(Proof of Transcript Evidence, p. 68)

As a follow up to my response to Mr Smyth's question regarding alcohol use rates in the ACT, I provide the following adapted excerpt from *The extent and nature of*

[4] Epidemiology Branch, ACT Government Health Directorate (2011), ACT Inmate Health Survey 2010: Summary results, ACT Government, Canberra, ACT.

alcohol, tobacco and other drug use, and related harms, in the Australian Capital Territory: [5]

"Overall, 86.3% of ACT residents aged 14 years and above state that they have consumed alcohol in the past 12 months, with the proportion of males drinking (88.1%) being slightly higher than females (85.0%). These figures are for 2010, and are in each case lower than for 2004. The ACT's 2010 drinking prevalence was higher than the national figure: 86.3% compared with 79.9%.

The proportion of ACT residents 14 years and older who drink alcohol daily (5.4%) is well below the national rate (7.2%). The proportion drinking at levels that place them in the 'risky' category of lifetime alcohol-related harm (using the National Health and Medical Research Council's definition of consuming more than two standard drinks per day on average) is similar to the national proportion: 19.5% of recent drinkers compared with 20.1% nationally.

TABLE 1

ALCOHOL CONSUMPTION, RISK STATUS, ACT & AUSTRALIA, 2010

Risk status	*ACT (%)*	*Australia (%)*
Abstainers	13.5	19.5
Low risk	67.0	60.4
Risky	19.5	20.1

Persons aged 14 years and over
Base: people who consumed alcohol in the previous 12 months

Per capita alcohol consumption

The ACT's adult per capita consumption of alcohol for the 2000/01 year has been estimated as 9.8 litres of pure alcohol, similar to the national figure of 9.3 litres. Later data are not available as some years ago the ACT Government ceased collecting data on wholesale purchases of alcoholic beverages by ACT retailers once its capacity to tax such sales was removed by a decision of the High Court of Australia. The problematic consequences of this have been recognised by the Government, and at the time of writing it is re-establishing a data collection system to provide, prospectively, alcohol sales data that will enable trends in per capita consumption to be monitored in the ACT."

I note that in the evidence I gave, I made reference to the pending publication of the above cited report. Since then the report has been published and I attach it as a piece of follow up information for the Committee.

Alcohol related harms: drink driving

I would also like to highlight that when considering alcohol, use is of course an important consideration but so too are the harms associated with this use. In the case of alcohol use a major harm is drink driving.

ACT Policing drink driving statistics (30 June 2010 – 1 July 2011) reveal that most people apprehended for drink driving were medium to high-range (e.g. over .05 g%

[5] Adapted excerpt from: McDonald, D 2012, The extent and nature of alcohol, tobacco and other drug use, and related harms, in the Australian Capital Territory, 4th edition, ACT Government Health Directorate, Canberra. p.2-3

blood alcohol concentration) and/or repeat offenders.[6] This clearly indicates that targeted law enforcement and health interventions are required to address this particular population, particularly since we know that:

- Approximately 70% of drink drive first offenders are not detected reoffending;
- High range and repeat offenders are the most likely to have established problems of alcohol dependence or abuse;
- The majority of convicted drink driver offenders whose licenses are suspended choose to drive while suspended.[7],[8] For example, a Western Australian study of repeat drink drivers found that 74% admitted driving on at least one occasion whilst having their license disqualified.[9]

ATODA is advocating for improved road safety in the ACT and increased access to treatment for high range first and repeat drink driving offenders through implementing a comprehensive alcohol ignition interlock[10] program as a collaboration between law enforcement and health services. The purpose of which could be to:

- Improve road safety in the ACT;
- Reduce impaired driving by high range first and repeat drink drivers;
- Implement an evidence based interlock program which incorporates both
- sanctions and treatment interventions;
- Promote a law enforcement and health partnership to addressing impaired
- driving; and
- Address individual drink driving re-offending through installing interlocks and concurrently addressing problematic alcohol use and driving behaviours.

I attach for the Committee's reference a copy of ATODA's proposal - *Improving road safety in the ACT by implementing: A comprehensive, collaborative and evidence-based alcohol ignition interlock program.*

7. MR SMYTH: "Other drugs, so cannabis and harder drugs: is drug use there going up or down?" (Proof of Transcript Evidence, p. 68)

As a follow up to my response to Mr Smyth's question regarding drug use rates in the ACT, I provide the following adapted excerpt from *The extent and nature of alcohol, tobacco and other drug use, and related harms, in the Australian Capital Territory:* [11]

---

[6] ACT Government Justice and Community Safety Directorate. *Alcohol and Drug Awareness Course Statement of Requirements Project No. 17910.110* (August 2011)

[7] International Council on Alcohol, Drugs and Traffic Safety Working Group on Alcohol Interlocks 2001, *Alcohol Ignition Interlock Devices Volume I: Position paper*, International Council on Alcohol, Drugs and Traffic Safety (ICADTS).

[8] Lenton, S, Fetherston, J & Cercarelli, R 2010, 'Recidivist drink drivers' self-reported reasons for driving whilst unlicensed - a qualitative analysis', *AccidentAnalysis and Prevention*, vol. 42, no. 2, pp. 637-44.

[9] 2002 Fetherston and colleagues study cited in Road Safety Council of Western Australia 2003, *Report of the Repeat Drink Driving Working Group*, Western Australia: Author.

[10] *What are alcohol ignition interlocks?*
Alcohol ignition interlocks (interlocks) are devices fitted to vehicles with an aim of preventing the vehicle from being operated by a driver whose breath alcohol concentration exceeds a predetermined level. In order to operate a vehicle fitted with an interlock, the driver must first provide a specimen of breath below the predetermined breath alcohol concentration. Typically, in order to prevent alcohol affected drivers from circumventing the device (e.g. someone other than the driver providing the specimen), interlocks require additional retests at random intervals in order to keep the vehicle running.

[11] Adapted excerpt from: McDonald, D 2012, The extent and nature of alcohol, tobacco and other drug use, and related harms, in the Australian Capital Territory, 4th edition, ACT Government Health Directorate, Canberra. p.4-5

"In 2010, 13.9% of ACT survey respondents aged 14 years and above reported having used an illicit drug in the 12 months prior to the survey. This figure is marginally lower than the national rate of 14.7%.

Cannabis is the illicit drug most commonly used in the ACT (as elsewhere in Australia), with 9.5% of ACT residents aged 14 years and above reporting recent use of the drug (i.e. having used it in the past 12 months) in 2010.11 Prevalence of use of the other illegal drugs is very low. The following table lists the drug types with reported 2010 prevalence of use exceeding 1%.

TABLE 3
RECENT USE OF AN ILLICIT DRUG, ACT AND AUSTRALIA, 2010

Drug type	*ACT (%)*	*Australia (%)*	*ACT:Australia rate ratio*
Cannabis	9.5	10.3	0.9
Ecstasy	2.3	3.0	0.8
Meth/amphetamine (speed)*	1.2	2.1	0.6
Pain killers/analgesics*	2.9	3.0	1.0
Cocaine	1.8	2.1	0.9
Hallucinogens	1.5	1.4	1.1
Any illicit drug	*13.9*	*14.7*	*0.9*

Persons aged 14 years and over.
'Recent use' means within the last 12 months.
*For non-medical purposes
*The prevalence of reported use in the ACT of the other illicit drugs covered in the National Drug Strategy Household Survey (inhalants, heroin, ketamine, GHB, steroids, methadone/buprenorphine, and other opiates) has relative standard errors greater than 50%, meaning that the figures are too unreliable for general use. Consequently, they are not reported here.

In 2010, the self-reported levels of use of all types of illicit drugs in the ACT listed in Table 3 were similar to or below the national figures. Overall, the ACT level of any illicit drug use in the year before the 2004 survey (13.9%) was 0.9 times the national proportion of 14.7%.

Compared with the 2007 National Drug Strategy Household Survey, the ACT component of the 2010 Survey showed a similar prevalence of recent use of any illicit drug, and of cannabis and cocaine specifically. It showed lower levels of MDMA (ecstasy) and meth/amphetamine use, and higher levels of pain killer/analgesics and hallucinogen use."

Drug related harms: arrests and infringements

I would also like to highlight that it is important that we consider drug use but also consider their related harms. In the case of illicit drug use one of the major harms is people coming into contact with the criminal justice system. I provide the following adapted excerpt from *The extent and nature of alcohol, tobacco and other drug use,*

and related harms, in the Australian Capital Territory about drug related arrests in the ACT:[12]

"The Australian Crime Commission provides data concerning drug-crime arrests. Using data provided by ACT Policing, they advise that, in the ACT in the 2009-10 year, 405 people classified as drug 'consumers' were arrested or issued with a SCON (a Simple Cannabis Offence Notice), and 54 people classified as 'providers' were arrested, a total of 459 offenders. This means that 88% of the ACT total were consumers, a proportion similar to the national figure of 81%. In the previous year, 89% were classified as consumers.

For all drugs, the ACT arrest plus SCON rate was 129 per 100,000 population, just 34% of the equivalent national rate of 385 per 100,000.

Cannabis offences are the most frequent. Some 93% (96% in the previous year) of people arrested for a cannabis offence or issued with a SCON in the ACT were consumers, compared with 86% nationally. Cannabis consumers were 64% (59% in the previous year) of all illicit drug arrests and SCONs in the ACT, compared with 57% nationally."

ATODA strongly supports the recent developments related to reforming the ACT's infringement system to support better outcomes for disadvantaged people, including enabling community work orders and payment plans. These developments acknowledge that the use of traffic and parking infringement notices can have a disproportionate impact upon disadvantaged members of the ACT community.

Much of the impact infringements can have among disadvantaged people is exacerbated by the fact that many infringement schemes specifically target persons for health- related behaviours, including ATOD related behaviours.

ATODA supports discussions to reform the ACT's infringements schemes to bring them, at a minimum, into line with other jurisdictions. In particular, ATODA supports moves in the ACT to address the disproportionate negative impact infringement schemes can have among certain portions of the ACT community for two reasons:

1. Infringement schemes can lead to poor outcomes among disadvantaged people and their families, including among many with ATOD problems; and,
2. Many infringements target people with ATOD-related problems or for ATOD-related behaviours, which could be better addressed as a health issue.

Consequently, ATODA believes that reforms to the parking and traffic infringement schemes proposed should be extended to cover all infringements and fines, including infringements made for ATOD-related behaviours, such as smoking, drinking alcohol, or possession of illicit drugs.

I attach for the Committee's reference a copy of ATODA's proposal - *ACT Infringement Schemes Reform: Implementing effective and appropriate responses to*

[12] Adapted excerpt from: McDonald, D 2012, The extent and nature of alcohol, tobacco and other drug use, and related harms, in the Australian Capital Territory, 4th edition, ACT Government Health Directorate, Canberra. p.4-5

offending by disadvantaged people including alcohol, tobacco and other drug (ATOD) related offending.

7. MR SMYTH: "All right. And hep C is on the rise or decreasing? (Proof of Transcript Evidence, p. 68)

As a follow up to my response to Mr Smyth's question regarding hepatitis C rates in the ACT, I provide the following adapted excerpt from *The extent and nature of alcohol, tobacco and other drug use, and related harms, in the Australian Capital Territory:*[13]

"Injecting drug use is a major risk factor for the transmission of the hepatitis C virus (HCV) and the hepatitis B virus (HBV) through sharing injecting equipment and contaminated injecting environments. As the Kirby Institute points out, 'Based on reported cases, [in 2010] hepatitis B and hepatitis C transmission in Australia continued to occur predominantly among people with a recent history of injecting drug use'.36 In 2010, injecting drug use was the source of infection in 86% of the newly diagnosed cases of HCV infection in Australia for which data on the source were available (the same proportion as in the previous year). For hepatitis B, injecting drug use accounted for 74% of newly diagnosed cases (55% the previous year).

The most recent five years of data on hepatitis B infections in the ACT and Australia follow. The incidence has fluctuated markedly over the last two decades.

TABLE 13
NUMBER AND RATE* OF DIAGNOSES OF HEPATITIS B INFECTION, 2006-2010
ACT AND AUSTRALIA

Year of diagnosis	*2006*		*2007*		*2008*		*2009*		*2010*	
	Number	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*
ACT	77	20.8	68	19.1	59	16.0	106	28.0	96	25.7
Australia	6,499	31.0	7,137	33.5	6,765	31.1	7,335	33.0	4,640	30.3

* Rate per 100,000 population
Source: The Kirby Institute, The University of NSW 2011, *HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2011*, The Kirby Institute, the University of New South Wales, Sydney.

In 2010 there were 223 (165 in the previous year) diagnoses of HCV infection in the ACT, a rate of 58 (44 in the previous year) per 100,000, and higher than the national rate of 50 (52 in the previous year) per 100,000. Both the national and ACT rates of diagnoses have fallen steadily in recent years.

TABLE 14
NUMBER AND RATE* OF DIAGNOSES OF HEPATITIS C INFECTION, 2006-2010
ACT AND AUSTRALIA

Year of diagnosis	*2006*		*2007*		*2008*		*2009*		*2010*	
	Number	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*	*Number*	*Rate*

[13] Adapted excerpt from: McDonald, D 2012, The extent and nature of alcohol, tobacco and other drug use, and related harms, in the Australian Capital Territory, 4th edition, ACT Government Health Directorate, Canberra. p.4-5

ACT	191	52.8	202	54.8	200	54.6	165	43.8	223	58.5
Australia	12,285	58.6	12,202	57.4	11,458	52.9	11,474	52.0	7,608	50.1

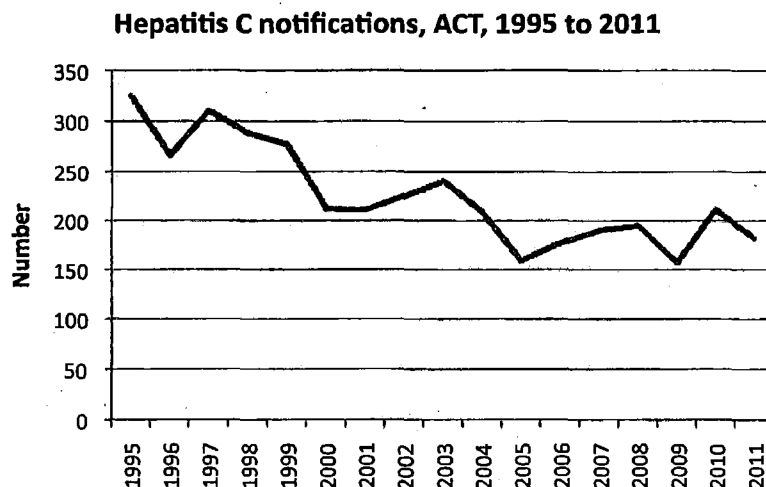
* Rate per 100,000 population
Source: The Kirby Institute, The University of NSW 2011, *HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2011*, The Kirby Institute, the University of New South Wales, Sydney.

Figure 5 shows trend data derived from the National Notifiable Diseases Surveillance System that operates under the auspices of the Communicable Diseases Network Australia. As the managers of the Surveillance System explain:

> Under this scheme, notifications are made to the States or Territory health authority under the provisions of the public health legislation in their jurisdiction. Computerised, de-identified unit records of notifications are supplied to the Australian Government Department of Health and Ageing on a daily basis, for collation, analysis and publication on the Internet, (updated 3 times per week), and in the quarterly journal Communicable Diseases Intelligence.

Figure 5 demonstrates a steady decline in hepatitis C notifications to 2009, with significant fluctuations in the two years since then.

FIGURE 5



Source: National Notifiable Diseases Surveillance System <http://www9.health.gov.au/cda/Source/Rpt_4.cfm>.

9. MR COE: "Does ATODA advocate turning public space and public places, such as city centres, into smoke-free environments?" (Proof of Transcript Evidence, p. 69)

I would like to provide supporting documentation to my evidence to Mr Coe's question, please therefore find attached the *Workplace Tobacco Management Project Research Findings (Evaluation) Report* (December 2011) for the Committee's reference.

10. THE CHAIR: "You have just talked about the program which you are looking to get up and running and you mentioned vulnerable groups...

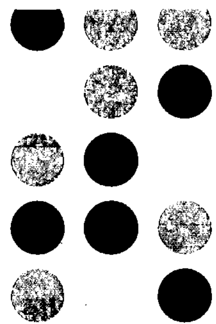
So have you done any work with other groups to look at how you can jointly approach this issue?" (Proof of Transcript Evidence, p. 70)

I would like to provide some follow up information to the evidence I provided in response to the Chair's question, including:

- Please see attached ATODA's *Making tobacco a service delivery priority for disadvantaged groups: Future directions paper*, which provides further information regarding vulnerable groups, tobacco and priorities for action.

- *Aboriginal and Torres Strait Islander Tobacco Control Strategy, 2010/11 - 2013/14.* The Strategy aims to improve the health of the ACT Aboriginal and Torres Strait Islander communities through improved tobacco control measures. Specifically, the Strategy aims to:
    - Prevent people taking up smoking;
    - Increase access to assisted tobacco control initiatives; and
    - Reduce rates of smoking and increase quit attempts (assisted and unassisted);
    - Increase access to assisted tobacco control initiatives; and
    - Increase levels of understanding and awareness of health issues surrounding smoking. [14]

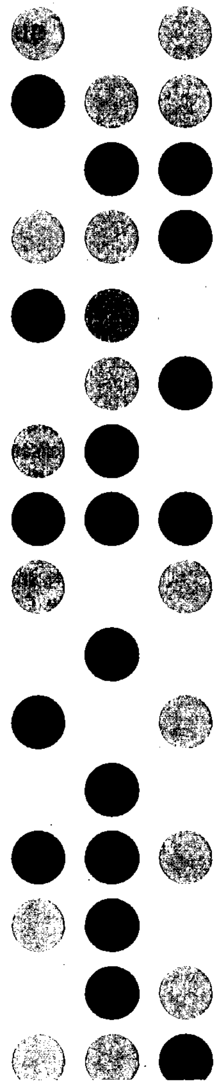
[14] This strategy is available from:
http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=674821399&sid=



nsp

needle & syringe programs:

a review of the evidence



Needle and Syringe Programs have been one of the major public health success stories. However, some people are still uncertain about their role. This Booklet provides a review of evidence for Needle and Syringe Programs in a question and answer format. More general answers to some of the most frequently asked questions about Needle and Syringe Programs are provided in the other booklet in this Kit - **needle & syringe programs:2005 your questions answered**

To obtain copies of the Needle and Syringe Program Information Kit contact:
phd.publications@health.gov.au or phone 1800 020 103 extension 8654.
The Information kit is also available online. Go to http://www.health.gov.au
and enter needle and syringe program information kit in the search field.

Suggested reference:
Dolan, K. MacDonald, M., Silins, E. & Topp, L. 2005. *Needle and syringe programs: A review of the evidence.* Canberra: Australian Government Department of Health and Ageing.

Needle and syringe programs: A review of the evidence
ISBN: 0 642 82747 8
Publications Approval Number: 3711

Copyright: Paper-based publications © Commonwealth of Australia [2005]
This work is copyright. Apart from any use as permitted under the Copyright Act 1968,
no part may be reproduced by any process without prior written permission from the Commonwealth.
Requests and inquiries concerning reproduction and rights should be addressed to the Commonwealth
Copyright Administration, Attorney General's Department, Robert Garran Offices, National Circuit,
Canberra ACT 2600 or posted at http://www.ag.gov.au/cca

Summary 4

How many people inject drugs worldwide? 5

How many people inject drugs in Australia? 5

Which drugs are injected in Australia? 5

What is Australia's National Drug Strategy? 6

What are Australia's strategies on HIV/AIDS and hepatitis C? 8

What are Needle and Syringe Programs? 9

Why do we have syringe vending machines? 11

Do Needle and Syringe Programs prevent HIV, hepatitis C and hepatitis B? 12

Are sterile needles and syringes provided to prisoners? 15

How do we know the data collected about drug use are reliable? 16

Are Needle and Syringe Programs cost-effective? 16

Do Needle and Syringe Programs lead injecting drug users into treatment? 17

Do Needle and Syringe Programs increase drug use? 18

Do Needle and Syringe Programs increase crime or violence? 18

Do Needle and Syringe Programs increase discarded used needles and syringes? 19

What is the chance of getting HIV, hepatitis C or hepatitis B from a discarded used needle? 20

Why aren't retractable needles and syringes available to injecting drug users? 21

Is it legal for people who inject drugs to carry needles and syringes? 21

What can be learnt from overseas Needle and Syringe Programs? 22

What is the level of community support for Needle and Syringe Programs? 23

Conclusion 24

References 25

Summary

This booklet summarises the literature on the provision of sterile needles and syringes to people who inject drugs and other related issues. The proportion of the Australian population thought to inject drugs is just under two percent, or approximately 313,500 people.[1] The first case of HIV infection in a drug injector without other risk factors in Australia was detected in 1985. Needle and Syringe Programs started in Australia the following year. At that time, hepatitis C infection was already well established among drug injectors with more than half being infected.[2]

Workers at Needle and Syringe Programs do much more than just provide injecting equipment. They are often the first point of contact between health services and people who inject drugs. Needle and Syringe Program workers are able to provide education and information on healthcare issues and drug related harm and facilitate entry into drug treatment. Some Programs also provide primary medical care to this disadvantaged population who often have very poor health.

Australian Governments invested $130 million in Needle and Syringe Programs between 1991 and 2000. This resulted in the prevention of an estimated 25,000 cases of HIV and 21,000 cases of hepatitis C among injecting drug users. The savings to the health system in avoided treatment costs over a lifetime are estimated to be between $2.4 and $7.7 billion.[3]

While Needle and Syringe Programs enjoy strong public support in Australia, there have from time to time been misunderstandings about their role. In the past, Needle and Syringe Programs have been accused of encouraging drug use and increasing the number of inappropriately discarded needles and syringes in public places. However, Australian and international studies have shown that neither of these concerns are supported by impressive evidence. Research has shown that Needle and Syringe Programs do not increase injecting drug use. This could be attributed to the ability of health workers to offer health information, drug education and referral into treatment.

Some members of the public have also raised concerns about inappropriately discarded needles and syringes and the possibility of contracting HIV or hepatitis C from a discarded used needle. The chance of a member of the public contracting either HIV or hepatitis C from a discarded used needle is extremely low. Worldwide, there has never been a reported case of a member of the public contracting HIV in this way.

Countries where Needle and Syringe Programs have been implemented have averted HIV epidemics among injecting drug users, while countries that have not implemented these measures have often experienced uncontrolled epidemics. There is strong evidence that if HIV becomes endemic among injecting drug users it can then spread to their sexual partners and children resulting in high mortality rates and large social and economic costs to the entire community.

There is abundant evidence from Australia and international research of the substantial public health benefits of Needle and Syringe Programs. The Australian Medical Association supports Needle and Syringe Programs as one of a number of measures which prevent the spread of HIV and other blood borne diseases.[4]

How many people inject drugs worldwide?

It is difficult to estimate how many people inject drugs because it is an illegal and highly stigmatised activity. Between 1998 and 2003 the number of injecting drug users worldwide was estimated to be approximately 13.2 million. Most (78%) injecting drug users live in developing or transitional countries in Eastern Europe, Asia and the Pacific. Injecting drug use also occurs in Western Europe, North America, New Zealand, Australia and many other countries.[5]

How many people inject drugs in Australia?

According to the National Drug Strategy Household Survey, just under two percent of the Australian population, or 313,500 people, reported having injected drugs at some time in their lives.[1] People aged 20 to 29 were more likely to inject drugs than other age groups and males were more likely to inject than females.

Which drugs are injected in Australia?

In 2004, methamphetamine (83.6%) was the most commonly reported drug recently injected by drug users, followed by heroin (23.1%).[1]

The proportion of the population reporting use of methamphetamine fluctuated between 2% and about 4% from 1991 to 2004.[1] The majority (76%) of dependent methamphetamine users in Australia are considered to be injecting drug users and therefore at risk of contracting and transmitting HIV and hepatitis C.[6]

The proportion of the population reporting heroin use in Australia has remained relatively stable, ranging between 0.4% of the population in 1991 and 0.2% of the population in 2004, with a peak at 0.8% in 1998.[1]

Current estimates of the number of dependent methamphetamine users suggests that the 'at risk' population for the transmission of blood borne viruses is likely to be at least double that of heroin injectors.[6]

Other drugs injected in Australia include morphine, cocaine, methadone and anabolic steroids.[7]

What is Australia's National Drug Strategy?

Australia's National Drug Strategy, which was first developed in 1985, is widely recognised as one of the most progressive and respected drug strategies in the world.

An evaluation of the National Drug Strategy (1993-1997) found that the harm minimisation approach, which had been introduced in the initial strategy, was fundamental to its ongoing success. The National Drug Strategy, Australia's Integrated Framework 2004-2009, builds on the experience and achievements of the National Drug Strategic Framework 1998-99 to 2003-04.

Australia's harm minimisation strategy refers to policies and programs that aim to reduce drug related harm. A wide range of integrated approaches involve a balance between demand reduction, supply reduction and harm reduction. The strategy encompasses:[8]

- Supply reduction strategies to disrupt the production and supply of illicit drugs and the control and regulation of licit substances
- Demand reduction strategies to prevent the uptake of harmful drug use including abstinence oriented strategies and treatment to reduce drug use
- Harm reduction strategies to directly reduce drug related harm to individuals and communities.

Harm minimisation aims to improve health, social and economic outcomes for both the community and individuals. Harm minimisation does not condone illegal behaviours such as injecting drug use, but acknowledges that these behaviours occur despite vigorous efforts to reduce supply and demand. Consequently, authorities have a responsibility to develop and implement public health and law enforcement measures that contribute to reducing the harm to individuals and the community.

The current National Drug Strategy, Australia's Integrated Framework, achieves its objectives by adopting:[8]

- The principle of harm minimisation, including a balanced approach between supply reduction, demand reduction and harm reduction strategies, between preventing use and harms, and facilitating access to treatment
- A comprehensive approach, which includes all drugs and other mood altering substances
- A partnership between Commonwealth, State and Territory Governments, health, law enforcement and education agencies, community based organisations and industry in tackling drug related harm
- An emphasis on rigorous research, evidence based practice and evaluation and assessment of interventions.

While the practice of injecting drug use continues, the provision of sterile injecting equipment through Needle and Syringe Programs is an important harm reduction strategy to reduce the spread of blood borne viruses such as HIV and hepatitis C.[9]

A major component of the National Drug Strategy is the National Illicit Drug Strategy, Tough on Drugs. Development and implementation of the National Illicit Drug Strategy occurs in consultation with the Australian National Council on Drugs, State and Territory Governments, non-government organisations and the community sector.

In the 2003-04 Federal Budget, the Government reaffirmed its support for the Council of Australian Governments' Illicit Drug Diversion Supporting Measures for Needle and Syringe Programs Initiative under the National Illicit Drug Strategy.

The measures aim to:

- Increase education, counselling and referral services through Needle and Syringe Programs and increase training for healthcare workers
- Diversify existing Needle and Syringe Programs to increase the accessibility of Needle and Syringe Programs through pharmacies and other outlets, and provide information and training.

What are Australia's strategies on HIV/AIDS and hepatitis C?

The first National HIV/AIDS Strategy was launched in 1989. According to Professor Richard Feachem, then at the World Bank:[10]

The first National HIV/AIDS Strategy released by the Commonwealth Government in 1989 provided a framework for an integrated response to the HIV epidemic and a plan for action across a range of policy and program activities. Needle and Syringe Programs were a key component of the education and prevention strategy.

Professor Feachem concluded that Needle and Syringe Programs should remain a foundation of Australia's prevention efforts.

In 2005, the government launched the fifth National HIV/AIDS Strategy, Revitalising Australia's Response. This strategy continued to support Needle and Syringe Programs as an effective health intervention.

Australia's HIV/AIDS Strategy has received international recognition. According to the Joint United Nations Programme on HIV/AIDS Best Practice Collection:[11]

[In Australia], early and vigorous HIV prevention programmes aimed at injecting drug users resulted in stable and low rates of HIV prevalence among drug users and related population groups. It is generally agreed that this prompt - and sustained - action fundamentally altered the course of the country's epidemic.

Hepatitis C is also a significant public health issue in Australia. Advanced liver disease due to hepatitis C is the most common reason for liver transplants in Australia. About one percent of the community is infected with hepatitis C. An estimated 16,000 new hepatitis C infections occur each year.[12] As hepatitis C is a slow progressing blood borne viral infection, many people with this condition are unaware they are infected until symptoms appear much later.

In 1999, Australia became a world leader in its strategic response to hepatitis C by developing the National Hepatitis C Strategy 1999-2000 to 2003-2004. The second National Hepatitis C Strategy 2005-2008 builds on the successes of the first. A priority area of the second strategy is to strengthen the capacity of Needle and Syringe Programs in providing hepatitis C education and referral to treatment.

The three focal points of the strategy are:

- Improving access to treatment and support, and increasing treatment uptake among people with hepatitis C
- Improving and increasing the reach of prevention and education efforts
- Improving the current hepatitis C surveillance system.

What are Needle and Syringe Programs?

Needle and Syringe Programs are a public health measure, consistent with the National Drug Strategy's harm minimisation framework, to reduce the spread of infections such as HIV and hepatitis C among injecting drug users. They provide a range of services that include provision of sterile injecting equipment, education on reducing drug use, health information, and referral to drug treatment, medical care and legal and social services. The injecting equipment provided includes needles and syringes, swabs, vials of sterile water and 'sharps bins' for the safe disposal of used needles and syringes. Needle and Syringe Programs do not supply drugs or allow people to inject drugs on the premises. Governments provide sterile injecting equipment to prevent people sharing needles and syringes which can lead to the spread of HIV and hepatitis C. Needle and Syringe Program workers also address the transmission of HIV via sexual contact by providing condoms and safe sex education.

Needle and Syringe Program workers educate injecting drug users about the importance of responsible disposal of used needles and syringes. Needle and Syringe Programs are also an important point for collection of used injecting equipment. Many Needle and Syringe Program workers visit areas where injecting drug use is common and remove any used injecting equipment that has been discarded.

Research into the health needs of people who inject drugs suggests that this is a population with a wide range of complex healthcare needs. Needle and Syringe Programs are seen as a potential point of contact for referral to healthcare services designed to meet the needs of the target population. Some Needle and Syringe Programs provide primary health care that is accessible at the moment it is sought, and are staffed by people who are sympathetic to the needs of a very marginalised group.[13]

The first Australian Needle and Syringe Program began in Darlinghurst, Sydney in 1986 as a trial project.[14] The testing of syringes returned to this Program

detected an increase in HIV prevalence over time, suggesting that HIV was spreading among the clients.[14,15] In the following year Needle and Syringe Programs became New South Wales Government policy. The other states and territories followed soon after. There are now over 3,000 Needle and Syringe Program outlets in Australia. Needle and Syringe Programs tend to be located in relatively public places because they need to be accessible. Staff at Needle and Syringe Programs provide services in a non-judgemental manner and develop a rapport with individuals who are otherwise hard to reach. Several different types of Needle and Syringe Programs are in operation in Australia.

Primary outlets are stand-alone agencies that are specifically established to provide the full range of Needle and Syringe Program services, including dispensing of sterile injecting equipment and collecting of used needles and syringes, sometimes along with primary medical care, education and counselling and referral services.

Secondary outlets offer needle and syringe distribution and disposal as one of a range of other health or community services. In some cases they will also provide additional equipment, education and referral services as part of their commitment to the prevention of blood borne virus transmission. Typical secondary outlets include hospital Emergency Departments and Community Health Centres.

Mobile and outreach services visit hard to reach people who inject drugs but are unable or unwilling to attend other outlets. They provide Needle and Syringe Program services, often out of hours, by vehicle or on foot. The benefits of Needle and Syringe Programs are maximised if isolated, disadvantaged and vulnerable groups of injecting drug users are also provided with Needle and Syringe Program services.

Pharmacy Needle and Syringe Programs are another important way to maximise access to sterile injecting equipment. Many pharmacies across Australia provide sterile injecting equipment, needle and syringe disposal services, health information and sometimes referral services. Some pharmacy Needle and Syringe Programs operate on a commercial basis and others are supported by Government schemes.

Needle and Syringe Programs currently operate in many countries including: Argentina, Australia, Austria, Belarus, Belgium, Brazil, Bulgaria, Canada, China, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, India, Indonesia, Iran, Italy, Kazakhstan, Kyrgyzstan, Latvia, Luxembourg, Malaysia, Moldova, Myanmar, Nepal, Netherlands, New Zealand,

Norway, Philippines, Poland, Portugal, Russia, Slovak Republic, Salvador, Slovenia, Spain, Sweden, Switzerland, Tajikistan, Thailand, Ukraine, United Kingdom, United States of America and Vietnam.

Why do we have syringe vending machines?

Injecting drug use occurs during all hours and is not usually confined to the hours that services are open. Difficulties in accessing sterile needles and syringes have been cited as a factor contributing to sharing of injecting equipment which increases the risk of HIV and hepatitis C infection.[16] Ensuring 24 hour access to sterile needles and syringes remains important for Australia to maintain low rates of HIV transmission and to contain the further spread of hepatitis C among people who inject drugs.

Syringe vending machines dispense needle and syringe packs for a small fee. In some states and territories these packs are known as Fitpacks™. Fitpacks are sturdy plastic containers that contain sterile needles and syringes and other injecting equipment. Fitpacks also double as disposal containers. The containers have an internal moulded flap designed to 'lock in' used needles and syringes to prevent re-use and inappropriate disposal. A 'sharps bin' is located at each syringe vending machine to allow for the safe disposal of used injecting equipment.

Syringe vending machines usually operate 24 hours and provide sterile needles and syringes to injecting drug users who do not wish to access face to face Needle and Syringe Programs. The machines are monitored and restocked by Needle and Syringe Program staff. Most syringe vending machines are located outside hospitals, community or sexual health centres and alcohol and drug services. More than 100 syringe vending machines are located throughout metropolitan, regional and rural New South Wales. One machine operates in Western Australia and the Australian Capital Territory is currently conducting a 12 month trial of four machines. A syringe vending machine trial is also underway in Queensland. The New South Wales Department of Health is not aware of any instances where access by children has been reported to have occurred.[17] Syringe vending machines are also used in other countries including Austria, France, Germany and Switzerland.

In Marseille, France it was reported that 21% of injecting drug users used syringe vending machines as their main source of sterile needles and syringes. The majority of users were more likely to be under 30, less likely to have been in drug treatment and less likely to have shared injecting equipment than non-users.[18]

A study in Berlin, Germany found that more than three quarters (77%) of injecting drug users used syringe vending machines more than four times a week.[19]

A review conducted for the World Health Organization of the effectiveness of syringe vending machines in preventing HIV infection among injecting drug users identified no negative studies and no evidence that syringe vending machines caused non-injecting drug users to become injectors.[20]

Do Needle and Syringe Programs prevent HIV, hepatitis C and hepatitis B?

HIV prevention strategies have resulted in an AIDS incidence in Australia of 1.5 per 100,000 population by 2003, similar to that recorded in Canada and the United Kingdom and considerably lower than in France (2.2), Spain (3.3) and the United States (15.0 in 2002). AIDS incidence refers to the number of new AIDS diagnoses reported over a certain time period. The estimated HIV prevalence (the proportion of people infected with HIV at any point in time) in Australia was substantially lower than that recorded in North America, Europe and most other countries within the Asia-Pacific region in 2003.[21]

Estimated HIV prevalence 2003

Country	Rate per 100 000 population
Asia Pacific	
Cambodia	2600
Thailand[1]	1500
Myanmar	1200
Papua New Guinea	600
Malaysia	400
Australia	69
Europe	
Spain	700
Italy	500
France	400
United Kingdom	200
Germany	100
North America	
United States[1]	600
Canada	300

[1] Data not adjusted for reporting delays

Since reporting began, HIV incidence and prevalence among injecting drug users in Australia has been relatively low compared to many other countries.[22,23,24] In 1999-2003, HIV prevalence among people attending Needle and Syringe Programs in Australia remained around 1% and less than 0.5% among men and women seen at metropolitan sexual health centres who identified themselves as injecting drug users.[21]

In the United States, access to sterile needles and syringes is restricted by laws prohibiting the possession of needles and syringes and a Congressional ban on the use of federal funds to operate Needle and Syringe Programs. There are approximately 140 Needle and Syringe Programs in the United States. By comparison, more than 3,000 Programs operate across Australia. Among the estimated one to one and a half million injecting drug users in the United States, approximately 19,000 HIV infections occur annually.[25] The Centers for Disease Control and Prevention in the United States estimate that between 1994 and 2000 injecting drug users and their sexual partners represented approximately one third of all people infected with HIV.[26] In Australia between 1994 and 2003, approximately 8% of HIV diagnoses were in people with a history of injecting drug use.[21]

Professor Penny and Dr Wodak, leading Australian HIV experts, commented:

> *The risk of HIV in injecting drug users is not limited to themselves but to their sexual partners and, tragically to their children. In New York City, which has a population about the same size as New South Wales but rampant HIV among IDUs [injecting drug users], more than 17,000 paediatric cases of AIDS have been reported, compared to 42 in New South Wales. These paediatric cases in New York City were in almost all cases the direct result of one or other parent being an IDU. There is a serious risk to Australian children of HIV infection acquired from their parents should an uncontrolled epidemic erupt among IDUs, if present programs are curtailed.*[27]

In sharp contrast to HIV infection, the prevalence and incidence of hepatitis C is high among injecting drug users in Australia. Hepatitis C has been more difficult to contain because the virus is spread more easily through blood to blood contact than HIV and was already well established among injecting drug users before the introduction of Needle and Syringe Programs. An injecting drug user sharing an unclean needle used by another injecting drug user of unknown infection status is at between 150 and 800 times higher risk of infection with hepatitis C than HIV.

Many people in the community, including some injecting drug users, are unaware of the risk factors for contracting hepatitis C and unknowingly engage in behaviours that put them at risk. Injecting drug use is the leading risk behaviour for transmission of hepatitis C in Australia. It is estimated that 81% of existing hepatitis C infections are due to unsafe injecting practices.[12] The prevalence of hepatitis C infection is likely to have been even higher in Australia if Needle and Syringe Programs had not been introduced.

The Australian National Council on Drugs (ANCD) recommended the following to help control hepatitis C:

The ANCD believes that the hepatitis C epidemic requires a greater concentration of effort in regard to education and information through existing Needle and Syringe Program services in order to decrease its incidence within the injecting drug user population, particularly among those injecting stimulants and among young injectors.

Over the past 15 years Needle and Syringe Programs have been the subject of extensive scientific evaluation. These studies have confirmed that Needle and Syringe Programs substantially reduce the number of HIV infections. Studies in the United States have found that providing needles and syringes can decrease HIV-risk injecting behaviour by up to 74%.[28] Almost all studies of risk behaviour of people attending Needle and Syringe Programs have found a decrease or at least no increase in risky practices.[29,30,31,32,33,34]

In Windham, Connecticut USA, a Needle and Syringe Program closed in March 1997, after several years of operation and following 10 months of heated community debate. Injecting drug users from Windham were interviewed before and three months after the closure of the Program. After the Program closed, 51% of injecting drug users were forced to obtain their syringes from unsafe sources, such as family, friends or street dealers, compared with 14% when the program was operating. The number of injections per syringe increased from 3.5 to 7.7 injections after the Program closed. The proportion of injecting drug users who reported sharing injecting equipment in the preceding month rose from 16% to 34%. There was no decrease in the number of needles and syringes discarded in public places and no effect of the visibility on the Windham illicit drug scene after the closure of the Needle and Syringe Program.[35]

In Australia there was a dramatic decrease in needle and syringe sharing among injecting drug users from almost 100% in 1986 to 28% in 1996.[34,36] In 2001, 13% of injecting drug users in Australia reported sharing a needle and syringe.[37]

Studies continue to confirm the beneficial effect of Needle and Syringe Programs in reducing transmission of HIV. A study conducted between 1978 and 1999 compared HIV prevalence in 103 cities around the world. In the cities that had introduced Needle and Syringe Programs, the HIV prevalence had decreased by an average of 19% annually. In the cities that had not introduced Needle and Syringe Programs, the HIV prevalence had increased by an average of 8% annually.[3]

The World Health Organization commissioned a review of evidence of the effectiveness of Needle and Syringe Programs to reduce HIV which concluded:[38]

> *There is compelling evidence that increasing the availability and utilisation of sterile injecting equipment for both out-of-treatment and in-treatment injecting drug users contributes substantially to reductions in the rate of HIV transmission.*

Are sterile needles and syringes provided to prisoners?

In 1991, the World Health Organization Regional Office for Europe recommended the provision of sterile injecting equipment in prisons as part of a comprehensive HIV prevention strategy. Presently, Switzerland, Germany, Spain, Moldova, Kyrgyzstan, and Belarus have introduced these programs into prisons. Other countries which are planning to implement Needle and Syringe Programs in prisons include Greece, Iran, Italy, Kazakhstan, Portugal, Tajikistan and Ukraine. A 2004 Canadian review of prison Needle and Syringe Programs found these Programs to be safe, effective, and an essential part of the required response to HIV, hepatitis C and other problems associated with injecting drug use.[39] There is no evidence as yet of serious unintended negative consequences of Needle and Syringe Programs in prisons.

High rates of HIV and hepatitis C infection in prison populations have been reported in numerous countries. Fortunately, HIV prevalence among people entering prisons in Australia has remained relatively low, at less than 0.2% from 2000 to 2003.[21] However, hepatitis C infection among prisoners is much more prevalent than in the general community. Needle and Syringe Programs are currently not available in prisons in Australia.[40]

How do we know the data collected about drug use are reliable?

Some of the data collected about Needle and Syringe Programs includes reports by drug users of their own illegal and socially stigmatised behaviours. This inevitably raises concerns about the accuracy of these data. However, numerous investigations have demonstrated that carefully collected self-reported data are generally accurate and can be used for studies of illicit drug users. A review of the literature found that reports by illicit drug users were reliable (likely to be confirmed on repeat testing) and valid (likely to be confirmed by interviews with significant others).[41] The data are likely to be accurate if the drug user is provided with strong assurances of confidentiality and anonymity.[42] Studies have specifically assessed the accuracy of self-reported risk behaviours of injecting drug users and found them to be reliable[43] and not significantly affected by attempts to provide socially desirable responses.[44]

Are Needle and Syringe Programs cost-effective?

A 2002 review of HIV and hepatitis C prevalence in 103 cities around the world before and after Needle and Syringe Programs found that Needle and Syringe Programs were very cost-effective.[3]

Australian Governments invested $130 million in Needle and Syringe Programs between 1991 and 2000. This resulted in:[3]

- An estimated 25,000 cases of HIV infection being prevented
- An estimated 21,000 cases of hepatitis C infection being prevented
- An estimated 4,590 lives being saved by 2010
- An estimated saving to the health system in avoided treatment costs over a lifetime of between $2.4 and $7.7 billion.

If the United States had adopted Needle and Syringe Programs in 1987 as Australia did, and continued their expansion until 1995 at the same rate as Australia, then between 4,400 and 10,000 HIV infections would have been prevented. This would have saved the United States health care system between US$240 and US$540 million.[45]

Five United States Government funded reviews concluded that Needle and Syringe Programs were cost-effective in the prevention of HIV without increasing illicit drug use.[46,47,48,49,50] These conclusions were confirmed at the 1997 United States National Institutes of Health Consensus Development Conference and further supported by a World Health Organization review in 2004.[20]

Do Needle and Syringe Programs lead injecting drug users into treatment?

Needle and Syringe Programs can be important points of contact for the highly marginalised population of injecting drug users as they provide harm reduction education and referral to drug treatment, medical, legal and social services.[51,52,53] Many Needle and Syringe Program clients have never been in contact with other health or social services.[32,54,55]

The Australian Needle and Syringe Program Survey 2000-2004 found that the proportion of Needle and Syringe Program clients who participated in drug treatment had increased from 68% in 2000 to 76% in 2004.

Studies in London,[56] New Haven, USA[57,58] and Seattle, USA[59] found that Needle and Syringe Programs acted as 'gateways' to more traditional medical treatment for drug dependence for many clients. Over two years, almost 600 drug users attending a Needle and Syringe Program in New Haven requested treatment for drug problems. Over a 16 month period, 38% of clients attending a London Program were referred to drug treatment and medical services. In Seattle, drug users attending Needle and Syringe Programs were five times more likely to enter drug treatment than injectors who did not attend.

A 2000 study in America found Needle and Syringe Program attendance was associated with substantially reduced injecting or cessation of injecting compared to injecting drug users who had never attended a Needle and Syringe Program.[60]

In 2004, a policy brief published by the World Health Organization concluded that Needle and Syringe Programs involving face to face contact increased the enrolment of drug users into drug treatment and primary care services.[38]

Do Needle and Syringe Programs increase drug use?

Despite numerous research studies investigating the possibility of serious negative consequences, there is no convincing evidence that Needle and Syringe Programs increase illicit drug use.[61,62] A 2004 review of potential unintended negative consequences associated with Needle and Syringe Programs found that the Programs:

- Do not encourage more frequent injection of drugs[63,33]
- Do not increase syringe lending to other injecting drug users[52,63]
- Do not increase recruitment of new injecting drug users[57,33,64]
- Do not increase social network formation[65]
- Do not increase transition from non-injecting drug use to injecting drug use[62]
- Do not affect injecting drug users' motivation to reduce drug use.[66]

In Australia, the proportion of the population who reported having injected drugs in the last 12 months remained at 0.6% to 0.7% between 1995 and 2001 and had decreased to 0.4% in 2004.[1] If Needle and Syringe Programs encouraged injecting drug use, it would be expected that, all other factors remaining equal, the proportion of the population reporting recently injecting drugs would have increased rather than decreased.

Do Needle and Syringe Programs increase crime or violence?

There is no evidence to suggest that Needle and Syringe Programs increase crime or violence.

Researchers in Baltimore, USA examined arrest patterns in areas with and without Needle and Syringe Programs and found no difference.[67]

A 2001 survey of 220 residents from a large urban neighbourhood in New York, USA found that Needle and Syringe Programs did not adversely affect the rates of violent crime, such as assaults or robbery, in their vicinity.[68]

Do Needle and Syringe Programs increase discarded used needles and syringes?

Numerous studies have found no evidence that Needle and Syringe Programs increase the number of used needles and syringes discarded in public areas.[20,35,69]

A survey of a random sample of 32 city blocks in areas with high levels of drug use in Baltimore, USA found no significant increase in the number of discarded needles and syringes during the first two months of a Needle and Syringe Program's operation.[70] A follow-up of the study two years later found there was still no difference in the number of discarded needles and syringes by distance from the Program site and that the Program did not increase the number of discarded needles and syringes.[71]

In Tasmania, it was found that approximately 99% of needles and syringes were disposed of in a responsible manner. Between 1997 and 1998, an estimated 2,800 needles and syringes were distributed in Tasmania for each single report of used discarded equipment.[72]

The Queensland Needle Availability Program in 1999 reported that 1.4 million needles and syringes were distributed during a twenty month period in Brisbane, with less than 0.1% discarded inappropriately.[73]

A 2003 survey of Local Governments in Western Australia found that on average, less than four inappropriately disposed needles and syringes were collected each month statewide. The survey also found almost half (44%) of Local Governments did not collect any inappropriately disposed needles and syringes and only three Local Governments collected 50 or more inappropriately disposed needles and syringes per month.[74]

All State and Territory Health Departments collect self-reported data from Needle and Syringe Program clients regarding their methods of disposal of injecting equipment. A 2004 study of 1,092 Needle and Syringe Program clients in New South Wales found most disposed of their last used needle and syringe safely. A relatively small minority (less than 1%) of those surveyed reported discarding their last used needle and syringe in a public place.[17]

What is the chance of getting HIV, hepatitis C or hepatitis B from a discarded used needle?

There are two types of injuries from used needles. Occupational needlestick injuries are sustained by healthcare workers and other staff in the course of their work. The other type of injury is when a member of the public is pricked by a used needle that has been inappropriately discarded in the community.

The likelihood of HIV infection after an occupational needlestick injury from a HIV positive patient in a healthcare setting was estimated to be 0.3% or one in 316 occasions.[75] The risk of contracting hepatitis C (0% to 7%) and hepatitis B (23% to 37%) from a needlestick injury is higher in these cases.[76]

The probability of a member of the public becoming infected with HIV, hepatitis C or hepatitis B after being pricked by an inappropriately discarded used needle in the community is very much lower, for a variety of reasons:

- The needle often has to pierce clothes or shoes before penetrating the skin
- The needle and syringe may have been exposed to the elements for some time
- HIV is a fragile virus once outside the body, especially when exposed to unfavourable environmental conditions[77]
- The syringe is likely to contain much less blood than syringes encountered in a healthcare setting.[78]

A 2003 Australian review of injuries from discarded used needles in the community found the risk of blood borne virus transmission was very low.[79] An American study found the likelihood of HIV transmission after an injury from a discarded used needle sustained in the community was estimated to be one in 4,000 occasions.[80]

A retrospective analysis of 120 people with injuries from discarded used needles in the community attending a Sydney hospital from 1996 to 2001 found no individuals had acquired HIV, hepatitis C or hepatitis B as a result.[81]

In 2002, an Australian study of children with injuries from discarded used needles in the community was conducted to determine whether any of the

children had become infected with HIV, hepatitis C or hepatitis B. The study was conducted over 32 months. Out of 50 children, 36 were tested at least three months after the injury and there were no cases of HIV, hepatitis C or hepatitis B infection.[82]

There has been only one published case in the world of hepatitis C transmission after an injury from a discarded used needle in the community.[83] In Australia to date, there have been no cases published of a member of the public becoming infected with HIV, hepatitis C or hepatitis B after an injury from a discarded used needle in the community.

Why aren't retractable needles and syringes available to injecting drug users?

Evidence based trials of retractable needles and syringes with injecting drug users were conducted in Australia in 2004. The trials were designed to assess the suitability and acceptability of retractable needles and syringes to injecting drug users.

The results indicated a number of technical limitations with the retractable needle and syringe technology piloted and an overall lack of retractable needles and syringes that are suitable to be used by injecting drug users.

Is it legal for people who inject drugs to carry needles and syringes?

Legislation in all States and Territories, except Western Australia, excludes possession of a needle and syringe from being an offence. It is understood that the fear of prosecution for possession of needles and syringes may result inadvertently in injecting drug users being more likely to share injecting equipment and dispose of their equipment inappropriately.

Some studies suggest that drug users may be more likely to discard injecting equipment because they fear the police may use the equipment to charge them with a drug related offence.[84,85,86]

Some countries have different laws regarding the possession, sale or distribution of injecting equipment. In the United States, 43 States and the District of Columbia have drug paraphernalia laws that penalise injecting drug users for needle and syringe possession.[87] In jurisdictions in the United States where drug paraphernalia laws were strictly enforced, a higher

prevalence of HIV infection was observed despite lower risk taking behaviour.[20] Legal barriers to possessing needles and syringes in Houston, Texas resulted in a higher prevalence of HIV with up to 35% of injecting drug users infected with HIV.[88]

The American Psychiatric Association supports the removal of government restrictions on the availability of sterile needles and syringes specifically within the structure of organised Needle and Syringe Programs.[89] The Association encourages government sponsored efforts to:

- Broaden the availability of Needle and Syringe Programs in targeted areas
- Provide public health education to promote safer hygiene practices among injecting drug users
- Continue to endorse the core strategy of increasing the availability of quality detoxification and treatment programs for all substance users.

Legislation that penalises injecting drug users carrying their own needles and syringes and penalises outreach workers who make such equipment available was identified in a review published by the World Health Organization as an important barrier to HIV control among injecting drug users.[20]

What can be learnt from overseas Needle and Syringe Programs?

Needle and Syringe Programs have been shown in many settings to attract high risk injecting drug users who are therefore more likely to have acquired HIV before attending the Program. This appears to explain why cities such as Vancouver and Montreal have observed higher rates of HIV among Needle and Syringe Program attendees compared to non-attendees.[20]

In Vancouver, which has the largest Needle and Syringe Program in North America, HIV infection among injecting drug users has still spread despite Needle and Syringe Programs. It was found that frequent Needle and Syringe Program attendees in Vancouver were younger, significantly more likely to report unstable housing, frequent injecting, frequent cocaine injecting, involvement in the sex industry, injecting in shooting galleries and incarceration within the preceding six months while also significantly less likely to report enrolment in methadone maintenance than non-attendees.[90] These risk factors among attendees were likely to account for the observed

association between frequent Needle and Syringe Program attendance and HIV infection.

A cohort of people who inject drugs has been studied in Montreal where a Needle and Syringe Program has operated since 1988. A report from this study found that attendees were more than twice as likely to become infected with HIV than non-attendees.[53] The authors concluded that the higher rates of HIV among Program attendees were associated with restrictions on the number of sterile needles and syringes which could be provided on each visit. Since attendees engaged in higher risk behaviours, including more frequent injecting than non-attendees, the authors concluded that the number of needles and syringes distributed was likely to have been substantially less than was actually required to control HIV infection.

The experience in Canada suggests that a comprehensive strategy must be adopted by Needle and Syringe Programs if they are to be effective in reducing the transmission of blood borne viruses among injecting drug users and should include:[91]

- Education for injecting drug users
- Increased availability of sterile injecting equipment
- Access to effective drug treatment acceptable to the target population
- Organised involvement of people who inject drugs

What is the level of community support for Needle and Syringe Programs?

More than half (55%) of respondents to the 2004 National Drug Strategy Household Survey indicated that they support Needle and Syringe Programs.[1]

In Perth, 87% of a sample of 400 members of the general public agreed that injecting drug users 'should be legally able to obtain new needles from authorised sources', while 93% felt that the provision of new needles and syringes was important to stop the spread of HIV.[92]

In New South Wales, 90% of a sample of 300 members of the community from urban and rural areas supported the continuation of the State's Needle and Syringe Programs, and 96% agreed that Needle and Syringe Programs play an important part in stopping the spread of HIV in Australia.[93] In five suburbs around the Kings Cross area in Sydney, 305 residents were randomly selected for

a telephone survey and 82% agreed that Needle and Syringe Programs should continue.[94]

In Australia in November 1998, the Inaugural Metropolitan Mayors Statement on Drugs recognised the importance of Needle and Syringe Programs as part of the National HIV/AIDS Strategy and undertook to encourage appropriate agencies and pharmacies to provide needles and syringes.

A 1997 United States telephone survey found that 71% of respondents supported the lifting of a ban on federal funding for Needle and Syringe Programs.[95] In a national referendum in Switzerland, 70% of voters rejected a proposal to discontinue Needle and Syringe Programs.[96]

The 2nd International Policy Dialogue on HIV/AIDS in Warsaw in 2003 developed a framework for effective action on HIV and injecting drug use. This emphasised the need for a pragmatic focus on factors which reduce the immediate risks and harms of HIV transmitted through injecting drug use, such as Needle and Syringe Programs.[97]

A 2004 review published by the World Health Organization concluded:[20]

There is overwhelming evidence that increasing the availability and utilisation of sterile injecting equipment to injecting drug users contributes substantially to reductions in HIV transmission, and that there is no convincing evidence of major unintended negative consequences of such programs.

Conclusion

There is always bound to be a degree of controversy about Needle and Syringe Programs. For some people, personal beliefs and values shape their attitudes towards public health interventions to a greater extent than scientific evidence. However, evidence of the effectiveness of Needle and Syringe Programs is consistent and compelling and has been sufficient to persuade many major scientific authorities and governments around the world about the substantial benefits of these programs. Needle and Syringe Programs are a critical component of strategies to reduce the spread of HIV, hepatitis C and other blood borne viral infections among injecting drug users and the wider community. These Programs have been found to be highly cost-effective compared to the cost of treating HIV and hepatitis C infection. Needle and Syringe Programs have not been found to increase drug injecting, discarded used injecting equipment or result in any other serious negative consequences. These programs also facilitate referral to drug treatment and other health services. In areas where Needle and Syringe Programs have been established, they generally receive strong community support.

Authors:

Dr Kate Dolan, Mr Edmund Silins and Ms Libby Topp, National Drug and Alcohol Research Centre, UNSW, Sydney.

Ms Margaret MacDonald, National Centre in HIV Epidemiology and Clinical Research UNSW, Sydney. 1999, 2005.

References

1. Australian Institute of Health and Welfare. 2005. *National Drug Strategy Household Survey 2004.* Canberra: Australian Institute of Health and Welfare.

2. Australian National Council on AIDS and Related Diseases. 1998. *Estimating the number of injecting drug users in Australia using the Delphi technique*. Sydney: National Centre in HIV Epidemiology and Clinical Research.

3. Commonwealth of Australia. 2002. *Return on investment in needle and syringe programs in Australia.* Canberra: Commonwealth Department of Health and Ageing.

4. Australian Medical Association. 2004. *Position Statement: Blood borne viral infections.* Canberra: Australian Medical Association.

5. Aceijas, C., Stimson, G., Hickman, M. and Rhodes, T. 2004. Global overview of injecting drug use and HIV infection among injecting drug users. *AIDS.* 18: 2295-2303.

6. McKetin, R., McLaren, J., Kelly, E., Hall, W. and Hickman, M. 2005. *Estimating the number of regular and dependent methamphetamine users in Australia: Technical Report*. Sydney: National Drug and Alcohol Research Centre, University of New South Wales.

7. Thein, H., Maher, L. and Dore, G. 2004. *Illicit Drug Reporting System Drug Trends Bulletin October 2004.* Sydney: National Centre in HIV Epidemiology and Clinical Research, University of New South Wales.

8. Commonwealth of Australia. 2004. *National Drug Strategy - Australia's Integrated Framework: 2004-2009.* Canberra: Australian Government Department of Health and Ageing.

9. Ministerial Council on Drug Strategy. 1998. *National Drug Strategic Framework 1998-99 to 2002-03. Building partnerships. A strategy to reduce the harm caused by drugs in our community*. Canberra: Commonwealth of Australia.

10. Feachem, R.G.A. 1995. *Valuing the past ... Investing in the future. Evaluation of the National HIV/AIDS Strategy 1993-94 to 1995-96.* Canberra: Australian Government Publishing Service.

11. UNAIDS. 1999. *Drug use and HIV/AIDS, UNAIDS Best Practice Collection Key Material.* Geneva: UNAIDS.

12. Commonwealth of Australia. 2005. National Hepatitis C Strategy 2005-2008. Canberra: Australian Government Department of Health and Ageing.

13. Rowe, J. 2003. *Who's using?: The Health Information Exchange [HIE] and the development of an innovative primary health care response for injecting drug users.* Melbourne: Salvation Army Crisis Service.

14. Wodak, A., Dolan, K.A., Imrie, A.A., Gold, J., Wolk, J., Whyte, B.M. and Cooper, D.A. 1987. Antibodies to human immunodeficiency virus in needles and syringes used by intravenous drug abusers. *Medical Journal of Australia.* 147: 275-276.

15. Wolk, J., Wodak, A., Morlet, A., Guinan, J.J., Wilson, E., Gold, J. and Cooper, D. 1988. Syringe seroprevalence and behavioural and demographic characteristics of intravenous drug abusers using syringe exchanges in Sydney, Australia, 1987. *AIDS.* 2: 373-378.

16. Dwyer, R., Fry, C., Carruthers, S., Bolleter, A., Dolan, K., Donald, A., Byrne, J. and Loxley, W. 2002. *ABRIDUS: The Australian Blood-borne Virus Risk and Injecting Drug Use Study- A study of hepatitis C risk practices and contexts in Melbourne, Perth and Sydney.* Melbourne: Turning Point Alcohol and Drug Centre Incorporated.

17. New South Wales Department of Health. 2005.

18. Obadia, Y., Feroni, I., Perrin, V., Vlahov, D. and Moatti, J.P. 1999. Syringe vending machines for injection drug users: an experiment in Marseille, France. *American Journal of Public Health.* 89(12): 1852-1854.

19. Stark, K., Leicht, A. and Muller, R. 1994. Characteristics of users of syringe vending machines in Berlin. *Sozial und Praventivmedizin.* 39(4): 209-216.

20. Wodak, A. and Cooney, A. 2004. *Evidence for action technical papers: effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users.* Geneva: World Health Organization.

21. National Centre in HIV Epidemiology and Clinical Research. 2004. *HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2004.* Canberra: National Centre in HIV Epidemiology and Clinical Research, Australian Institute of Health and Welfare.

22. Crofts, N., Aitken, C.K. et al., 1999. The force of numbers: why hepatitis C is spreading among Australian injecting drug users while HIV is not. *Medical Journal of Australia.* 170: 220-221.

23. National Centre in HIV Epidemiology and Clinical Research. 2005. *Australian NSP Survey, Prevalence of HIV, HCV and injecting and sexual behaviour among IDUs at Needle and Syringe Programs, National Data Report.* Sydney: The University of New South Wales.

24. MacDonald, M., Wodak, A.D., Ali, R., Crofts, N., Cunningham, P., Dolan, K., Kelaher, M., Loxley, W., van Beek, I. et al., 1997. HIV prevalence and risk behaviour in needle exchange attenders: A national study. *Medical Journal of Australia.* 166: 237-240.

25. Strathdee, S.A., Patrick, D.M., Currie, S.L. 1997. Needle exchange is not enough: Lessons from the Vancouver injecting drug use study. *AIDS.* 11: F59-F65

26. Lee, L., McKenna, M. and Sharpe, T. 2003. HIV diagnoses among injection-drug users in states with HIV surveillance - 25 states, 1994-2000. *Morbidity and Mortality Weekly Report.* 52(27): 634-636.

27. *Sydney Morning Herald.* 1997. August 19, p15.

28. Center for AIDS Prevention Studies. Does needle exchange work, University of California. Website http://www.caps.ucsf.edu/NEPrev.html

29. Frischer, M. and Eliot, L. 1993. Discriminating needle exchange attenders from non-attenders. *Addiction.* 88: 681-687.

30. Hankins, C., Gendron, S., Bruneau, J. and Roy, E. 1994. Evaluating Montreal's needle exchange CACTUS-Montreal, in *Proceedings of the Workshop on Needle Exchange and Bleach Distribution Programs.* Washington: National Academy Press, p83-90.

31. Peak, A., Rana, S., Maharjan, S.H., Jolley, D. and Crofts, N. 1995. Declining risk for HIV among injecting drug users in Kathmandu, Nepal: The impact of a harm reduction programme. *AIDS.* 9: 1067-1070.

32. van Ameijden, E.J.C., van den Hoek, J.A.R., van Haastrecht, H.J.A. and Coutinho, R.A. 1992. The harm reduction approach and risk factors for human immunodeficiency virus (HIV) seroconversion in injecting drug users, Amsterdam. *American Journal of Epidemiology.* 136: 236-243.

33. Watters, J.K., Estilo, M.J., Clark, G.L. and Lorvick, J. 1994. Syringe and needle exchange as HIV/AIDS prevention for injection drug users. *Journal of the American Medical Association.* 271: 115-120.

34. Crofts, N., Webb-Pullman, J. and Dolan, K. 1996. *An analysis of trends over time in social and behavioural factors related to the transmission of HIV among IDUs and prison inmates. Evaluation of the National HIV/AIDS Strategy.* Canberra: Australian Government Publishing Service.

35. Broadhead, R.S., van Hulst, Y. and Heckathorn, D.D. 1999. Impact of the closure of a needle exchange program. *Social Problems.* 46(1): 48-66.

36. MacDonald, M., Wodak, A., van Beek, I., Cunningham, P. et al., 2000. Hepatitis C virus antibody prevalence among injecting drug users at selected needle and syringe programs in Australia, 1995-1997. *Medical Journal of Australia.* 172(2): 55-56.

37. Australian Institute of Health and Welfare. 2003. *Statistics on drug use in Australia 2002.* Canberra: Australian Institute of Health and Welfare.

38. World Health Organization. 2004. *Evidence for action on HIV/AIDS and injecting drug use. Policy brief: Provision of sterile injecting equipment to reduce HIV transmission.* Geneva: World Health Organization.

39. Lines, R., Jurgens, R., Betteridge, G., Stover, H., Laticevschi, D. and Nelles, J. 2004. *Prison needle exchange: Lessons from a comprehensive review of international evidence and experience.* Montreal: Canadian HIV/AIDS Legal Network.

40. Black, E., Dolan, K. and Wodak, A. 2004. *Supply, demand and harm reduction strategies in Australian prisons: implementation, cost and evaluation. Research paper 9.* Canberra: Australian National Council on Drugs.

41. Darke, S. 1998. Self-report among injecting drug users: A review. *Drug and Alcohol Dependence.* 51: 253-263.

42. Magura, S., Goldsmith, D., Casriel, C., Goldstein, P.J. and Lipton, D.S. 1987. The validity of methadone clients' self-reported drug use. *International Journal of the Addictions.* 22: 727-749.

43. De Irala, J., Bigelow, C., McCusker, J., Hindin, R. and Zheng, L. 1996. Reliability of self-reported human immunodeficiency virus risk behaviours in a residential drug treatment population. *American Journal of Epidemiology.* 143: 725-731.

44. Latkin, C., Vlahov, D. and Anthony, J.C. 1993. Socially desirable responding and self-reported HIV infection risk behaviors among intravenous drug users. *Addiction.* 88: 517-526.

45. Lurie, P. and Drucker, E. 1997. An opportunity lost: HIV infections associated with lack of a national needle-exchange programme in the USA. *Lancet.* 349: 604-608.

46. Lurie, P., Reingold, A.L., Bowser, B. eds. 1993. *The public health impact of needle exchange programs in the United States and abroad.* San Francisco: University of California.

47. Normand, J., Vlahov, D. and Moses, L.E. eds. 1995. *Preventing HIV transmission: The role of sterile needles and bleach.* Washington: National Academy Press.

48. National Commission on Acquired Immune Deficiency Syndrome. 1991. *The twin epidemics of substance use and HIV.* Washington DC: National Commission on Acquired Immune Deficiency Syndrome.

49. United States General Accounting Office. 1993. *Needle exchange programs: Research suggests promise as an AIDS prevention strategy.* Washington DC: House of Representatives.

50. Office of Technology Assessment. 1995. *The effectiveness of AIDS prevention efforts.* Washington: Office of Technology Assessment.

51. Hahn, J.A., Vranizan, K.M. and Moss, A.R. 1997. Who uses needle exchange? A study of injection drug users in treatment in San Francisco, 1989-1990. *Journal of Acquired Immune Deficiency Syndrome and Human Retrovirology.* 15: 157-164.

52. Schechter, M.T., Strathdee, S.A., Cornelisse, P.G.A., Currie, S., Patrick, D.M., Rekart, M.L. and O'Shaughnessy, M.V. 1999. Do needle exchange programs increase the spread of HIV among injection drug users: An investigation of the Vancouver outbreak. *AIDS.* 13(6): F45-F51.

53. Bruneau, J., Lamothe, F., Franco, E., Lachance, N., M, D., Soto, J. and Vinclette, J. 1997. High rates of HIV infection among injection drug users participating in needle exchange programs in Montreal: Results of a cohort study. *American Journal of Epidemiology.* 146: 994-1002.

54. Klee, H. and Morris, J. 1995. The role of needle exchanges in modifying sharing behaviour: Cross-study comparisons 1989-1993. *Addiction.* 90: 1635-1645.

55. Stimson, G.V. 1989. Syringe exchange programmes for injecting drug users. *AIDS.* 3: 253-260.

56. Carvell, A.M. and Hart, G.J. 1990. Help-seeking and referrals in a needle exchange: A comprehensive service to injecting drug users. *British Journal of Addiction.* 85: 235-240.

57. Heimer, R., Kaplan, E.H., Khoshnood, K., Jariwala, B. and Cadman, E.C. 1993. Needle exchange decreases the prevalence of HIV-1 proviral DNA in returned syringes in New Haven, Connecticut. *American Journal of Medicine.* 95: 214-220.

58. Heimer, R. 1998. Can syringe exchange serve as a conduit to substance abuse treatment. *Journal of Substance Abuse Treatment.* 15(3): 183-191.

59. Hagan, H., McGough, J.P., Thiede, H., Hopkins, S., Duchin, J. and Alexander, E.R. 2000. Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors. *Journal of Substance Abuse Treatment.* 19(3): 247-52.

60. Gibson, D.R. 2000. Two- to seven-fold decreased risk associated with use of needle exchange. *In University of California 3rd annual Conference on AIDS Research in California, 17th Annual AIDS Investigators' Meeting.* San Francisco.

61. Wolk, J., Wodak, A., Guinan, J.J., Macaskill, P. and Simpson, J.M. 1990. The effect of a needle and syringe exchange on a methadone maintenance unit. *British Journal of Addiction.* 85: 1445-1450.

62. Guydish, J., Bucardo, J., Young, M., Woods, W., Grinstead, O. and Clark, W. 1993. Evaluating needle exchange: Are there negative effects? *AIDS.* 7: 871-876.

63. Hartgers, C., Buning, E.C., van Santen, G.W., Verster, A.D. and Coutinho, R.A. 1989. The impact of the needle and syringe-exchange program in Amsterdam on injecting risk behaviour. *AIDS.* 3(9): 571-576.

64. van Ameijden, E.J. and Coutinho, R.A. 2001. Large decline in injecting drug use in Amsterdam, 1986-1998: explanatory mechanisms and determinants of injecting transitions. *Journal of Epidemiology & Community Health.* 55(5): 356-363.

65. Junge, B., Valente, T., Latkin, C., Riley, E. and Vlahov, D. 2000. Syringe exchange not associated with social network formation: results from Baltimore. *AIDS.* 14(4): 423-426.

66. Bluthenthal, R.N., Gogineni, A., Longshore, D. and Stein, M. 2001. Factors associated with readiness to change drug use among needle exchange users. *Drug & Alcohol Dependence.* 62: 225-230.

67. Bor, J. 1999. Needle programs no spur to crime. *Baltimore Sun,* p1B.

68. Galea, S., Ahern, J., Fuller, C., Freudenberg, N. and Vlahov, D. 2001. Needle exchange programs and experience of violence in an inner city neighbourhood. *Journal of Acquired Immune Deficiency Syndromes.* 28(3): 282-288.

69. Oliver, K.J., Friedman, S.R., Maynard, H., Magnuson, L. and Des Jarlais, D.C. 1992. Impact of a needle exchange program on potentially infectious syringes in public places. *Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology.* 5: 534-535.

70. Doherty, M.C., Garfein, R.S., Vlahov, D., Junge, B., Rathouz, P.J., Galai, N., Anthony, J.C. and Beilenson, P. 1997. Discarded needles do not increase soon after the opening of a needle exchange program. *American Journal of Epidemiology.* 145: 730-737.

71. Doherty, M.C., Junge, B., Rathouz, P., Garfein, R.S., Riley, E. and Vlahov, D. 2000. The effect of needle exchange program on numbers of discarded needles: a 2-year follow-up. *American Journal of Public Health.* 90(6): 936-939.

72. Department of Community and Health Services, personal communication. Tasmania.

73. Queensland Department of Health. 1999. *Report on the Queensland Needle Availability Support Program.* Brisbane: Queensland Department of Health.

74. Western Australia Department of Health. 2005.

75. Bell, D. 1997. Occupational risk of human immunodeficiency virus infection in healthcare workers: an overview. *American Journal of Medicine.* 102(5B): 9-15.

76. Centers for Disease Control. 2001. Updated U.S. public health service guidelines for the management of occupational exposure to HBV, HCV and HIV and recommendations for post exposure prophylaxis. *Morbidity and Mortality Weekly Report.* 50(RR11): 1-42.

77. Resnick, L., Vere, K., Salahuddin, S.Z., Tondreau, S. and Marham, P.D. 1986. Stability and inactivation of HTLV III/LAV under clinical and laboratory environments. *Journal of the American Medical Association.* 225: 1187-1191.

78. Gaughwin, M.D., Gowans, E., Ali, R. and Burrell, C. 1991. Bloody needles: The volume of blood transferred in simulations of needlestick injuries and shared use of syringes for injection of intravenous drugs. *AIDS.* 5: 1025-1027.

79. Thompson, S., Boughton, C. and Dore, G. 2003. Blood-borne viruses and their survival in the environment: is public concern about community needlestick exposure justified? *Australian and New Zealand Journal of Public Health.* 27(6): 602-607.

80. AIDS/TB Committee of the Society for Healthcare Epidemiology of America. 1997. Management of healthcare workers infected with hepatitis B virus, hepatitis C virus, human immunodeficiency virus, or other blood-borne pathogens. *Infection Control and Hospital Epidemiology.* 18: 349-363.

81. O'Leary, F. and Green, T. 2003. Community acquired needlestick injuries in non-health care workers presenting to an urban emergency department. *Emergency Medicine Australasia.* 15(5-6): 434-440.

82. Russell, F. and Nash, M. 2002. A prospective study of children with community-acquired needlestick injuries in Melbourne. *Journal of Paediatrics and Child Health.* 38(2): 322.

83. Libois, A., Fumero, E., Castro, P., Nomdedeu, M., Cruceta, A., Gatell, J.-M. and Garcia, F. 2005. Transmission of hepatitis C virus by discarded-needle injury. *Clinical Infectious Diseases Journal.* 41: 129-130.

84. Fitzgerald, J.L., Broad, S. and Dare, A. 1999. *Regulating the street heroin market in Fitzroy/Collingwood.* Melbourne: University of Melbourne.

85. Aitken, C., Moore, D., Higgs, P., Kelsall, J. and Kerger, M. 2002. The impact of a police crackdown on a street drug scene: evidence from the street. *International Journal of Drug Policy.* 13: 189-198.

86. Maher, L. and Dixon, D. 2001. The cost of crackdowns: policing Cabramatta's heroin market. *Current Issues in Criminal Justice.* 13(1): 5-22.

87. Burris, S., Vernick, J., Ditzler, A. and Strathdee, S. 2002. The legality of selling or giving syringes to injection drug users. *Journal of American Pharmaceutical Association.* 42(2): S13-18.

88. Richard, A.J., Mosier, V. and Atkinson, J.S. 2002. New syringe acquisition and multi-person use of syringes among illegal drug users. *Journal of Public Health Policy.* 23(3): 324-343.

89. American Psychiatric Association. 2003. Needle Exchange Programs Position Statement. *American Psychiatric Association Operations Manual.*

90. Schechter, M., Strathdee, S.A., Cornelisse, P.G., Currie, S., Patrick, D.M., Rekart, M.L. and O'Shaughnessy, M.V. 1999. Do needle exchange programmes increase the spread of HIV among injection drug users: an investigation of the Vancouver outbreak. *AIDS.* 13(6): F45-51.

91. Wodak, A., Strathdee, S.A., Friedman, S.R. and Byrne, J. 1998. The global response to the threat of HIV infection among and from injecting drug users. *AIDS Targeted Information.* 12: R41-R44.

92. Lenton, S. 1994. Illicit drug use, harm reduction and the community: *Attitudes to cannabis law and needle and syringe provision in Western Australia.* Perth: National Centre for Research in to the Prevention of Drug Abuse.

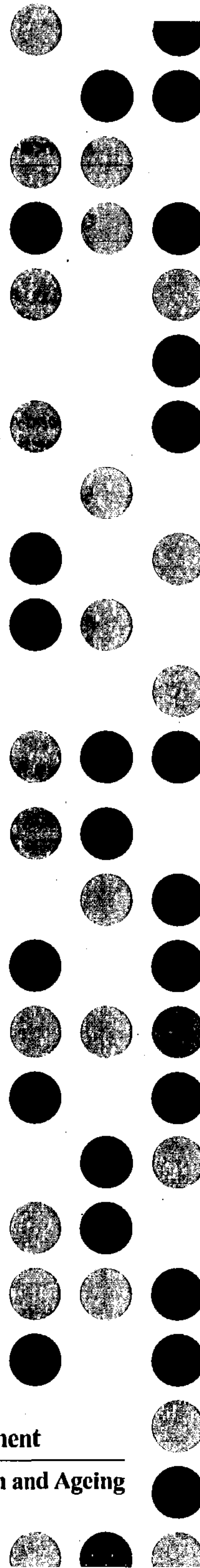
93. Schwartzkopf, J., Spooner, S., Flaherty, B., Braw, J., Grimsley, A., Scanlon, K. and Stewart, K. 1990. *Community attitudes to needle and syringe exchange and to methadone programs.* Sydney: New South Wales Department of Health.

94. MacDonald, M., Rutter, S., Wodak, A. et al., 1999. *K2 and Kings Cross community attitudes to the needle syringe program, discarded syringes and public injection, 1997-1998.* Sydney: New South Wales Department of Health.

95. The Lindesmith Centre. 1997. *71% of Americans Support Lifting Ban on Federal Funding for Needle Exchange Programs.* Press release.

96. *Sydney Morning Herald.* 1997. September 30, p8.

97. UNAIDS, Health Canada, Open Society Institute and Canadian International Development Agency. 2003. The Warsaw Declaration: A Framework for Effective Action on HIV/AIDS and Injecting Drug Use. *In Second International Policy Dialogue on HIV/AIDS.* Warsaw, Poland.



Australian Government

Department of Health and Ageing

Improving road safety in the ACT by implementing:
A comprehensive, collaborative and evidence-based alcohol ignition interlock program

1. Proposal

This is a proposal to improve road safety in the ACT and reduce impaired driving by supporting access to treatment for high range first and repeat drink driving offenders through implementing a comprehensive alcohol ignition interlock program as a collaboration between law enforcement and health services.

2. Background and rationale

Addressing impaired driving is a road safety priority for action by the ACT Government and for the law enforcement, public health and alcohol tobacco and other drug agencies. The ACT Government acknowledges that impaired driving due to alcohol and/or other drugs is one of the main causal factors for serious injury and fatal road crashes in the ACT.

ACT Policing drink driving statistics (30 June 2010 – 1 July 2011) reveal that most people apprehended for drink driving were medium to high-range (e.g. over .05 g% blood alcohol concentration) and/or repeat offenders.[1] This clearly indicates that targeted law enforcement and health interventions are required to address this particular population, particularly since we know that:

- Approximately 70% of drink drive first offenders are not detected reoffending;
- High range and repeat offenders are the most likely to have established problems of alcohol dependence or abuse;[2]
- The majority of convicted drink driver offenders whose licenses are suspended choose to drive while suspended.[3,4] For example, a Western Australian study of repeat drink drivers found that 74% admitted driving on at least one occasion whilst having their license disqualified.[5]

International research highlights the prevalence of problematic alcohol use in the drink drive recidivist, and high blood alcohol concentration (BAC), driving populations, and the challenges this provides for creating behavioural change:

> "Preventing repeated drink-driving is difficult, in part, because many recidivists are alcohol dependent or suffer from other comorbid disorders. As many as 54% of repeat impaired-driving offenders may meet clinical criteria for alcohol dependence and 40% or more may meet criteria for lifetime drug abuse... As a result, recidivist drink-drivers may be less receptive to traditional deterrence and may need a more comprehensive approach".[6]

These populations are unlikely to respond to brief educational interventions. A more intensive and comprehensive approach is needed.

ATODA understands that the ACT Government, law enforcement, public health agencies and the alcohol, tobacco and other drug (ATOD) sector have all expressed interested in progressing an alcohol interlock program in the ACT to seek to reduce and prevent the harms associated with high range and repeat drink-driving. A key challenge for these stakeholders is to collaborate to ensure that an effective and evidence-informed program is introduced in the ACT.

3. What are alcohol ignition interlocks?

Alcohol ignition interlocks (interlocks) are devices fitted to vehicles with an aim of preventing the vehicle from being operated by a driver whose breath alcohol concentration exceeds a predetermined level. In order to operate a vehicle fitted with an interlock, the driver must first provide a specimen of breath below the predetermined breath alcohol concentration. Typically, in order to prevent alcohol affected drivers from circumventing the device (e.g. someone other than the driver providing the specimen), interlocks require additional retests at random intervals in order to keep the vehicle running.

4. Existing interlock programs

Interlock programs currently operate in many international and Australian jurisdictions, including NSW, Victoria, Queensland and South Australia, and Tasmania plans to introduce this initiative soon.

There exists a body of scientific literature from studies and reviews relating to many programs allowing consideration of the most effective programs and the identification of successful features.

4.1 Features of successful interlock programs

The evidence shows that interlocks reduce drink driving recidivism whilst fitted to participants' vehicles and that good practice interlock programs utilise interlock devices as a component central to a coordinated set of activities. These activities should include:

- The provision of supports necessary to assist participant compliance (e.g. regular inspection, servicing and calibration of each device, visible evidence of the interlock restriction on the participant's drivers licence); and
- Incorporate treatment interventions to address underlying alcohol problems (e.g. regular motivational interviewing, engagement with treatment services);[7]

5. Purpose of an ACT interlock program

The purpose of an ACT interlock program could be to:

- Improve road safety in the ACT;
- Reduce impaired driving by high range first and repeat drink drivers;
- Implement an evidence based interlock program which incorporates both sanctions and treatment interventions;
- Promote a law enforcement and health partnership to addressing impaired driving; and
- Address individual drink driving re-offending through installing interlocks and concurrently addressing problematic alcohol use and driving behaviours.

6. Effectiveness of interlock programs

The outcomes of interlock programs vary, with all sources struggling to show improved road safety at a population level owing to inadequate coverage of the target population in many interlock programs. Some sources report significantly reduced recidivism rates amongst participants for the programs' duration while other sources report programs producing little or no measurable benefit.

> "Ignition interlocks are an effective DUI [drinking under the influence] countermeasure, but they do not work of all offenders, and they do not work in all situations. This strongly suggests that ignition interlock devices and their programmatic use needs to be targeted to offenders and situations where they work most effectively, and integrated carefully with other DUI countermeasures that have been shown to be effective." [8]

Interlocks can effectively separate the drinking from the driving (thus making the roads safer), at the same time as treatment interventions and education can address the underlying cause of offending (e.g. alcohol dependence and abuse).

The greatest road safety improvements from the use of interlocks will very likely come from ensuring that people most likely to reoffend are physically restricted from doing so.

7. A comprehensive approach to interlocks is effective as a means of preventing re-offending

7.1 Interlocks, on their own, prevent re-offending when installed

In its simplest form, interlocks are one means of preventing drink driving. The evidence indicates that:

- The majority of interlocks programs are effective in reducing drink driving recidivism of participants while the interlocks were installed;
- Interlocks reduce drink driving amongst program participants until removed from the vehicle.[9],[10]
- Once interlocks have been removed, participants' levels of drink-driving return to the level seen before fitting the interlocks.[11],[12]

7.2 Example: interlocks may prevent re-offending after removal when alcohol consumption is addressed as part of the program

The Swedish interlock program aims to change previous drink driving habits as well as reducing the alcohol consumption of participants. The program has led to lower levels of alcohol consumption and significantly lower ongoing recidivism post program completion.[13],[14] The program is described as "a voluntary 2-year program for DWI [driving while intoxicated] offenders involving strict medical requirements, including counselling and regular checkups by a medical doctor."[15]

> "Of the participants, 60% had diagnoses of alcohol dependence or abuse and 68% self-reported dangerous or harmful alcohol habits when starting the 2-year program. During the program, alcohol consumption generally decreased significantly as measured through five biological alcohol markers, and the rate of DWI recidivism fell sharply from a yearly rate of approximately 5% to almost zero. Successful completion of the program appears to have lasting effects in terms of far lower rates of DWI

recidivism, even 2.5 years later. The effects on DWI recidivism are paralleled by reduced rates of traffic accidents involving injuries."[16]

Those with continually high levels of alcohol consumption (some 40% of participants) are not permitted to remain in the program. This feature is in contrast with approaches elsewhere (including Australia). Schonfeld and Sheehan's 2004 critique of Australian interlock programs reported that participants in the 2001-03 Queensland interlock trial "were not expecting to reduce their alcohol consumption levels (despite consuming harmful levels), and the participants' propensity to report "false positives" and attribute violations to "machine error" rather than examine their own inappropriate drinking behaviours."[17]

8. Priority population

8.1 Targeting interlocks for maximum benefit

Interlock program eligibility criteria needs to be targeted to maximise benefit, including maximising participation and creating opportunities for the greatest road safety improvements. However, 'maximising participation' does not automatically lead to the greatest road safety improvements.

8.2 High range first and repeat offenders

High range first offenders and repeat offenders constitute the greatest risk of drink driving recidivism. As this group includes offenders most likely to be alcohol dependent, these same offenders are the most likely to reoffend prior to being relicensed.[18]

8.4 Interlocks are ineffective with low range first offenders

Low range first offenders are the drink drivers least likely to be alcohol abusers or alcohol dependent and are statistically the least likely to be detected drink driving again. While it may be tempting to maximise program participation by making interlocks mandatory for this group, doing so is unlikely to be cost-effective and is unlikely to return measurable road safety improvements. Furthermore, due to the typically short periods of licence suspension set by the courts for low range first offences, mandating interlocks for this group is likely to unintentionally increase the rate of disqualified driving.

9. Balancing use of interlocks with other sanctions

How soon after being convicted of a drink drive offence should a person be eligible to participate (i.e. drive legally) in an interlock program?

The evidence indicates that, for maximum benefit, participation in an interlock program should be available to drink drivers as soon as possible after a drink driving conviction. Requiring a period of full license suspension prior to interlock eligibility may contribute to our inability to place the interlocks onto the vehicles of the most persistent drinking drivers.[19] Offenders who participate in an interlock programs have 50% to 75% lower recidivism rates while on the interlock than similar offenders whose licenses have been fully suspended (and therefore should not be driving at all).[20]

It may seem counter-intuitive to allow high range and repeat offenders to drive with an interlock as soon as possible after a conviction, however the evidence supports doing exactly that.[21]

> "An early interlock installation must not be viewed as a reduction in punishment, but as a punishment that enhances public safety, even though driving is permitted."[22]

This is a challenging consideration as the evidence may be counterintuitive with what many in the community have been conditioned to believe about deterring drink drivers by fully suspending offenders' licences.

The evidence indicates that there are greater benefits of immediately installing interlocks compared with simply suspending licences.

10. Mandatory vs voluntary

The evidence suggests that many offenders understand that the likelihood of being detected driving whilst disqualified is low and will decline the opportunity of participating in an interlock program (therefore avoiding the cost, the inconvenience and the stigma of participation) on that basis.

The weight of evidence, coupled with the recommendations of the Western Australian Repeat Drink Drive Working Group and the International Council on Alcohol, Drugs and Traffic Safety, supports the mandatory use of interlocks for high range and repeat offenders.

However the evidence indicates that interlocks should be voluntary for low range first offenders. Consequently, interlocks should be available to the courts in all circumstances involving drink-driving offences.

11. Implementation issues

A number of other issues need to be considered prior to the implementation an interlock program in the ACT:

11.1 Length of the Program

The length of time an interlock is subject to the use of an interlock will vary depending upon with their use is voluntary or mandatory. In addition, because interlocks are an effective tool to prevent drink-driving, it is reasonable the risk of future drink-driving by offenders to be weighed heavily in the courts consideration about whether an interlock should be removed. There is no reason why interlocks could not be imposed, when mandatory, for an indeterminate length of time. If such an approach is taken, the courts should consider, at a minimum, the following:

- The offenders participation in therapeutic interventions
- The opinion of health staff about the offenders response to interventions
- The overall likelihood of the offender continuing to drink-drive

11.2 Consequences for non-compliance

ATODA believes that non-compliance with interlock requirements could warrant sanctions. However, exclusion from the interlock program should not be considered

an appropriate sanction in such contexts. Increased reporting requirements or more intense supervision or treatment could be warranted. Short-periods of license disqualification (e.g. over the weekend) may also be an appropriate sanction, but it would be desirable that they do not interfere with the offenders employment obligations.

11.3 Coupling the use of interlocks with therapeutic interventions

Coupling the use of interlocks with interventions to address the offenders problematic alcohol use, as well as other health and social interventions, is essential to ensuring the effectiveness of any interlock program and maximising it's cost-effectiveness. In the ACT, assessment and referral to appropriate alcohol and other drug services could be undertaken by the Court Alcohol and Drug Assessment Services (CADAS) run by the Alcohol and Drug Service, Health Directorate.

CADAS could provide alcohol assessments and a mechanism for making services available to offenders, monitoring their participation in therapeutic interventions, and providing information to the Courts about an offender's response to interventions and likelihood of continuing to drink-drive.

11.4 Who should pay

The cost of installing, maintaining, and removing interlocks should be borne by the offender if they have the resources to pay the costs. In circumstances where fines are also imposed, the Courts may consider it appropriate to have fines reduced by the total that the offender will pay for the use of interlocks. Among offenders with limited financial capacity, the use of Government funded concessions, subsidies, and instalment programs should be pursued. Persons reliant on Centrelink, or who may otherwise be driven to financial hardship as a result of the costs should be considered priorities for any financial assistance to engage in the program.

11.5 Evaluating the program

Evaluation of any interlock program in the ACT is essential. It will determine whether the program has achieved its aims and objectives and the relative costs of such a program compared with other approaches to preventing drink driving. A framework for any evaluation should be developed prior to the implementation of an interlock program. It would be desirable if any external bodies involved with the evaluation component of the program have experience with the ACT's legal system and alcohol interventions.

12. Policy context

This proposal is consistent with the ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014, ACT Road Safety Strategy 2011-2020, ACT Road Safety Action Plan 2011-2013 and the Chief Minister's Targeted Assistance Strategy.[23]

12. Further information

Please contact Carrie Fowlie, Executive Officer, ATODA, on carrie@atoda.org.au or (02) 6255 4070.

References

[1] Justice and Community Safety. *Alcohol and Drug Awareness Course Statement of Requirements Project No. 17910.110* (August 2011)
[2] For further information see the ATODA proposal *Improving ACT road safety through implementing: Comprehensive, collaborative and evidence-based alcohol ignition interlock program.*
[3] International Council on Alcohol, Drugs and Traffic Safety Working Group on Alcohol Interlocks 2001, *Alcohol Ignition Interlock Devices Volume I: Position paper*, International Council on Alcohol, Drugs and Traffic Safety (ICADTS).
[4] Lenton, S, Fetherston, J & Cercarelli, R 2010, 'Recidivist drink drivers' self-reported reasons for driving whilst unlicensed - a qualitative analysis', *Accident Analysis and Prevention*, vol. 42, no. 2, pp. 637-44.
[5] 2002 Fetherston and colleagues study cited in Road Safety Council of Western Australia 2003, *Report of the Repeat Drink Driving Working Group*, Western Australia: Author.
[6] Babor, TF et al. 2010, *Alcohol: no ordinary commodity - research and public policy*, 2nd edn, OUP, Oxford, p. 174.
[7] Babor, TF et al., 2010, *Alcohol: no ordinary commodity - research and public policy*, 2nd edn, OUP, Oxford, pp. 174-7.
[8] DeYoung, DJ, Tashima, HN & Masten, SV 2005, 'An evaluation of the effectiveness of ignition interlock in California', in Marques, PR (ed) *Alcohol ignition interlock devices Volume II: research, policy, and program status 2005*, International Council on Alcohol, Drugs and Traffic Safety (ICADTS).
[9] See:

- DeYoung, DJ, Tashima, HN & Masten, SV 2005, 'An evaluation of the effectiveness of ignition interlock in California', in Marques, PR (ed) *Alcohol ignition interlock devices Volume II: research, policy, and program status 2005*, International Council on Alcohol, Drugs and Traffic Safety (ICADTS).
- Marques, P, Tippetts, S, Allen, J, Javors, M, Alling, Christer, Yegles, M, Pragst, F, & Wurst, F 2009, 'Estimating driver risk using alcohol biomarkers, interlock blood alcohol concentration tests and psychometric assessments: initial descriptives', *Addiction*, 105, 226-239.
- International Council on Alcohol, Drugs and Traffic Safety Working Group on Alcohol Interlocks 2001, *Alcohol Ignition Interlock Devices Volume I: Position paper*, International Council on Alcohol, Drugs and Traffic Safety (ICADTS).
- Road Safety Council of Western Australia 2003, *Report of the Repeat Drink Driving Working Group*, Western Australia: Author.

[10] Coben, JH & Larkin, GL 1999, 'Effectiveness of ignition interlock devices in reducing drunk driving recidivism', *American Journal of Preventive Medicine*, 1999;16(1S).
[11] Willis, C, Lybrand, S & Bellamy, N 2004, 'Alcohol ignition interlock programmes for reducing drink driving recidivism', *Cochrane Database Syst Rev*, no. 4, p. CD004168.
[12] Voas, RB, Marques, PR, Tippetts, AS & Beirness, DJ 1999, 'The Alberta Interlock Program: the evaluation of a province-wide program on DUI recidivism', *Addiction*, 94(12), 1849-1859.
[13] Bjerre, B 2005, 'Primary and secondary prevention of drinking and driving by the use of alcolock device and program: the Swedish experience', in Marques, PR (ed) *Alcohol ignition interlock devices Volume II: research, policy, and program status 2005*, International Council on Alcohol, Drugs and Traffic Safety (ICADTS).
[14] Bjerre and Thorsson 2007
[15] Bjerre, B 2005, 'Primary and secondary prevention of drinking and driving by the use of alcolock device and program: the Swedish experience', in Marques, PR (ed) *Alcohol ignition interlock devices Volume II: research, policy, and program status 2005*, International Council on Alcohol, Drugs and Traffic Safety (ICADTS).
[16] Bjerre, B 2005, 'Primary and secondary prevention of drinking and driving by the use of alcolock device and program: the Swedish experience', in Marques, PR (ed) *Alcohol ignition interlock devices Volume II: research, policy, and program status 2005*, International Council on Alcohol, Drugs and Traffic Safety (ICADTS).
[17] Schonfeld, C & Sheehan, M 2004, *Critical overview of Alcohol ignition interlock programs in Australia*, Paper for the 17th International Conference on Alcohol Drugs and Traffic Safety, T2004, Glasgow. Queensland: Centre for Accident Research and Road Safety – Queensland.
[18] International Council on Alcohol, Drugs and Traffic Safety Working Group on Alcohol Interlocks 2001, *Alcohol Ignition Interlock Devices Volume I: Position paper*, International Council on Alcohol, Drugs and Traffic Safety (ICADTS).
[19] International Council on Alcohol, Drugs and Traffic Safety Working Group on Alcohol Interlocks 2001, *Alcohol Ignition Interlock Devices Volume I: Position paper*, International Council on Alcohol, Drugs and Traffic Safety (ICADTS).

[20] Voas, RB, Roth, R & Marques PR 2005 'The hard suspension barrier: Does New Mexico's interlock licensing law solve the problem?', in Marques, PR (ed) *Alcohol ignition interlock devices Volume II: research, policy, and program status 2005*, International Council on Alcohol, Drugs and Traffic Safety (ICADTS).

[21] See:

- Clayton, A & Beirness, D 2008, A review of international evidence on the use of alcohol ignition interlocks in drink-drive offences, Department of Transport, London.
- International Council on Alcohol, Drugs and Traffic Safety Working Group on Alcohol Interlocks 2001, *Alcohol Ignition Interlock Devices Volume I: Position paper*, International Council on Alcohol, Drugs and Traffic Safety (ICADTS).
- Road Safety Council of Western Australia 2003, *Report of the Repeat Drink Driving Working Group*, Western Australia: Author.

[22] International Council on Alcohol, Drugs and Traffic Safety Working Group on Alcohol Interlocks 2001, *Alcohol Ignition Interlock Devices Volume I: Position paper*, International Council on Alcohol, Drugs and Traffic Safety (ICADTS).

[23] *Chief Minister commissions Expert Panel to develop Targeted Assistance Strategy* Media Release 07/11/2011. http://www.chiefminister.act.gov.au/media.php?v=11094

Additional references:

- Bjerre, B & Kostela, J 2008, 'Primary prevention of drink driving by the large-scale use of alcolocks in commercial vehicles', *Accident Analysis and Prevention*, vol. 40, no. 4, pp. 1294-9.
- Popkin, CL, Stewart, JR, Martell, C & Birckmayer, JD 1992, *An evaluation of the effectiveness of the interlock in preventing recidivism in a population of multiple DWI offenders*. Chapel Hill, NC: University of North Carolina Highway Safety Research Center, Final report for the Governor's Highway Safety Program, Project No. AL-92-02-02.

ACT Infringement Schemes Reform:
Implementing effective and appropriate responses to offending by disadvantaged people including alcohol, tobacco and other drug (ATOD) related offending

March 2012

The purpose of this paper is to outline some issues, contextual factors and recommendations for reform to the ACT's multiple infringement systems, particularly those that relate to alcohol, tobacco and other drugs (ATOD). This paper compliments and supports ATODA's 2012-13 ACT Budget consultation submission, Priority area 4, *Reducing re-offending and poverty through social inclusion*[1] and ATODA's submission to the ACT Targeted Assistance Strategy.[2]

1. Background and rationale

Infringement notices, whether they be related to parking or traffic offences,[3] antisocial or disruptive behaviour,[4] failure to comply with smoking ordinance,[5] or possession of small amounts of cannabis,[6] are an important and effective manner of responding to low-level offending and road traffic violations in the ACT. They are an important tool in the ACT Government's response to managing a modern community such as the ACT.

However, there has been recent acknowledgement by the ACT Government and community that the use of traffic and parking infringement notices can have a disproportionate impact upon disadvantaged members of the ACT community.[7] Much of the impact infringements can have among disadvantaged people is exacerbated by the fact that many infringement schemes specifically target persons for health-related behaviours, including ATOD related behaviours.

ATODA supports discussions to reform the ACT's infringements schemes to bring them, at a minimum, into line with other jurisdictions. In particular, ATODA supports moves in the ACT to address the disproportionate negative impact infringement schemes can have among certain portions of the ACT community for two reasons:

1. Infringement schemes can lead to poor outcomes among disadvantaged people and their families, including among many with ATOD problems; and,
2. Many infringements target people with ATOD-related problems or for ATOD-related behaviours, which could be better addressed as a health issue.

Consequently, ATODA believes that reforms to the parking and traffic infringement schemes proposed should be extended to cover all infringements and fines, including infringements made for ATOD-related behaviours, such as smoking, drinking alcohol, or possession of illicit drugs, as well as extending the reforms to include the following:

1. Instalment plans for all fines and infringements, including those which are ATOD-related;
2. Options for community service, education or treatment as payment;
3. Options to waive fines for certain members of the community;
4. Matching fine amounts with the capacity of individuals to pay;
5. Adequately supporting Police;
6. Adequately supporting the Courts;
7. Promoting access to appropriate health and social services; and,
8. Trialling evidence-based responses to ATOD-related and low-level offending.

At the time of writing, an evaluation of the ACT's drug diversion programs and services is being undertaken. Consequently, it will be necessary to consider any potential reforms within that context. ATODA believes that by integrating existing drug diversion programs with these preceding proposed activities, a genuinely effective, informed, and efficient response to low-level and ATOD-related offending can be implemented in the ACT.

2. Infringements can lead to poor outcomes for disadvantaged people

2.1 Infringements and fines cause additional financial stress

The proportionate impact upon individuals issued with fines differs depending upon their ability to pay and their social and health characteristics. For many disadvantaged residents of the ACT, an infringement notice or resultant suspension of license or registration[8] can represent one of many factors contributing to a decent into, or entrenchment of, social disadvantage and resultant legal difficulties, financial difficulties, poor health, homelessness, etc. For many ACT residents experiencing ATOD difficulties, limited income, chaotic lifestyles, and social disadvantage make the current infringement notice scheme a substantial risk to the community by promoting and entrenching disadvantage, particularly economic disadvantage.

2.2 Failure to pay infringements and fines can lead to a criminal record

Generally, if a person pays an infringement notice within the specified time period, a person's liability for the offence is discharged. When offenders fail to pay an infringement or fine, they are often given a criminal record. A criminal record is a major barrier to social engagement, especially by limiting opportunities for employment. The Human Rights and Equal Opportunity Commission (HREOC) released a discussion paper outlining the impact criminal records can have on an individual's opportunities for employment, education, and social engagement.[9] That paper outlined the following impacts of discrimination due to criminal history:

- Refused a job;
- Dismissed from employment;
- Denied training opportunities;
- Denied promotion;
- Subjected to less favourable working conditions or terms of employment; and,
- Harassed in the workplace.

ATODA recognises and suggests further consideration of work that has been done in this area by ATOD consumer groups, including:

- Australian Illicit and Injecting Drug Users League (AIVL);[10] and
- Association of Participating Services Users (APSU)[11]

2.3 Calls for reform

Street Law, a project of the Welfare Rights and Legal Centre that provides legal services to persons who are homeless or at risk of homelessness, released a report in 2011 outlining how the current infringement scheme can contribute to homelessness among disadvantaged ACT residents, why this occurs, and how it can be addressed.[12] The report provides a description of the ACT's parking and road traffic infringement notice schemes, problems with that system, and its impact upon disadvantaged members of the community. The report highlights specific consideration of persons experiencing "Addiction to drugs, alcohol or a volatile substance." ATODA broadly supports the recommendations made by Street Law that relate to:

- A review of the ACT's system for administering infringements;
- Characteristics of a new infringement system;
- Low income and disadvantaged members of the community; and,
- Court ordered instalment plans.

Further, for over a decade the ACT Council of Social Service (ACTCOSS) has been encouraging the investigation of a tiered system of fines which would be in proportion to one's income. The ability to levy larger fines through the use of a progressive system would have a number of benefits for the community. With an approach such as this, fines would act as a greater deterrent for upper and middle income earners without causing substantial and unnecessary financial difficulty for people in poverty and disadvantage. It would also allow courts to impose far more severe penalties for serious crimes, without having to resort to custodial sentences.[13]

ATODA believes that these courses of action can help to improve the ACT's infringement notice system, reduce the negative impact upon disadvantaged members of the ACT community experiencing ATOD difficulties and align with the ACT Government's policy.

2.4 Reform in other Australian Jurisdictions

Similar reforms have been, or are being, implemented in all jurisdiction in Australia.[14]

In NSW the *Fines Further Amendment ACT 2008* (NSW)[15] made reforms to improve the system for the administration and enforcement of court fines and penalty notices, particularly for vulnerable groups. That act provided for the following:

- Permitted a system of staged payment of fines without accruing late penalties;
- Clarified the discretionary powers of police to provide cautions instead of fines in some circumstances;
- Introduced a statutory system for the administrative review of penalty notices in some circumstances; and,
- Established a two-year pilot fine mitigation scheme that allowed certain

disadvantaged persons to undertake unpaid work, education, or treatment instead of paying fines called Work and Development Orders (WDO).

2.5 Social and economic benefits of reform

The burden of the ACT's infringement schemes on individuals and the community as well as the anticipated benefits of reform mirror those in other Australian jurisdictions. Not only is addressing the disproportionate impact of the current system good social policy - it also has a potentially strong economic benefit to the ACT community and Government; the reforms may increase ACT Government revenue, reduce demand on an already overstretched court system, improve economic productivity and efficiency, and reduce health and welfare expenditure in the long-term.

ATODA particularly highlights Street Law's findings that the system in place for recovering revenue in the ACT from infringements does not work, for example:

- $29.7 million or 16% of ACT Government 2009 – 2010 revenue was attributable to "taxes, fees and fines"; and,
- In 2010, the ACT Government is owed more than $24 million in infringements that have been outstanding for at least 361 days.[16]

ATODA agrees that it is safe to conclude from these figures that whilst infringements provide a significant source of revenue for the ACT Government, the means for recovering that revenue are inadequate.

An initiative similar to the reforms proposed has been rolled out in NSW. A 2011 evaluation found that the scheme has helped to: [17]

- Reduce reoffending in the fine enforcement system, and secondary offending in the broader criminal justice system. In particular, preliminary statistitcs indicate 82.5% of clients have not received another fine or penalty notice;
- Engage clients in appropriate ATOD treatment or activities that they may not have otherwise engaged in, including treatment;
- Reduce client stress, anxiety and feelings of hopelessness and despair;
- Promote client agency, self-esteem and self-efficacy;
- Build client skills, provide them with an incentive to work, and may lead to employment; and,
- Reduce costs to government associated with fine enforcement, ongoing offending behaviour, welfare dependency, mental health problems and drug and alcohol addiction.

Reforming the ACT infringement system could see similar outcomes which would greatly benefit disadvantaged people, people with problematic ATOD use, the broader community and the ACT Government.

3. Infringement schemes and fines that target ATOD-related behaviours

The *Magistrates Court Act 1930*, pt 3.8[18] provides a system of infringement notices for offences against various Acts. The infringement notice system is intended to provide an alternative to prosecution. Police are also authorised to serve fines for

certain offences. A number of offences for which infringements and fines are available specifically target ATOD-related behaviours. Examples include:

- Drink driving offences[19]
- Drug driving offences[20]
- Smoking in cars with children[21]
- Smoking in a no smoking areas[22]
- Public order offences related to alcohol[23]
- Simple Cannabis Offence Notice Scheme (SCONs)[24]

3.1 Drink driving and drug driving offences

Under the *Road Transport (Alcohol and Drugs) Act 1977*, it is an offence to drive a vehicle while under the influence of alcohol and/or other drugs.

In cases of drinking while under the influence of alcohol, a drivers license is automatically suspended and the Courts determine the sanction, usually a fine and attendance at a road education program, although imprisonment is an option.

The maximum penalty for drug driving is a fine of 10 penalty units for a first offence, or 25 penalty units and up to three months imprisonment for a repeat offender. A court can also issue a period of licence disqualification.

The Illicit Drug Reporting System (IDRS)[25] and the Ecstasy and Related Drug Reporting System (EDRS)[26] report findings related to driving risk behaviours. While not representative of regular drug users in the ACT, they do indicate that drink driving and drug driving may be trends among ACT residents who regularly consume illicit drugs.

In 2010, of those regular injecting drug users who reported driving in the six months prior to interview, 21% admitted to driving under the influence of alcohol and 79% reported driving under the influence of an illicit drug in that period.[27] Among regular ecstasy users who reported driving in the six months prior to interview, 68% admitted to driving under the influence of alcohol and 61% admitted to driving under the influence of illicit drugs in that period.[28]

3.2 Smoking in cars with children

The *Smoking in Cars with Children (Prohibition) Bill 2011*[29] will make it an offence to smoke in a car when a child is present. Police may issues fines up to $5,550. There is no provision in the Bill for police to mandate or refer offenders to health interventions.

3.3 Smoking in no smoking areas

It is an offence to smoke in areas designated as smoke free.[30] In such circumstances, infringements notices for $110 can be made. The cost of serving a reminder notice for an infringement notice offence against the Smoke-Free Act is $34.

3.4 Public order offences related to alcohol

Under the *Liquor Act*,[31] the following offences exist for which an infringement notice may be made to individuals:[32]

- Failure to leave premises when directed (s138)
- Consume liquor off licensed premises (s139)
- Consume liquor at certain public places (s199)[33]

3.5 Simple Cannabis Offence Notice Scheme

The Simple Cannabis Offence Notice Scheme (SCONS) is a police diversionary program that provides police discretion to issue a cannabis offence notice in lieu of arresting individuals found in possession of up to 25 grams of cannabis or 2 cannabis plants. Seventy-three SCONS were made in 2009-10.[34] ATODA understands that the rates of payments of SCONS are low in the ACT.

5. Current approaches to preventing ATOD-related behaviour

Many offences for which infringements can be issued by the police or courts directly target ATOD-related behaviours. Consequently, these offences can be considered to target persons experiencing health-related problems and/or who are in a state of relative poor health. As a result, approaches to such offending needs to be a joint effort between law enforcement and health services if they are going to effectively divert offenders form the criminal justice system and prevent increased demand on the Courts – and seek to address the underlying health problem.

Many criminal justice responses to ATOD-related crime are often ineffective at preventing re-offending. This is because much ATOD-related offending is a direct consequence of the individual's ATOD-difficulties, such as dependence. For example, 79% of respondents to the ACT's Inmate Health Survey reported being intoxicated on alcohol or other drugs at the time of committing their most recent offence.[35] Unless ATOD-related problems are addressed in this population, it is likely they will remain at substantial risk of reoffending. Consequently, Australian jurisdictions are moving towards novel and evidence-based responses to dealing with ATOD-related offending.[36]

National and international evidence repeatedly shows that for a large number of repeat offenders, their ATOD problems are a major contributor to their reoffending.[37] This for example is very much the case with recidivist drink drivers, we refer you to ATODA's paper *Improving road safety in the ACT by implementing: a comprehensive, collaborative and evidence-based alcohol ignition interlock program.*[38]

6. Recommendations

6.1 Review of ACT infringements schemes

ATODA recommends a review is conducted into the ACT's infringment schemes, including those ATOD-related, and that a governance group is established to support this work with representation from key stakeholders including StreetLaw, ACTCOSS and ATODA.

6.2 Instalment plans for ATOD-related fines and infringements

Avenues must be made available for offenders to make payments for their fines in instalments. Such avenues should be available to persons receiving Centrelink payments, students, or persons with a concession card. Persons receiving opioid-maintenance therapy or in treatment for ATOD or mental health problems should also be considered. In NSW, regular automatic deductions from Centrelink payments is available after registration with the State Debt Recovery Office (SDRO).

ATODA believes a similar model could be effective in the ACT, but recognises that some of the Territory's most disadvantaged members may, in fact, not be in receipt of Centrelink payments that they are entitled to.

6.3 Options for community service, education or treatment as payment

Alternatives to payment should be made available to persons experiencing financial hardship or who would otherwise be severely disadvantaged by the need to pay fines Community service or placements in services can provide a far greater benefit to the community than payment of fines. Additionally, engagement in such activities can help offenders to gain skills and experience that can assist them in finding and maintaining suitable employment, as well as providing an opportunity for social interaction and personal development.

For persons experiencing demonstrable health problems, participation in ATOD or mental health treatment, under supervision from appropriate agencies, and as part of a comprehensive case plan, should be considered as an alternative to the payment of fines. The NSW Work and Development Orders Scheme can provide guidance about the features, structure, and management of any such scheme.

6.4 Options to waive fines for certain members of the community

Police, Government agencies, and the Courts should have discretion to waive fines among severely disadvantaged members for the community or among those who are simply unable to pay. These could include for example people who are homeless, people who are disabled, prisoners, or those in residential treatment for ATOD problems.

6.5 Adequately support Police

Police are often at the front end of any response to ATOD-related offending. Consequently, it is vital that they be adequately trained, resourced, and supported to perform their increasingly complex roles. Where police discretion is concerned, the community expects Police to be able to make very complex decisions within a very short period of time.

A range of other ATOD-related issues directly impact upon the Police every day including related to violence and anti-social behaviour, the night time economy, within public spaces, and so forth. A recent report by the National Centre for Education and Training on Addiction (NCETA) has outlined ATOD-related workforce development issues for Australian Police, they propose action in three key areas:

- System-wide action;
- Capacity building; and
- Professional development.[39]

6.6 Promote access to appropriate health and social services

Targeting persons for behaviours associated with health problems without promoting access to appropriate interventions is unlikely to be an effective way of preventing reoffending among certain groups[40] - nor is it likely to address the underlying problem (e.g. having a problem with alcohol). Consequently, ATODA believes that increasing access to appropriate interventions to address the underlying causes of certain offending, should be a priority in any reforms to infringement systems. Many responses to low-level ATOD-related offending do not permit for this.

Existing drug diversion initiatives in the ACT include services that can be utilised in any reforms to infringement notice schemes. Key strategies to achieving this are utilising opportunities for assessment and referral and increasing the use of existing services by Police and the Courts.

Using fines in conjunction with evidence-based interventions for health and social problems works better. Applications for an instalment plan for payment could be used as an opportunity for screening and referral regardless of the type of infringement. Individuals could be referred to legal or financial services, or to health services for a clinical assessment.

6.7 Implement evidence-based responses to ATOD-related and low-level offending

The literature on effective responses to ATOD-related offending is large, including offence-specific responses.[41] One good example is the inability of the current system to effectively address high-range and repeat drink-drivers.

Drink-driving offences

International research highlights the prevalence of problematic alcohol use in the drink drive recidivist, and high blood alcohol concentration (BAC), driving populations, and the challenges this provides for creating behavioural change:

> "Preventing repeated drink-driving is difficult, in part, because many recidivists are alcohol dependent or suffer from other comorbid disorders. As many as 54% of repeat impaired-driving offenders may meet clinical criteria for alcohol dependence and 40% or more may meet criteria for lifetime drug abuse... As a result, recidivist drink-drivers may be less receptive to traditional deterrence and may need a more comprehensive approach".[42]

7. Priority population

Efforts to improve the ACT's use of infringement notices in response to low-level and ATOD-related offending will particularly benefit Aboriginal and Torres Strait Islander people and communities.

In the ACT, the Aboriginal and Torres Strait Islander population is over-represented in terms of socio-economic disadvantage,[43] involvement with the criminal justice system,[44] and ATOD problems.[45]

In the *2008 National Aboriginal and Torres Strait Islander Social Survey*, 20% of Aboriginal and Torres Strait ACT residents reported running out of money for living expenses and 36% were smokers.[46]

Limited financial resources among many Aboriginal and Torres Strait Islander people mean that financial sanctions can have a particularly strong impact.

Enforcement of such laws by Police may result in the perceived or actual targeting of Aboriginal and Torres Strait Islander people and communities.

Aboriginal and Torres Strait Islander Australian's are more likely to have a criminal record than the general population, as well as being over-represented within the criminal justice system.

In 2008, almost half of Aboriginal and Torres Strait Islander males (48%) and 21% of females aged 15 years or over had been formally charged by police (over their life time). Just over one-in-six (15%) reported having been arrested in the last 5 years and 3% had been incarcerated in the last 5 years.[47]

Having a criminal record can, in certain circumstance, make infringement schemes unavailable to police (e.g. SCONs) meaning that further involvement with the criminal justice system is more likely for this population.

Improving the ACT's infringement notice schemes will serve to help to address disadvantage among the ACT's Aboriginal and Torres Strait Islander population, and specific groups within that population such as people with ATOD problems.

8. Policy context

This proposal is consistent with the:

- *ACT Alcohol, Tobacco and other Drugs Strategy 2010-2014*;
- Health Directorate - ACT Government Evaluation of the ACT's Drug Diversion Programs;
- Expert Panel to develop the ACT Targeted Assistance Strategy;
- New smoking in cars with children legislation and public advertising campaign;
- ACT Road Safety Strategy; and,
- Draft ACT Comorbidity Strategy.

9. Further information

For further information regarding this papper please contact Carrie Fowlie, Executive Officer, ATODA, on carrie@atoda.org.au or (02) 6255 4070.

References:

[1] Alcohol Tobacco and Other Drug Association ACT. (2012). *Submission to the ACT Budget Consultation 2012 – 2013.* Canberra. Available online at: www.atoda.org.au
[2] Alcohol Tobacco and Other Drug Association ACT (2012) *Submission to the ACT Targeted Assistance Strategy.* Canberra. Available online at: www.atoda.org.au
[3] ACT Parliamentary Counsel. (1999) *Road Transport (General) Act 1999* (ACT). Available online at: http://www.legislation.act.gov.au/a/1999-77/default.asp
[4] ACT Parliamentary Counsel. (2010). *Criminal Code Act 1900* (ACT); *Liquor Act 2010 (ACT)*; Available online at: http://www.legislation.act.gov.au/a/2010-35/default.asp
[5] ACT Parliamentary Counsel. (2011). *Magistrates Court (Smoke-free Public Places Infringement Notices) Regulation 2010.* Available online at: http://www.legislation.act.gov.au/sl/2010-50/
[6] ACT Parliamentary Counsel. (2010). *Drugs of Dependence ACT 1989.* Available online at: http://www.legislation.act.gov.au/a/alt_a1989-11co/default.asp
[7] Street Law. (2011). *The Downward Spiral: How a fine can cause homelessness in the ACT.* Welfare Rights and Legal Centre: Canberra. Available online at: streetlaw.org.au/files/view/?id=34
[8] For example: ACT Parliamentary Counsel. (2012). *Road Transport (General) Act 1999 (ACT).* Available online at: http://www.legislation.act.gov.au/a/1999-77/default.asp
[9] Human Rights and Equal Opportunity Commission. (2004). *Discrimination in employment on the basis of criminal record: Discussion paper.* Canberra: HREOC. Available online at: http://www.hreoc.gov.au/human_rights/criminalrecord/discussion.html
[10] Australian Illicit and Injecting Drug Users League. (2011). *Why Wouldn't I Discriminate Against Them All? A Report on Discrimination towards the Injecting Drug User Community.* Available online at: http://www.aivl.org.au/database/sites/default/files/images/AIVL%20IDU%20Stigma%20&%20Discrimination%20Report%20Nov%202011.pdf
[11] Association of Participating Services Users. (2011). *Locked Out.* Self-Help Addiction Resource Centre. Available online at: http://www.apsuonline.org.au/wp-content/uploads/2011/09/Locked-Out.pdf
[12] Street Law (2011). The Downward Spiral: How a fine can cause homelessness in the ACT. Welfare Rights and Legal Centre: Canberra. Available online at: streetlaw.org.au/files/view/?id=34
[13] ACT Council of Social Service (2001) *Budget Submission.* www.actcoss.org.au
[14] Table A, Appendix 1: Street Law (2011). The Downward Spiral: How a fine can cause homelessness in the ACT. Welfare Rights and Legal Centre: Canberra. Available online at: streetlaw.org.au/files/view/?id=34
[15] Parliament of NSW. (2008). *Fines Further Amendment Act 2008* (NSW). Available online at: http://www.parliament.nsw.gov.au/prod/parlment/nswbills.nsf/1d4800a7a88cc2abca256e98001 21f01/adc2bee98349b5fbca25750d0004ae37?OpenDocument
[16] Street Law (2011). The Downward Spiral: How a fine can cause homelessness in the ACT. Welfare Rights and Legal Centre: Canberra. Available online at: streetlaw.org.au/files/view/?id=34
[17] Street Law (2011). The Downward Spiral: How a fine can cause homelessness in the ACT. Welfare Rights and Legal Centre: Canberra. Available online at: streetlaw.org.au/files/view/?id=34
[18] ACT Parliamentary Counsel. (2012). *Magistrates Court Act 1930.* Available online at: http://www.legislation.act.gov.au/a/1930-21/default.asp
[19] ACT Parliamentary Counsel. (2011) *Road Transport (Alcohol and Drugs) Act 1977.* Available online at: http://www.legislation.act.gov.au/a/1977-17/default.asp
[20] ibid.
[21] ACT Parliamentary Counsel. (2011). *Smoking in Cars with Children (Prohibition) Bill 2011.* Available online at: http://www.legislation.act.gov.au/b/db_42926/default.asp
[22] ACT Parliamentary Counsel. (2011). *Smoke-Free Public Places Act 2003*; *Magistrates Court (Smoke-free Public Places Infringement Notices) Regulation 2010.* Available online at: http://www.legislation.act.gov.au/sl/2010-50/
[23] ACT Parliamentary Counsel. (2012). *Liquor Act 2010 (ACT).* Available online at: http://www.legislation.act.gov.au/a/2010-35/default.asp
[24] ACT Parliamentary Counsel. (2010). *Drugs of Dependence ACT 1989.* Available online at: http://www.legislation.act.gov.au/a/alt_a1989-11co/default.asp
[25] Cassar, J. and Burns, L. (2010) Australian Capital Territory Drug Trends 2009. Findings from the Illicit Drug Reporting System (IDRS). Australian Drug Trend Series No. 39. Sydney, National Drug and Alcohol Research Centre, University of New South Wales.
[26] Cassar, J. and Burns, L. (2010). Australian Capital Territory Drug Trends 2009. Findings from the Ecstasy and Related Drugs Reporting System (EDRS). Australian Drug Trend Series No. 48. Sydney, National Drug and Alcohol Research Centre, University of New South Wales.

[27] Cassar, J. and Burns, L. (2010). Australian Capital Territory Drug Trends 2009. Findings from the Illicit Drug Reporting System (IDRS). Australian Drug Trend Series No. 39. Sydney, National Drug and Alcohol Research Centre, University of New South Wales.
[28] Cassar, J. and Burns, L. (2010). Australian Capital Territory Drug Trends 2009. Findings from the Ecstasy and Related Drugs Reporting System (EDRS). Australian Drug Trend Series No. 48. Sydney, National Drug and Alcohol Research Centre, University of New South Wales.
[29] ACT Parliamentary Counsel. (2011). *Smoking in Cars with Children (Prohibition) Bill 2011.* Available online at: http://www.legislation.act.gov.au/b/db_42926/default.asp
[30] ACT Parliamentary Counsel. (2011). *Magistrates Court (Smoke-free Public Places Infringement Notices) Regulation 2010.* Available online at: http://www.legislation.act.gov.au/sl/2010-50/
[31] ACT Parliamentary Counsel. (2012). *Liquor Act 2010 (ACT).* Available online at: http://www.legislation.act.gov.au/a/2010-35/default.asp
[32] ACT Parliamentary Counsel. (2011). *Magistrates Court (Liquor Infringement Notices) Regulation 2010.* Available online at: http://www.legislation.act.gov.au/sl/2010-47/
[33] See Columns 2, Schedule 1 of: ACT Parliamentary Counsel. (2011). *Magistrates Court (Liquor Infringement Notices) Regulation 2010.* Available online at: http://www.legislation.act.gov.au/sl/2010-47/
[34] ACT Parliamentary Counsel. (2010). *Drugs of Dependence ACT 1989.* Available online at: http://www.legislation.act.gov.au/a/alt_a1989-11co/default.asp
[35] Epidemiology Branch, ACT Government Health Directorate (2011), ACT Inmate Health Survey 2010: Summary results, ACT Government, Canberra, ACT.
[36] Hughes, C. and Ritter, A. (2008). Monograph No. 16: A summary of diversion programs for drug and drug-related offenders in Australia. DPMP Monograph Series. Sydney: National Drug and Alcohol Research Centre.
[37] See for example: Wundersitz, J. (2007). Criminal justice responses to drug and drug-related offending: are they working? Technical and Background Paper. Canberra, Australian Institute of Criminology.
[38] Alcohol Tobacco and Other Drug Association ACT (2012) *Improving road safety in the ACT by implementing: a comprehensive, collaborative and evidence-based alcohol ignition interlock program.* Canberra.
[39] Roche, A.M., Duraisingam, V., Triffnoff, A., & Nicholas, R. (2009). In persuit of Excellence: Alcohol and Drug Related Workforce Development Issues for Australian Police into the 21st Century. National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide.
[40] Ibid.
[41] See, for example: Melissa, B. (2005). "A comparative review of best practice guidelines for the diversion of drug related offenders." *International Journal of Drug Policy* **16**(4): 223-234.
[42] Babor, TF et al. 2010, Alcohol: no ordinary commodity - research and public policy, 2nd edn, OUP, Oxford, p. 174.
[43] Policy Division, ACT Chief Minister's Department. (2011). *ACT Aboriginal and Torres Strait Islander Population: A demographic analysis.* Canberra: ACT Government. Available online at: http://www.cmd.act.gov.au/__data/assets/pdf_file/0011/154487/ACT-Aboriginal-Torres-Strait-Islanders.pdf
[44] SCRGSP (Steering Committee for the Review of Government Service Provision) 2012, *Report on Government Services 2012*, Productivity Commission, Canberra. Chapter 8.
[45] Australian Bureau of Statistics. (2010). 2008 National Aboriginal and Torres Strait Islander Social Survey, 2008. 4714.0. Canberra: ABS.
[46] ibid.
[47] ibid.

AMC Inmate Health Survey

Alcohol Tobacco and Other Drug Research Project

Introduction

Understanding the health status of the inmates of the Alexander Maconochie Centre (AMC), the ACT's prison, is one of the ways to develop appropriate policy and service responses to for this unique population. Conducting inmate health surveys is a key mechanism towards developing this understanding.

In 2010, the ACT Government Health Directorate conducted the first inmate health survey at the AMC with a summary results paper being completed in July 2011 and released publicly in November (http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1321337363&sid=). The summary report provides broad information about alcohol, tobacco and other drug (ATOD) related issues for inmates and commits to a series of additional reports, including one focused on ATOD.

The ACT Government, ATOD sector and allied stakeholders have made significant investments towards improving ATOD policies and services in the AMC. The results from the Inmate Health Survey are an essential data source for this ongoing work.

The survey data was collected in May 2010, so it is important that the analysis and availability of the ATOD information is timely so as to be able to inform decision-making and development processes.

A Canberra Collaboration of ATOD researchers has been established in the ACT to strengthen linkages between research, policy and practice (see www.atoda.org.au for further details). Engaging members of the Collaboration in progressing this key area of work could effective and efficient.

It is therefore proposed that a research project be overseen by members of the Collaboration and undertaken by identified researcher/s to analyse the ATOD data from the Inmate Health Survey so as to be able to understand inmates' ATOD related issues and to inform policy, practice and future research in this area.

Proposed Project

The *AMC Inmate Health Survey Alcohol Tobacco and Other Drug Research Project* (the project) is a collaborative research project that aims to analyse, present and disseminate the alcohol, tobacco and other drug (ATOD) specific data from the 2010 Inmate Health Survey. The data are quantitative only; the ACT Health Directorate's Epidemiology Branch is the custodian of the unit record file.

The project will produce a comprehensive report on the ATOD aspects of the survey within the context of inmates' broader health status and other comorbidities. The report would produce factual data and draw implications for policy, services and future research in this area.

We propose a project comprising two phases: an initial report will analyse ATOD data from the 2010 ACT Inmate Health Survey. This initial report (data analysis and

brief demographic and descriptive analyses) would then be the basis for a workshop of key stakeholders, seeking their feedback on how the results resonate with their understandings of the ATOD situation within the AMC, and more broadly within the ACT context. A subsequent report will detail implications and will include the outcomes of the workshop, focusing on policy, service provision and implementation, and further research.

Both phases of the project would be made available electronically as appropriate. A public presentation of findings would also be conducted.

Potential stakeholders

It is proposed that this project could be conducted as part of the Canberra Collaboration. These stakeholders could include:

- Justice Health, ACT Government Health Directorate
- AOD Policy Unit, ACT Government Health Directorate
- Alcohol Tobacco and Other Drug Association ACT (ATODA)
- Australian Institute of Aboriginal and Torres Strait Islander Studies
- Epidemiology Branch, ACT Government Health Directorate
- National Centre for Population Health and Epidemiology, Australian National University
- ACT Branch, Public Health Association of Australia
- Wiunnunga Nimmityjah Aboriginal Health Service

Some key considerations

- Identify a researcher or researchers able and willing to undertake this project in a timely manner
- Determine who would own and be able to use the intellectual property brought into existence through the data analysis and ATOD report preparation
- Secure access to the unit record dataset through the Epidemiology Branch, ACT Government Health Directorate
- Identify a source of funding for the project

Funding estimates

Approximately $20,000 will be required to undertake the project. Significant in-kind resources will be provided to support the project, for example from ATODA, the researchers who developed the survey instrument and collected the data, and from ACT Justice Health regarding health policies and services at the AMC.

Next steps

Proposal was presented to the ACT ATOD Strategy Evaluation Group and the ACT Government Health Directorate and the AMC Health Policies and Services Advisory Group in early 2012 for their consideration.

For further information regarding this proposal please contact Carrie Fowlie, Executive Officer, ATODA, on carrie@atoda.org.au or (02) 6255 4070.

ATTACHMENT 1: Background and context

Prison inmate health[1]

On 30 June 2010, there were 29,700 prisoners in Australian prisons. Of these prisoners, 203 were inmates in the Australian Capital Territory (ACT) which represents less than one per cent of the nation's prisoners. The ACT's imprisonment rate decreased by 8% between 1999 and 2009 (from 81 to 75 prisoners per 100,000 adults).

Prison inmates are characterised by disadvantage, with histories of disrupted family and social backgrounds; abuse, neglect and trauma; poor educational attainment and limited employment opportunities; unstable housing; parental incarceration; juvenile detention; dysfunctional relationships and domestic violence; and previous episodes of imprisonment. With such multiple risk factors for poor health, it is hardly surprising that prison inmates are further characterised by physical and mental health far below that enjoyed by the general population.

Inmate Health Survey background and context[2]

In 1996, 2001 and 2008, NSW Corrections Health Service/Justice Health conducted Inmate Health Surveys to investigate the health status of the NSW prisoner population. These surveys provide comprehensive descriptions of prisoner health, covering issues such as drug use, bloodborne viruses and other infectious diseases, mental health, the relationship between physical and mental health, cardiovascular disease, Aboriginal and Torres Strait Islander health, intellectual disability, access to health services, smoking, and oral health. Similar but limited surveys have been conducted in Victoria, Queensland and New Zealand.

The 2010 ACT Inmate Health Survey was conducted by the ACT Government Health Directorate and was the first survey conducted in the ACT prison, the Alexander Maconochie Centre (AMC). In November 2011 the *ACT Inmate Health Survey 2010: Summary Results* was released publicly.

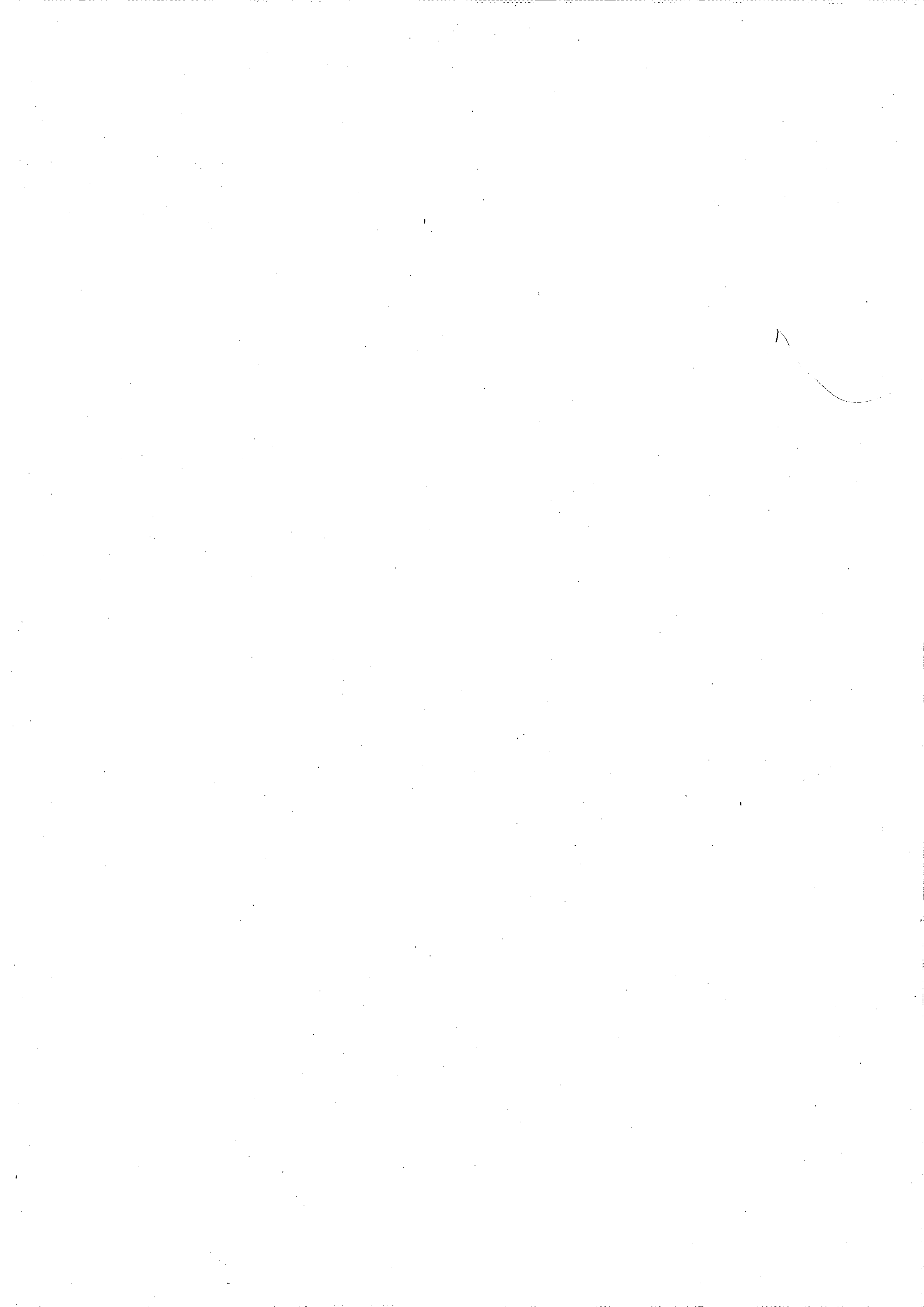
Results from the survey provide evidence to form a baseline assessment of the health needs of prisoners in the ACT. These results can inform the provision of health services and policy development to ensure that health service delivery in correctional facilities meets the needs of the inmate population. However, as a summary document, there is minimal ATOD detail provided. The summary acknowledges this and commits to presenting a series of subsequent reports, including one focused on ATOD results.[3]

Policy context

This initiative links with key policy areas, including the *ACT Alcohol Tobacco and Other Drug Strategy 2010 – 2014*, the Burnet Report, the Hamburger Report, and the AMC Health Services and Policy Advisory Group.

---

[1] Adapted excerpt from ACT Government 2011 *Inmate Health Survey 2010: Summary Results*, http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1321337363&sid=
[2] ibid
[3] ACT Government 2011 *Inmate Health Survey 2010: Summary Results*, p5.



Estimates - QToN No. E12- 617

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Shane Rattenbury MLA on 25 June 2012 : the Attorney-General took on notice the following question:

[Ref: Hansard Transcript 25 June 2012, page 761]

In relation to :

Do the Commonwealth projections for ACT Policing accord with the ACT Government projections?

Mr Corbell MLA : The answer to the Member's question is as follows:–

The ACT Government broad projections, in relation to the ACT Policing Agreement, are generally consistent with the Commonwealth budget estimates for the AFP.

The Commonwealth estimates also include items such as payments from other sources and Capital Upgrade Program funding provided by the ACT Government for ACT Policing facilities.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: Date: 10.7.12

By the Attorney-General, Mr Simon Corbell MLA

Estimates - QToN No. E12-618

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Coe MLA on 5 July 2012: Dr Peggy Brown took on notice the following question(s):

[Ref: Hansard Transcript [5 JULY 2012] [PAGE 25]]

In relation to :

1. Does the system allow multiple logons with the same user name, simultaneous logons?

Ms Gallagher MLA : The answer to the Member's question is as follows:–

1. The EDIS system does allow for multiple logons with the one user name such as in the case of NURSE or DOCTOR.

Approved for circulation to the Standing Committee on Estimates 2012-2013

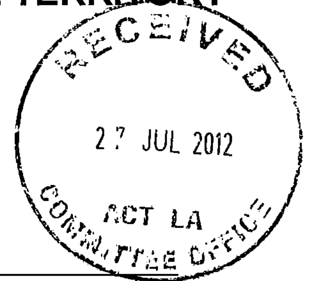
Signature: K. Gallagher Date: 9.8.12

By the Minister for Health, Katy Gallagher MLA

Estimates - QToN No. E12-619

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013



ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Coe MLA on 5 July 2012: Ms Redmond took on notice the following question(s):

[Ref: Hansard Transcript [5 JULY 2012] [PAGE 25]]

In relation to :

1. What information is available that is recorded in the audit trail as it has been configured in the past?

2. So what fields are recorded next to each alteration?

Ms Gallagher MLA : The answer to the Member's question is as follows:–

1. The audit trail notes each entry into the emergency department information system. It records the user name of the person making the entry. In most cases this will be a generic user name. The audit log also provides the date and time of each entry. Some other information is included if relevant for each entry, such as diagnosis code.

2. The audit will identify that a change has been made but will not record what has been changed in the data. The fields shown in the audit trail will vary depending on which tables and fields are affected.

Approved for circulation to the Standing Committee on Estimates 2012-2013

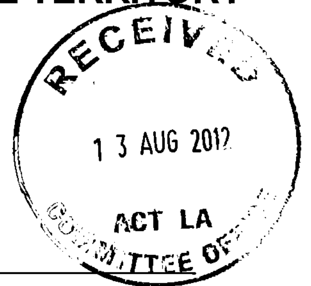
Signature: K. Gallagher Date: 26.7.12

By the Minister for Health, Katy Gallagher MLA

Estimates - QToN No. E12-620

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013



ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Smyth MLA on 5 JULY 2012: Ms Redmond took on notice the following question(s):

[Ref: Hansard Transcript [5 JULY 2012] [PAGES 28 & 29]]

In relation to :

1. How many people actually have a log onto EDIS or the ability to log onto EDIS?
2. Who are those people?
3. What positions would have those individual logons?

Ms Gallagher MLA : The answer to the Member's question is as follows:–

1. As per the ACT Auditor General's Report, Report No 6/2012 on Emergency Department Performance Information Health Directorate 2012 Section 3 Subclause 3.63 *"there are approximately 253 users who have permission to run the software."*

   In line with PWC ACT Health Directorate Emergency Department Information System Data Integrity Summary Report subclause 4.2.1 there are over 240 user ID's.

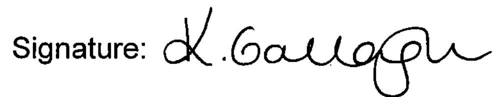
2. Emergency Department staff - medical, nursing, administrative and acute support.

   Staff External to the Emergency Department – medical and nursing in the following areas:
   - Coronary Care
   - Stroke Unit
   - Medical Assessment & Planning Unit
   - Surgical Assessment & Planning Unit
   - Paediatrics
   - Walk-In Centre
   - Oncology
   - Demand Management
   - Senior Staff of multiple Divisions

E12-620

3. As previously stated in Item 1 above there are 253 users. Of these users there are approximately 12 staff who utilise individual logons, these being administrative staff responsible for data validation and system maintenance and medical staff who are undertaking research activities

Approved for circulation to the Standing Committee on Estimates 2012-2013

Signature:  Date: 9.8.12

By the Minister for Health, Katy Gallagher MLA

Estimates - QToN No. E12-621

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Ms Hunter MLA on 5 JULY 2012: Dr Brown took on notice the following question(s):

[Ref: Hansard Transcript [5 JULY 2012] [PAGE 50]]

In relation to :

1. Outside of the ED who can enter the system and change data or enter data?

Ms Gallagher MLA : The answer to the Member's question is as follows:–

Any person who has been fully trained in the capabilities of all screens in EDIS and is not working under a logon that has screens isolated could enter or change data through the EDIS system.

Approved for circulation to the Standing Committee on Estimates 2012-2013

Signature: Katy Gallagher Date: 12.8.12

By the Minister for Health, Katy Gallagher MLA

Estimates - QToN No. E12-622

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Smyth MLA on 5 July 2012: Dr Brown took on notice the following question(s):

[Ref: Hansard Transcript [Estimates 05-07-12 Page 63}

In relation to Mr Smyth's question :

> ".... all they did was check something that occurred after the first day. Does that mean that there are other records that have not been checked, and this problem could be far worse."

Ms Gallagher MLA : The answer to the Member's question is as follows:–

No.

The PwC audit considered changes made from the next day and up to the three day cut off within EDIS following the patient's presentation.

Changes made on the day of presentation were not included in the audit as this would include all legitimate changes made by nursing staff in the normal course of operations.

PwC have advised that there is little risk that intentional data manipulation was missed as part of the methodology given the pattern employed to make unauthorised changes. The unauthorised changes were made following completion of episodes and finalisation of records by the EDIS administration team. As such, there is little chance of a significant number of unauthorised changes occurring prior to the day following presentation.

In addition, audit of changes made on the day of presentation would have identified a large number of amendments that were warranted due to the busy nature of an emergency department and would not fit with the established pattern of data manipulation changes.

The major issue noted in the audit related to unauthorised changes occurring in the days following a presentation and after EDIS administrators had completed their validation procedures.

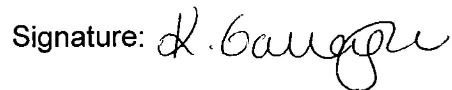
The audit methodology concentrated on changes that resulted in established target time benchmarks being achieved. For example, if a change was made by a generic log in two days after presentation but this change had no positive effect on the seen by doctor time meeting or exceeding a benchmark (eg 30 mins for Triage Cat 3) then this was not included as it did not appear to be intentional data manipulation.

There could be invalid changes made in the total estimated error population that were not intentional data manipulation but are still considered invalid and would be corrected in establishing the revised publicly reported information.

E12-622

The team have also reviewed to ensure this is consistent with the scripts that were run over the EDIS data. The definition of next day was based on calendar days but only picked up a record as invalid if it actually improved the achievement of benchmarks. In that regard, our methodology is conservative and in helping establish the corrected publicly reported information the team will endeavour to apply a 24 hour period as next day, although we don't expect this to have a major impact on the volume of records.

Approved for circulation to the Standing Committee on Estimates 2012-2013

Signature:  Date: 26.7.12

By the Minister for Health, Katy Gallagher MLA

Estimates - QToN No. E12- 623

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Ms Hunter on 26 June 2012 : Mr Rodney Bray took on notice the following question(s):

Ref: Hansard Transcript 26 June 2012 PAGE 979

In relation to : Repairs and Maintenance

Mr Bray: The repairs and maintenance is about 12 and a half million dollars annually, and it is much the same for the capital upgrades program.

MR SMYTH: And you have taken $1 million out of each?

Mr Bray: Over two financial years.

MR SMYTH: Yes.

Mr Bray: So there is a total of $4 million which is contributed to the work.

MS HUNTER: And could you provide on notice for the committee what is covered in those repairs and maintenance?

Mr Bray: The actual repairs and maintenance works?

MS HUNTER: Yes.

Mr Bray: Yes, I can. It is too detailed to go through that, but I can—

Dr Chris Bourke MLA: The answer to the Member's question is as follows:–

Please see attached program of works for 2012-13.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: [signature] Date: 10/7/12

By the Minister for Education and Training, Dr Chris Bourke MLA

E12-623

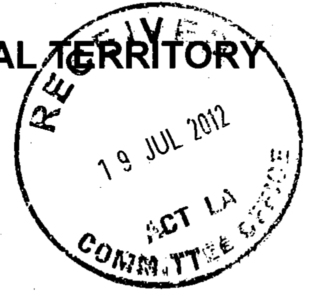
2012 -13 SCHOOLS REPAIRS AND MAINTENANCE BUDGET		
2012-13 Base R&M Budget	**$**	**12,744,000**
2012-13 Supplementary Funding	**$**	**500,000**
BUDGET TOTAL	**$**	**13,244,000**
[illegible]		
Unforeseen Works - Urgent and Minor Maintenance Repairs	$	3,994,000
Specific Works Projects	$	2,400,000
Stage 2 - Fire Protection Systems Upgrade	$	1,000,000
Roof Safety Assess Systems Inspections	$	100,000
HVAC maintenance (including after hours callouts)	$	1,500,000
Fire Protection essential repairs/maintenance	$	190,000
Emergency lighting essential reapirs/maintenance	$	130,000
Lifts/auto doors essential repairs/maintenance	$	100,000
[illegible]		[illegible]

Directorate Contract Management, Reports & Scheduled School Based Management (SBM) Maintenance		
Stage 1 - SBM stormwater and sewer line inspections - gutter cleaning and repairs as identified in CCTV for storm water and sewerage	$	700,000
HVAC contract management	$	700,000
Fire protection contract management	$	410,000
Fire Monitoring	$	150,000
Emergency lighting contract management	$	70,000
Lifts/auto doors contract management	$	200,000
Building Condition Assessment Reports including Tree Reports	$	700,000
Hazardous Materials Surveys Management Plans Survey Reports	$	300,000
Programmed Maintenance - Preschools	$	500,000
Insurance premiums	$	100,000
Sub-Total	**$**	**3,830,000**

TOTAL	**$**	**13,244,000**

Estimates - QToN No. E12- 624

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY



SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by MR DOSZPOT on 27 June 2012 : Mr Stephen Gniel, Executive Director, Learning, Teaching and Student Engagement took on notice the following question(s):

Ref: Hansard Transcript 27 June 2012 PAGE 1027

In relation to : Special Needs Transport – breakdown of how many students are transported to mainstream schools and special schools

MR DOSZPOT: How many students with a disability who attend mainstream schools require special transport?

Mr Gniel: Sorry, that is a total number.

MR DOSZPOT: That is a total number?

Mr Gniel: The total number is 600.

MR DOSZPOT: How many of those would be to special schools?

Mr Gniel: I would have to get those figures for you about the breakdown of who goes where.

MR DOSZPOT: I would appreciate that.

Mr Gniel: We can certainly do that.

DR CHRIS BOURKE MLA: The answer to the Member's question is as follows:–

Currently there are 299 students with a disability transported to special schools by special needs transport.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: [signature] Date: 10/7/12

By the Minister for Education and Training, Dr Chris Bourke MLA

Estimates - QToN No. E12- 625

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

RECEIVED
19 JUL 2012
ACT LA
COMMITTEE OFFICE

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Smyth on Tuesday 26 June 2012: Mr Rodney Bray took on notice the following question(s):

Ref: Hansard Transcript Tuesday 26 June PAGE 975

MR SMYTH: There is a pattern of school expansions. In the works in progress you have got Red Hill primary school, north Watson, Majura primary school expansion, Macgregor primary school expansion and this year we have had a Duffy primary school expansion. In each case, what are we expanding and how many classrooms are we adding?

DR BOURKE: The answer to the Member's question is as follows:–

The planned works at the four nominated ACT public schools are:

1. Red Hill School
   This project involves the expansion of Red Hill School with the construction of an additional six classrooms including two shared learning spaces. This will bring the school to a full four-stream school.

2. North Watson (Majura Primary School)
   This project involves the expansion of the Majura Primary School from 23 classrooms to a full four-stream school with an increase by five teaching spaces.

3. West Macgregor (Macgregor Primary School)
   This project involves the expansion of the Macgregor Primary School from 16 classrooms to a full four-stream school with an increase by 12 teaching spaces.

4. Duffy Primary School
   This project involves the expansion of the Duffy Primary School from 14 classrooms to a full 3-stream school with an increase of seven teaching spaces.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: [signature] Date: 9/7/12

By the Minister for Education and Training, Dr Chris Bourke MLA

Estimates - QToN No. E12- 626

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by MS HUNTER on 27 June 2012 : Mr Stephen Gniel, Executive Director, Learning, Teaching and Student Engagement took on notice the following question(s):

Ref: Hansard Transcript 27 June 2012 PAGE 1026

In relation to : Progress Report on the Disability Education Strategic Plan

MS HUNTER: I also wanted to find out how are we going with implementing recommendations out of the Shaddock review.

Mr Gniel Yes, so you will be aware that there were options provided by the Shaddock review.

MS HUNTER: I was about to say "findings".

Mr Gniel: "Options" was the word. We developed our strategic plan for disability education - excellence in disability that Mr Doszpot referred to earlier - from the options provided by the Shaddock review. We are continuing to implement a number of actions from that strategic plan, one of which you have raised earlier through Therapy ACT. One of the actions within that was to develop an agreement with Therapy ACT for the provision of services. We are also developing that with Health currently. They are some of the ones that, I guess.There is a whole raft of things that we are doing in that space that I can talk about if you would like me to continue.

MS HUNTER: Probably just more generally, but progress reports - are they—

Mr Gniel: Yes, so we provide progress reports to the disability education reference group at the meetings and get some feedback from them on how they see we are going as well. We also provide an annual report to the chief executive - I cannot remember whether it was the director-general or chief executive at that time - around the first year of that process. We will be doing that again in the coming months as well.

MS HUNTER: Are those reports publicly available?

Mr Gniel: No, that one was not. Actually, sorry, I think it is on the website. I would have to check, Ms Hunter.

MS HUNTER: Is it on the website?

Mr Gniel: Yes, I can check for you.

E12-626

DR CHRIS BOURKE MLA: The answer to the Member's question is as follows:–

The Disability Education Reference Group monitors the implementation of *the Excellence in Disability Education in ACT Public Schools Strategic Plan 2010-2013* and provides feedback on disability education matters. Presentations on the progress of the Plan are given to the Disability Education Reference Group at their term meetings, the minutes of which are on the Education and Training Directorate's website at the following link:
http://www.det.act.gov.au/school_education/disability_education/disability_education_reference_group

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: Date: 10/7/12

By the Minister for Education and Training, Dr Chris Bourke MLA

Estimates - QToN No. E12- 627

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by MR HARGREAVES on Wednesday 27 June 2012: DR BOURKE, Minister for Education and Training took on notice the following question(s):

Ref: Hansard Transcript Wednesday 27 June 2012 PAGE 1036

In relation to : List of people who participated in the roundtables held by the Minister about the Review of Funding for Schooling.

MR HARGREAVES: Yes. Because you rattled that off rather quickly, could you give us a list of those people who participated in the roundtables so that we can put it through the system?

DR BOURKE: The answer to the Member's question is as follows:–

- Australian Education Union
- Independent Education Union
- Association of Independent Schools
- Catholic Education Office
- ACT Principals' Association
- Teacher Quality Institute
- ACT Council of Parents and Citizens Associations
- Associations of Parents and Friends of ACT Schools
- Government Schools Education Council
- Non-government Schools Education Council
- Canberra Preschool Society
- Aboriginal and Torres Strait Islander Education Consultative Body
- Christian Schools Australia

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: [signature] Date: 10/7/12

By the Minister for Education and Training, Dr Chris Bourke MLA

Estimates - QToN No. E1228

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by MS BRESNAN on 27 June 2012 : Mr Stephen Gniel, Executive Director, Learning, Teaching and Student Engagement took on notice the following question(s):

Ref: Hansard Transcript 27 June 2012 PAGE 1029

In relation to : The number of students with a disability from both mainstream and special schools graduating in 2012.

THE CHAIR: We can spend a bit more time specifically on disability education and then move specifically to non-government, but there is crossover, as we have seen this morning. I want to ask a couple of questions. We have already talked about post-school options a bit today. I want to ask some more questions specifically around that. I think that last year's annual report, and the hearings, indicated that 40 students with disability were leaving school at the end of the year. That was last year. Do you have a figure for how many students from both mainstream and special schools will be graduating this year?

Mr Gniel: I do not have that figure, but I can certainly get that for you quite quickly.

DR CHRIS BOURKE MLA: The answer to the Member's question is as follows:–

Currently there are 92 year 12 students accessing Disability Education programs who will graduate in 2012. Of these, 32 are attending a specialist school and 60 are attending a mainstream school.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: [signature] Date: 10/7/12

By the Minister for Education and Training Dr Chris Bourke MLA

Estimates - QoN No. E12- 629

LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2012-2013

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by MR HARGREAVES : Mr Whybrow took on notice the following question:

Ref: Hansard Transcript Wednesday 27 June 2012 PAGE 1052

In relation to : Interest Subsidy Scheme – list of schools still utilising.

1. Can we have a list of the names of the schools that are still receiving the ISS (Interest Subsidy Scheme) please?

DR BOURKE : The answer to the Member's question is as follows:–

1. The details of schools receiving funding under the Interest Subsidy Scheme is confidential under the individual Deeds of Grant with each school and association. However, the Deed does allow the information to be provided to Legislative Assembly Committees. The information should therefore not be disclosed outside of the Select Committee on Estimates. The list below shows the schools and organisations that held current Interest Subsidy Scheme loans in 2011-12:

   - Catholic Education Office
   - Orana Steiner School
   - Trinity Christian School
   - Radford College
   - Canberra Girls' Grammar
   - Marist College
   - Daramalan College
   - St Edmunds College
   - Covenant College
   - Canberra Grammar School
   - Burgmann Anglican School
   - Emmaus Christian School
   - Canberra Montessori School.

All loans to Catholic systemic schools are administered through the Catholic Education Office.

Approved for circulation to the Select Committee on Estimates 2012-2013

Signature: [signature] Date: 19/7/12

By the Minister for Education and Training, Dr Chris Bourke MLA