QTON No. E12-616

ATODA
Alcohol Tobacco & Other Drug Association ACT

Ms Sam Salvaneschi
Secretary
Select Committee on Estimates 2012-2013
Committee Office, ACT Legislative Assembly
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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,

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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).

Results about future NSPs

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]

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[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.

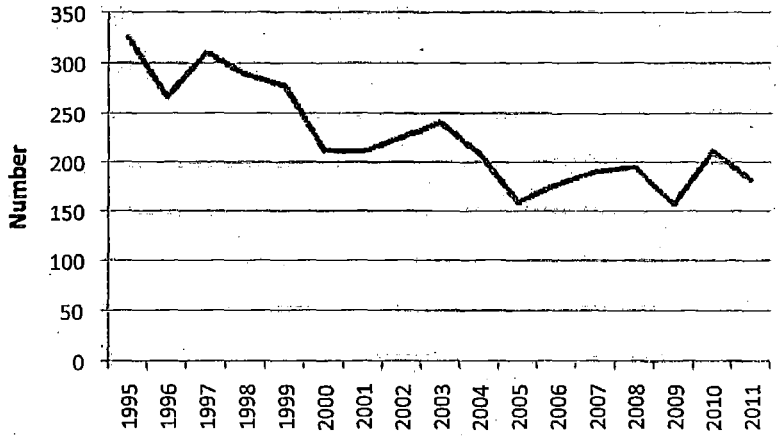
Figure 5 shows trend data derived from the National Notifiable Diseases Surveillance System that operates under the auspices of the Communicable Diseases Network Australia. As the managers of the Surveillance System explain:

> 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

Hepatitis C notifications, ACT, 1995 to 2011



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.

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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.

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Australian Government

Department of Health and Ageing

ATODA
Alcohol Tobacco & Other Drug Association ACT

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

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ATODA
Alcohol Tobacco & Other Drug Association ACT

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.

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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.

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[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=

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[3] ACT Government 2011 *Inmate Health Survey 2010: Summary Results,* p5.