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CAPITAL TERRITORY
GOVERNMENT

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

INQUIRY INTO SUBSTANCE ABUSE IN AUSTRALIA

ACT GOVERNMENT SUBMISSION

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TERMS OF REFERENCE FOR THE INQUIRY

In view of the level of community concern about the abuse of licit drugs such as alcohol, tobacco, over-the-counter and prescription medications, and illicit drugs like marijuana and heroin, the Standing Committee on Family and Community Affairs was requested by the Minister for Health and Aged Care, the Hon Dr Michael Wooldridge, MP, to report and recommend on:

The social and economic costs of substance abuse, with particular regard to:

- *family relationships*
- *crime, violence (including domestic violence), and law enforcement;*
- *road trauma;*
- *workplace safety and productivity; and*
- *health care costs.*

The ACT Government welcomes the opportunity to provide a submission to the House of Representatives Standing Committee on Family and Community Affairs inquiry into substance abuse in Australian communities. Substance abuse is a complex issue and one for which there are no easy answers. The ACT's approach has been one of harm minimisation and balance, with an emphasis on partnerships between the government and the whole community. It acknowledges the shared responsibility of improving and enhancing the safety and wellbeing of the community.

In this submission, data has been provided directly for the ACT, and is placed within a national context. Information is also provided from an international perspective. The Inquiry may find this useful to assist in further developing an Australian perspective.

THE SCOPE OF SUBSTANCE ABUSE

The problematic use of substances – including tobacco, alcohol, pharmaceutical products, inhalants, performance and image enhancing drugs (PIEDS), cannabis, heroin, and other illegal drugs – is one of the most significant social and public health issues facing Australia today. Nearly one in five deaths in Australia is substance-related. Researchers have estimated that during 1998, approximately 22,500 Australians died from substance-related causes and 175,000 were hospitalised as a result of conditions caused by harmful drug use (Single and Rohl 1997). It is conservatively estimated that the cost of harmful drug use to the Australian community is more than $18 billion each year (Collins and Lapsley 1996).

The harms associated with the problematic use of substances extend to the spread of blood-borne viruses, family and social disruption, attempted suicide, school and workplace problems, violence and crime and mental health problems.

These harms are spread widely throughout the community. Both those who use and misuse substances and those who do not are affected in a variety of ways. Indeed, the risk of suffering some harm, however indirectly, affects every person in the ACT to some degree.

THE GOVERNMENT POLICY CONTEXT

The ACT Government has a vision for Canberra as a 'clever, caring community'. With this in mind, the Government is committed to enhancing the health, well being and safety of the community. This includes reducing the harmful consequences associated with the use of all drugs.

The policy context for the ACT Government's approach to alcohol and other drug use is found in the *ACT Drug Strategy 1999 "From Harm to Hope*" which may be seen at Attachment A.

From Harm to Hope acknowledges that the health, economic, social and personal harms caused by alcohol, tobacco and other drugs are a major challenge for the ACT. The harms associated with the misuse of drugs are real and costly, both to the individual and the community.

The *ACT Drug Strategy 1999* outlines broad directions and provides a basis for coordinated action through drawing together the various initiatives to be undertaken in the areas of health, education, law enforcement, community safety and the environment.

The strategy emphasises a partnership between government agencies, non-government agencies and the community in addressing the complex issues surrounding alcohol and other drug use.

Through links with appropriate agencies and stakeholders, *From Harm to Hope* aims to:

- reduce the supply of harmful drugs;
- reduce harmful drug using behaviour and use of harmful drugs;
- reduce the demand for alcohol and other drugs, especially among young people; and
- minimise the harms to the individual and society associated with the use and misuse of alcohol and other drugs.

The *ACT Drug Strategy 1999* has been developed in the context of the *National Drug Strategic Framework 1998-99 to 2002-03* (MCDS 1998). The national framework contains two operating principles that are important foundations for the *ACT Drug Strategy 1999*, namely harm minimisation and social justice.

The *National Drug Strategic Framework 1998-99 to 2002-03* (MCDS 1998) defines the principle of harm minimisation as follows:

> *Harm minimisation aims to improve health, social and economic outcomes for both the community and the individual and encompasses a wide range of approaches, including supply reduction, demand reduction and harm reduction strategies.*

A harm minimisation approach involves preventing anticipated harms of alcohol and other drug use as well as reducing the actual harms of alcohol and other drug use. Harms to the individual or community may be in the areas of health, impact on the environment, public safety or nuisance, or crime.

The drug strategy is consistent with the ACT Government's vision and directions for health, as outlined in *Setting the Agenda - a Healthy Community*. This document provides a detailed framework for achieving a healthy, safe, diverse and contributing community, which is supported by accessible, cost-effective services (Attachment B).

The ACT Department of Health and Community Care funds a wide range of Government and non-Government agencies to assist people with issues around problematic drug use. A summary of current alcohol and drug service provision in the ACT is provided at Attachment C.

THE SOCIAL AND ECONOMIC COST OF SUBSTANCE ABUSE

FAMILY RELATIONSHIPS

CRIME, VIOLENCE & LAW ENFORCEMENT

ROAD TRAUMA

WORKPLACE SAFETY AND PRODUCTIVITY

HEALTH CARE COSTS

FAMILY RELATIONSHIPS

Overview

The use and misuse of drugs is a major community health problem. Many drugs cause harm to individuals, their families and the wider community. As outlined in *Drug Policy 2000: A New Agenda for Harm Reduction* (ADCA, April 2000), the family can play a major role in the prevention of alcohol and other drug problems, and can also play a significant role in assisting with the treatment of problems.

Tobacco use has a considerable impact on families as a result of smoking-related illness and death. The more than 18,000 deaths and 800,000 hospital bed days in Australia each year related to smoking represent emotional and financial stress for thousands of families.

In addition, recent research in the USA has detailed how tobacco use leaves thousands of young people without a mother or father, with a sizeable impact on tax-funded social security survivors insurance (Leistikow et al, 2000). For example, deaths from cardiovascular disease and cancer are common in smokers of child-rearing age, and one-quarter of smokers die during middle age.

Previously published studies have under-estimated or not included the impact of smoking-attributable deaths on children and the costs of insurance payments to survivors.

The study estimated that, for the USA in 1994, smoking-related deaths from cancer, stroke, heart or lung disease left 31,000 children without a father and 12,000 without a mother. Such losses are estimated to cost taxpayers approximately US$4 billion a year in survivors insurance taxes, in addition to the short-term and long-term emotional toll.

As the authors of the study note:
'The death of a parent is one of the most traumatic experiences a youth may have. Up to 40 percent of bereft children show emotional disturbance a year after the death of a parent, and over a longer term, such children may have a five-fold increase in childhood psychiatric disorder. Studies also suggest that adults who lost a parent in childhood are more vulnerable to depression, anxiety, attempted suicide and post-traumatic stress disorder.'

Current Service Provision

The ACT Government funds a wide range of educational and family support services to children and families in the ACT. These services can assist families deal with substance abuse issues.

The ACT Government recently launched a progressive initiative designed to further support, and ultimately strengthen, Canberra families. The ParentLink program recognises the importance of families and the difficult challenges they face and comprises a range of initiatives to connect parents with information and support services in the ACT, including a telephone and internet information service.

It should also be recognised that drug education and support is an issue which affects and involves the school community. The school environment is one in which the use and misuse of illegal drugs is prohibited.

All ACT schools must attend to drug education within the Health and Physical Education Framework established by the Department of Education and Community Services. ACT schools have relative autonomy over the specifics of curriculum development around drug education. Curriculum development is supported by annual professional development offered to teachers in ACT primary, secondary and college level schools and the Department of Education and Community Services acts as a central resource to assist teachers with selection of resources and policy/protocol development.

Recognising the need for school communities to work together to develop effective drug education programs, the ACT Department of Education and Community Services established the *Drug Education Framework for ACT Government Schools*. The Drug Education Framework aims to provide direction for schools to develop their own drug education strategy including the development of protocols on drug incidents in schools.

Protocols developed by schools for managing drug incidents need to be in line with the National Framework for Protocols for Drugs in Schools. A memorandum of understanding exists between the ACT Department of Education and Community Services and Australian Federal Police – ACT Policing to assist schools to develop their own protocols.

Most non-government alcohol and drug services in the ACT have an education component to their service, targeted at their particular interest group. In addition, the

ACT Government alcohol and drug program conducts ongoing drug education, primarily through its health promotion unit.

The National Initiatives in Drug Education project (NIDE), initiated by the then Commonwealth Department of Health and Family Services, has also provided schools with research and up to date resources on drug education.

Opportunities for Change

Parent Education Opportunities

As in other jurisdictions, research indicates that young people in the ACT can experiment with drug use at an early age. *The ACT Secondary Schools Survey 1998* indicates that by year 7:

- 32% of females and 10% of males reported having used marijuana;
- 30% of males and females reported having used inhalants;
- 8% of females and 3% of males reported having used narcotics.

The Department of Health and Community Care has received Commonwealth support for a proposal under the Council of Australian Governments Supporting Measures "Coping with Illicit Drugs" measure. This proposal is providing parents with the skills to handle drug-related issues in the family context. An important secondary objective of this proposal is the enhanced capacity of community service providers to deliver targeted skills development to families who are affected by or vulnerable to the harms related to illicit drug use.

Initiatives being funded by the Commonwealth Department of Education, Training and Youth Affairs (DETYA) under the COAG 'Tough on Drugs in Schools' initiative and the National School Drug Education Strategy are being developed in 2000 by the ACT Department of Education and Community Services (DECS). These include local school-community drug summits and the National School Drug Education Project.

Residential Support for Drug Affected Families

Commencing 2000/01, the Department of Health and Community Care will provide funding to the Alcohol and Drug Foundation of the ACT (ADFACT) for the provision of child and family psychosocial support. ADFACT manages a suite of residential programs for people with problematic drug and alcohol dependency. The primary service is Karralika, a 50 bed therapeutic community but the organisation also manages 4 half way houses – 1 for women and children (including a childcare centre to enable the resident women to attend treatment during the day), 1 for families and 2 for men.

Karralika is divided into 2 campuses – one at Isabella Plains and one at Fadden (for women and children). Fadden also has a childcare centre to enable the resident women to attend treatment during the day. This is the only facility of its kind in Australia.

The childcare facility is fully accredited and appropriately staffed. It currently looks after an average of 10 pre-school children each day and a number of older children at after school care.

The proposed funding will provide a part time child psychologist and a part time family therapist to work with the children of the Karralika and half way house residents as well as with the families as a whole. The proposal will also support specific funding for the continuation of the accredited childcare centre at Karralika for the use of residents of both Karralika and the family half way house.

Future broad directions include a greater emphasis on coordination with appropriate support from drug and alcohol agencies, provision of specialised accommodation for support agencies, increased awareness of the impact of substance abuse (eg: education of housing managers), introduction of early intervention strategies and investigation of semi-supported accommodation options.

CRIME, VIOLENCE AND LAW ENFORCEMENT

Overview

Access to consistent and quality data as well as the inability to bring the sources of data together has been problematic in the ACT (as elsewhere in Australia) in determining the nature of the relationship between drugs and crime. To address this issue and to avoid overlap and duplication across governments, national data collections are being progressed and refined to produce specialised data which directly links crime and drug use.

While a correlation between crime and drug use can be established, what is less clear is the causal effect of that relationship.

Tobacco has been identified as a 'gateway drug', the use of which has been associated with progression to the use and abuse of other drugs (US Dept. of Health and Human Services, 1994; Lindsay et al, 1997; Torabi et al, 1993; Kandel et al, 1992). Because of this, efforts aimed at minimising the risk of children becoming regular smokers can reduce the likelihood of their going on to use and abuse drugs.

The direct relationship between tobacco use and crime is minimal. Unlike the situation with illicit drugs, adults with a nicotine dependence do not have to break the law to obtain their drug of choice: it is freely available. There are, however, cases of businesses having decided to stop selling cigarettes because cigarettes have made them the target of constant break-ins. In the ACT, legislation in effect since 1991 has prohibited the sale of tobacco products to people under the age of 18; the purchase of tobacco products for use by someone under the age of 18 is also illegal.

Economic Cost

The Legal Aid Office estimates that 70% of its criminal law budget is spent in representing people who are abusing licit and illicit drugs. Cases involving substance abuse take longer, often requiring an assessment by the Treatment Referral Panel and pre-sentence reports.

The clients often have multifaceted issues which do not allow for speedy instructions, understanding of the court process and so on, and their problems are often more than simply criminal. For example, substance abuse can be evident in domestic violence issues, family law matters and the like.

According to ACT Corrective Services, the average cost of remandees held at the Belconnen Remand Centre is $5,561,780 per year. Detainees at the Periodic Detention Centre cost $858,283 per year. Projected costs for ACT prisoners in NSW jails in 99/00 is $7.6 million while the cost of offenders on community based orders is $2.4 million per year.

The average percentage of offenders with drug offences as the primary offence is 10.6%. This translates to drug-related offenders specifically costing an estimated $1.6 million per year. This figure, however, is a very conservative estimate as offenders are often convicted of numerous offences in which the drug-related offence is not the primary offence.

During 1998/99 in the ACT, victims of crime were given compensation in the order of $9 million. The percentage of these claims relating to victims of drug-related crime cannot be determined.

Current Service Provision

ACT Government and non-government agencies participated in a pilot project, *Limiting the Impact of Illicit Drug Use in the ACT* (1998, unpublished). Aspects of this report were considered confidential and as such, it has not been publicly released. However, a summary of the major findings follows.

One of the study's key aims was to connect drug use to criminality and harm using, as the sample group, regular illicit drug users who accessed ACT drug services. The study's research supported a 'drug-use-plus-disadvantage-exacerbates-crime' model rather than a simple 'drug-use-causes-crime' model.

Consistent with findings in other jurisdictions and nationally, the illegal drug users in the ACT were concentrated mainly between about 17 and 30 years of age, but with smaller numbers in their 30's and 40's. There were more male than female users (3:2 male/female ratio) with males deviating more frequently, and on average more seriously than females from both social norms and legal requirements. Females in the study, however, were more likely to report being victimised and males victimising others – a familiar pattern in crime generally – although both groups reported high levels of being victimised and victimising others.

A substantial number of illegal drug users in the study reported criminal involvement to support a drug habit as well as being charged for criminal activity. Furthermore, the trend over time was towards rising proportions being involved in crime to obtain drugs (this figure rose from less than 40% in 1994 to over 60% in 1998) and in being charged (from almost 40% in 1994 to about 50% in 1998). The ACT criminality data examined in the study also showed a considerable level of female involvement in crime to obtain drugs with 41% being females and 56% being males.

The illegal drug users in the study sample were also more subject to various forms of social harms and rising levels of health problems. They were less likely to be employed than the majority of the population (about 35% were unemployed in 1994 increasing to almost 60% in 1998). Many were homeless or in insecure accommodation (about 35% in 1994 which had risen to over 50% in 1998). Assaults among the group had also increased from about 25% in 1994 to about 40% in 1998.

The study also found a group of illegal drug users who used alcohol as well. The link between alcohol intoxication and crime, were similar to people who only drank excessively but were not illegal drug users, that is, their drunken behaviour were linked to violence, disorder and drink driving.

However, the study also revealed that illegal drug users were also linked to crime because of their use of illicit drugs. While intoxicated, they may have become involved in property crime to some extent, in public disorder and in robbery. According to the study, while only a few of the convicted burglars committed robberies, the robberies that did occur were committed by those with an illegal (mainly heroin) dependency.

Highlighted also in the study was the fact that illegal drug users were disproportionately involved in direct drug crimes such as possession and supply. The study concluded that this arose directly from the context of use and the lifestyle of the population.

The study also found a number of people in the ACT, mainly males aged 17-30, who were not part of the illegal drug using group, but who drank to excess either regularly or occasionally. Their drunken behaviour linked to crime in three ways: violence (probably including violence against women/violence in the home), public disorder and drink driving.

Another ACT study commissioned by the Department of Justice and Community Safety was the *ACT Residential Burglary and Attempted Residential Burglary Research Study* (December 1999, unpublished). This report is currently awaiting Ministerial approval to allow for public release.

The research touched on, among other things, drug use among convicted adult burglary offenders and its impact on the offences they committed.

Outcomes of the interviews with fifty convicted adult burglars found that the largest group of convicted burglars committed their crimes to support a heroin habit (64%). This was supported by the 1996/97 NRMA Report which suggested a conservative estimate that about 60% of residential burglaries are committed to fund a drug habit. The second largest group of burglary offenders interviewed maintained strong alcohol habits, and stole either for alcohol, or for the money to buy it.

Most of the burglars interviewed usually undertook burglaries most days if it was to fund their heroin dependency. Other burglars would burgle only once or twice a week to buy their weekend alcohol or to supplement a low income.

There was also a strong link to other criminal activity, particularly break and enter of commercial premises and car theft. If the offender did not undertake car theft for their burglary activities, some were stealing cars regularly as a form of transport for personal use. Several of the offenders reported stealing up to 100 or more cars a year. However, several of the offenders avoided car stealing and commercial premises break and enter altogether.

Although not quantified in the ACT with convicted adult residential burglars, the qualitative findings suggest a similar pattern in the ACT as found by the NSW Bureau of Crime Statistics. The Bureau found that adults and heroin users were more likely to sell stolen goods to legitimate businesses than juveniles and non-users of heroin.

Another interesting find from the interviews was that while some offenders admitted being under the influence of alcohol at the time of the burglary, the majority were under

the influence of other drugs (such as heroin, speed or rohypnol). They maintained the drugs 'heightened the senses' and gave them the courage to commit the burglary. The use of alcohol, however, was considered by the convicted burglars to increase the chance of being caught.

Opportunities for Change

The Council of Australian Governments agreed to a national approach to address illicit drug use in April 1999. Diversion by police of individuals in the early stages of their drug use away from the criminal justice system and into assessment and treatment was one of the key measures agreed by COAG.

The Department of Health and Community Care, in collaboration with the Department of Justice and Community Safety, Department of Education and Community Services and the Australian Federal Police, is developing a proposal for a police early diversion scheme that is consistent with the national criteria and complements current and proposed ACT diversion policy and practice. The Director of Public Prosecutions (DPP) has also been consulted in the development of this proposal.

The proposed scheme allows three streams. In the first stream, offenders would continue to be provided with educational material about the effects of cannabis by the police officer issuing the Simple Cannabis Offence Notice (SCON).

The second stream would provide an opportunity for people who commit an offence involving illicit drugs other than cannabis (and possibly serious cannabis abusers) to link in with existing drug assessment, education and treatment service systems. This would provide people with early incentives to address their drug use problem, in many cases before incurring a criminal record.

The third stream would involve the retention and expansion of the court-based diversion option through the *Drugs of Dependence Act 1989* Treatment Referral Program or, alternatively, as a condition of bail.

With regard to victims of crime, the ACT is currently reviewing its victims' assistance scheme with a view to introducing a scheme which ensures that victims injured by crime are given assistance (rather than just financial assistance) to address their health, practical and emotional needs.

The ACT Government has recently identified and funded three priorities for drug related law enforcement purposes:

1. With the development of the Police Diversion proposal, a one-year position has been established within the Australian Federal Police ACT Region to administer, monitor and coordinate the diversion program;

2. To reduce harms associated with alcohol and drug use to offenders, their families and the community as a result of drug related crime, the ACT Government is proposing to pilot a court-based alcohol and drug assessor to conduct immediate assessment of the offender before sentencing, develop treatment plans and negotiate access to treatment;

3. Funding has been made available for the provision of an information kit to be provided at the City Watch House for people who have been detained under the *Intoxicated Persons Care and Protection Act 1994*. Upon leaving the Watch House, people will receive the information kit which will include information about the Act, a bus ticket and a phone card for a small amount.

ROAD TRAUMA

Overview

Drink driving is second only to speeding as a contributing cause of road accidents. In the ACT, about 20% of all crashes involve drink driving, and such crashes cost our community around $35 million a year.

Between 1993 and 1997 an average of 21 people died in the ACT annually due to motor vehicle traffic accidents. Forty five per cent of those killed were the driver of the motor vehicle and 42 per cent involved colliding with another motor vehicle.

Australian Federal Police – ACT Region data indicates that for the year ending June 1996, 1604 drivers were charged with exceeding the random breath testing limit (at a rate of 11.7 per 1000 Random Breath Tests); for the year ending June 1997, 815 drivers were charged (7.3 per 1000 tests); and for the year ending June 1998, 1018 drivers were charged (7.1 per 1000 tests). These figures provide some indication of the extent of problem alcohol usage in the ACT.

The impact of tobacco use on road trauma, although not an area of major research, has received some attention in Australia and elsewhere. Some studies have indicated that tobacco smoking may have a detrimental effect on night driving, (Brison, R.J, 1990) and that drivers who smoke are more likely than non-smoking drivers to be involved in an accident.

Although there have been some incidents where smoking material itself has led to accidents, there is a growing consensus that risk-taking behaviour (which characterise people who smoke and those who engage in risk-taking while driving), rather than the activity of smoking (or searching for dropped cigarettes) is the more likely explanation. We are not aware of any quantification of the impact of tobacco use on road trauma.

Since December 1994, legislation has prohibited smoking on public transport vehicles in the ACT.

Economic Cost

According to the National Alcohol Indicators Bulletin No. 2 (May 2000), alcohol is a major cause of road injury in Australia, with the average cost of a single road fatality or hospitalisation in Australia estimated at about $750,000 and $132,000 respectively.

Current Service Provision

Legislation adopted in the ACT in 1998 allows the court to give drink driver offenders the option of attending a drink-driving rehabilitation course at the offenders expense. Program completion and fees paid are taken into consideration by the court when assessing the level of fine and other penalties.

The Alcohol and Drug Foundation of the ACT (ADFACT) has been conducting Drink Driver Education Programs (DDEP) since 1995. The DDEP is an 11 week education/rehabilitation program for drink drivers. It aims to prevent drink driving through the provision of accurate information about alcohol and driving, the harmful use of alcohol and through the development of appropriate skills and attitudes.

The ACT Policing Traffic Enforcement and Road Safety Plan sets out the monthly focus for enforcement action. These strategies include the Snowsafe campaign in liaison with NSW Police, back to school campaigns and the targeting of specific offences under the relevant legislation.

The main drink driving countermeasure is police traffic enforcement, particularly random breath testing. The 1999 to 2001 AFP ACT Region Traffic Law Enforcement Plan aims to breath test one in two drivers each year. This testing has helped to keep the ACT drink driving rate at the very low level of 0.8% of motorists tested.

Random Breath Tests	**1997-98**	**1998-99**
Number of screening tests conducted	142,894	103,936
Exceeding the Prescribed Concentration of Alcohol (PCA)	949	633

Whilst the number of Random Breath Tests conducted in 1998-99 against the previous reporting period was down, the reduction in positive test results may be early evidence that the community is reacting to the dangers of drink driving.

WORKPLACE SAFETY AND PRODUCTIVITY

Overview

Substance abuse in the workplace affects not only the safety and productivity of the individual concerned, but the workplace as a whole.

A number of Australian and overseas studies have found that workers who smoke are at increased risk of workplace accidents, suffer more days off work due to ill health, and are less productive at work due to time spent smoking. Major overseas employers have found that adopting 'wellness programs' for workers has increased both morale and productivity.

In the ACT, the widespread adoption of non-smoking as normal practice in workplaces, both voluntarily and as a result of an occupational health and safety code of practice, has been achieved by focusing on *where* people smoke rather than *whether* they smoke.

A number of recent studies (Chapman et al, 1999; and Chakoulpa & Warner 1999) have found that smoke-free workplace smoking policies do have a marked impact on tobacco consumption by reducing opportunities to smoke, and there is increasing evidence that these policies may also serve to reduce smoking prevalence (ie, the proportion of people who smoke).

It should also be noted that, with regard to the provision of a smoke-free environment for a person with a respiratory impairment, the Human Rights and Equal Opportunity Commission had determined that the failure to provide a smoke-free environment for patrons is a breach of the Commonwealth's Disability Discrimination Act (HREOC, 1997).

In addition, there have been numerous out of court settlements and one court case which found that workers were entitled to compensation for illness or death attributable to their exposure to tobacco smoke (Chakoulpa & Warner 1999; Winstanley et al 1995).

Economic Cost

Workplace costs of drug abuse can be categorised as resulting from either as a result of alcohol and other drug use for Australia in 1992 was estimated at $5624.4 million annually (Collins and Lapsley, 1996). This amount may be extrapolated to the ACT using the data presented in the report and population numbers for the ACT.

Collins and Lapsley have take into account absenteeism and reduced productivity, but have not taken into account the cost associated with injuries, diseases and deaths as a result of the use of tobacco, alcohol and drugs at the workplace. Nor has the report taken into account inspection of workplaces by regulators of occupational health and safety legislation who follow up injury and dangerous occurrences in workplaces.

Current Service Provision

In the ACT, there are no Regulations in relation to drugs or alcohol under the ACT *Occupational Health and Safety Act 1989*; nor is there a specific Code of Practice approved under the Act. There is reference to drugs and alcohol in the approved Code of Practice for the ACT Sex Industry (Section 13, "Drug & Alcohol Policy"). This section recommends employers and/or operators establish a drug and alcohol policy.

A number of workplaces in the ACT have their own drug and alcohol policies incorporated into occupational health and safety policies. The Construction Union (CFMEU)has recognised the benefits of drug and alcohol policies within workplaces and has negotiated to have these policies included in enterprise bargain agreements.

As an example, the Building Trades Group has a specific industry-based program aimed at introducing awareness of the hazards of drug and alcohol usage in workplaces. This group is self-funded except for a small portion of funding provided by Healthpact.

Employee assistance programs (EAPs) also provide assistance to employers, employees and their families in dealing with alcohol and work-related concerns.

Opportunities for Change

The need for a Regulation under the *Occupational Health and Safety Act 1989* in relation to smoke-free work places to complement the *Smoke Free Areas Act (Enclosed Places) 1994* and to give force to the Smoke Free Work Places Code of Practice could be examined. It could be beneficial to further develop Regulations and/or Codes of Practice relating to drug and alcohol use in the workplace, as well as continued support for employers to incorporate drug and alcohol policies into their occupational health and safety policies.

HEALTH CARE COSTS

Overview

The total costs of tobacco use in Australia are estimated to be $12.7 billion per year. Given the lack of sufficient ACT-specific data, the estimate of the total costs of smoking to the ACT, derived from national estimates (by Collins and Lapsley 1996) and not taking into account other factors, would be approximately $20 million (assuming ACT population is 1.6% of national population).

The health care costs of tobacco use have been examined in studies prepared in Australia and elsewhere, with a number having been published over the past five years. The issues highlighted by Warner and Chaloupka (see *Supplementary Paper on the Social and Economic Cost of Tobacco Use* at page 43) deserve special consideration. Recent studies have also begun to shed light on the health care costs of passive smoking, which has a particular impact on infants and young children, as well as on people with pre-existing ailments and conditions (NHMRC 1995). The extent to which health care costs are preventable and savings may be made through both primary prevention and reducing adult smoking has also received increasing attention (Lightwood & Glantz, 1997).

Particular issues which perhaps have not received sufficient attention in relation to health care costs include:

- Evidence that smoking by young people is associated with significant health problems during childhood and adolescence, including detrimental effects on the lungs and cardiovascular system (US Dept. of Health and Human Services, 1994).
- In smokers aged 35-44, nearly three-quarters of coronary heart disease deaths are due to smoking, and heart attacks among people in their 30s and 40s are 5 times more likely in smokers than in non-smokers (Holman et al 1994 and Doll et al 1994).
- Emerging evidence that increased risk of osteoporosis, especially in men, is associated with smoking during childhood and adolescence (Valimak et al, 1994).
- Recent studies which suggest that long-term smoking accelerates the process of rheumatoid arthritis and that the longer a person smokes, the worse their joints may become (Saag, 1997).
- Findings that tobacco use is a modifiable risk factor which increases heath care changes from 18%- 26%, after controlling for other factors (JAMA, 1999).
- Smoking causes one-quarter of cases of low birth-weight infants, placing a heavy burden on neonatal services. Smoking in pregnancy is also associated with

spontaneous abortion, ectopic pregnancy, ante-partum haemorrhage, premature rupture of the membrane and still birth (AMA, 1999).

- Approximately 154,000 hospital visits each year are smoking-related (Higgins et al, 2000).
- More than 800,000 hospital bed days are attributable to smoking each year (Higgins et al, 2000).
- Tobacco smoking causes 12% of disease problems in men and 7% in women Mathers et al, 1999).
- Chronic obstructive pulmonary disease and lung cancer, both smoking-related diseases, were the third and fifth leading causes of health problems (Mathers et al, 1999).
- Smoking increases the risk of serious eye conditions including macular degeneration (BMJ, 1996).

Using improved data and modelling, new US research (Washington Post, 1995) suggests that the costs of treating smoking-related diseases are higher than previous estimates. Health economists determined that cigarette smoking accounted for approximately 11.8 percent of total US medical spending in 1993, with total costs far higher than earlier estimates of US$50 billion.

The economic cost of alcohol consumption imposed on the Australian community is $4.495 billion every year. During 1992, the economic cost of illicit drug use, including lost productivity, drug treatment and law enforcement, was estimated to be $1.68 billion (Collins & Lapsley 1996).

The economic cost to Australia of harmful pharmaceutical drug use (in terms of, for example, medical services and lost productivity) are not quantifiable at present (Collins & Lapsley 1996).

For every 1,000 injecting drug users (IDUs) newly infected with hepatitis C in a given year, there is an implied $14.32 million in health care spending over the years as the disease manifested, with cumulative total costs of some $0.5 billion (1994 dollars) after 60 years as the costs of successive HCV-infected IDUs are added to the prevalence pool.

If the estimated 10,000 new HCV infections in IDUs in Australia per year continue for the next 60 years, total direct health care costs will be around $4 billion over that period (Brown and Crofts, 1998).

This model limits itself to the direct medical costs of ambulatory visits associated with ongoing monitoring and in-patient admissions to hospital for treatment over the course of the disease. This is not to deny the direct and indirect costs incurred by patients and their families, the way in which the disease may impinge on the ability of individuals to participate in the paid workforce or the costs of premature mortality.

It is estimated that some 20% of people with chronic hepatitis and 40% of those with cirrhosis may be unable to work as a result of their illness and be entitled to disability pensions. The additional costs of treating some patients with interferon and confounding factors such as carriage of hepatitis B virus or increased alcohol intake have not been taken into account.

If current estimates of about 8,000 to 10,000 new HCV infections per year giving rise to about 6,500 to 8,000 chronic carriers of HCV, solely as a result of injecting drug use, are at all accurate, then the current epidemic of HCV among IDUs is generating of the order of $90,115 million per year (1994) in direct health care costs alone.

In addition to the healthcare costs of contracting a bloodborne virus, the AVERAGE cost of a coronial investigation associated with an overdose death in the ACT is approximately $1,720 (this does not include police costs).

Other social harms included a rise in the practice of unsafe sex from about 35% in 1994 to around 55% in 1998); increases in overdoses from around 30% in 1994 to almost 50% in 1998). There was also an increase in the level of involvement in motor vehicle accidents from less than 20% in 1994 to about 30% in 1998). The illegal drug users were also more likely to suffer from psychological problems such as depression (which rose from about 60% in 1994 to almost 80% in 1998) and anxiety (which rose from over 40% in 1994 to almost 60% in 1998).

Hospital Costs

While hospital costs arising from drug and alcohol use in the ACT are hard to quantify, particularly because substance abuse is frequently co-morbid with other conditions, there is still a clear impact on hospital costs as a result of treatment costs for drug and alcohol conditions. Following is some hospital separation data where drug and alcohol use is a factor:

Proportion of separations for females with a mental disorder with principal or secondary diagnosis of drug use, ACT hospitals, 1997-98

	Organic psychotic conditions	Other psychoses	Neurotic, personality & other psychotic mental disorders	Total
			Percentage	
Unsanctioned drugs	0.0	35.9	64.1	100.0
Alcohol	10.3	33.3	56.4	100.0
Current use of tobacco	4.8	28.7	66.6	100.0
History of tobacco use	15.4	11.5	73.1	100.0
Multiple drug use	3.6	37.5	58.9	100.0
Total drug use	5.2	32.0	62.8	100.0
No drug use	23.1	19.9	57.0	100.0
Total mental disorders	18.7	22.9	58.4	100.0

Note: Includes non-ACT residents.

Source: *ACT Hospital Morbidity Data Collection 1997-98*

Proportion of separations for males with a mental disorder with principal or secondary diagnosis of drug use, ACT hospitals, 1997-98

	Organic psychotic conditions	Other psychoses	Neurotic, personality & other psychotic mental disorders	Total
			Percentage	
Unsanctioned drugs	6.1	43.6	50.3	100.0
Alcohol	15.0	35.0	50.0	100.0
Current use of	11.0	29.1	59.9	100.0
History of tobacco	12.0	12.0	76.0	100.0
Multiple drug use	11.2	35.8	53.0	100.0
Total drug use	10.4	33.4	56.2	100.0
No drug use	26.0	22.8	51.2	100.0
Total mental	18.9	27.6	53.5	100.0

Note: Includes non-ACT residents.

Source: *ACT Hospital Morbidity Data Collection, 1997-98*

ACT Government funding provided to drug related programs

The ACT Department of Health and Community Care funds services whose key role is to provide alcohol and other drug services. The cost of providing these services in the ACT during 1998/99 was $5,849,260.

There are a number of other services funded by the Department of Health and Community Care which are indirectly providing support on alcohol and drug related issues such as:

- The Junction Youth Health Service;
- Sexual Assault services;
- and a range of other generalist counselling, education and support services.

Health promotion activities around smoking are also conducted by the ACT Cancer Society ($42,650) and several other projects totalling $355,000 have been funded by Healthpact. Other areas of alcohol and drug education were also funded by Healthpact e.g: $23,000 on grants, $64,000 on sponsorship and $9,000 for the Alcohol and Drug Program.

There are several other stakeholders in the ACT who contribute funds either directly or indirectly to drug related programs. Examples of these programs include: law enforcement; abstinence based programs; corrections; education; health promotion; counselling; and rehabilitation.

Healthpact as the statutory body responsible for health promotion in the ACT, works closely with the Department of Health and Community Care. Healthpact funds community projects which focus on education or harm minimisation in their approach to drug and alcohol issues.

Examples of this approach include “Rave safe” ($5,000), “Live over lunch” ($10,000) and the “Safe Behaviour project” (Family Planning ACT) all of which support the education of young people about the impact of recreational drug use. These projects work with young people, event organisers and support workers to develop appropriate responses to these issues.

DRUG RELATED HEALTH IN THE ACT

The use of tobacco, alcohol and other drugs is commonplace in Australia, and the impact of associated harms affects all levels of our community. These harms may include accidents and injury, sickness and disease, premature death, crime, violence and anti-social behaviour, as well as personal and social disruption to families and relationships, loss of quality of life, loss of productivity and other economic costs.

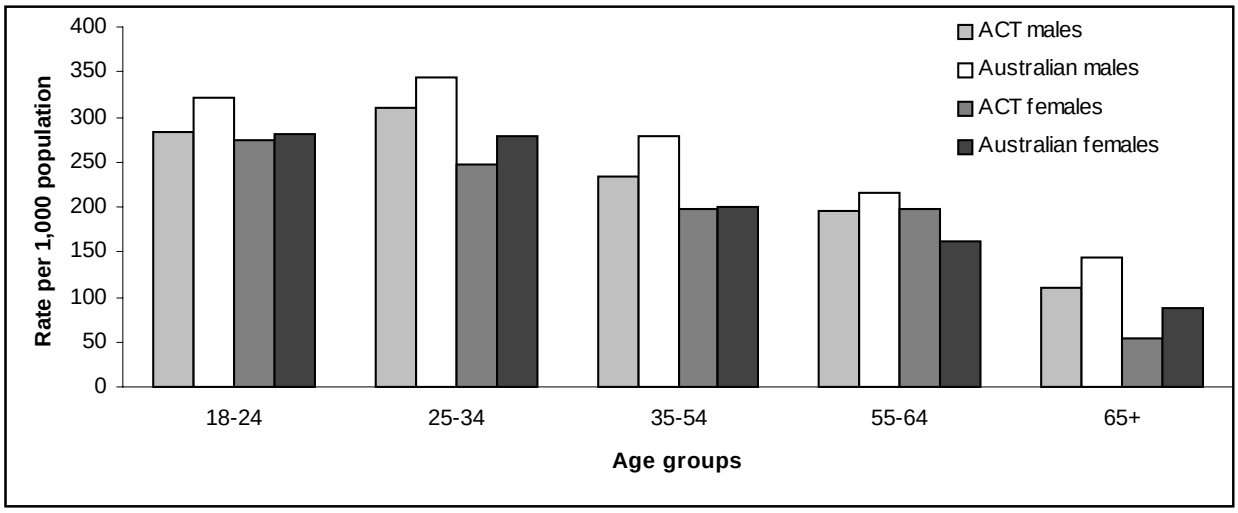
The *National Drug Strategy Household Survey 1995* (Department of Health and Family Services) indicates that drug usage patterns in the ACT are similar to those that occur in other States and Territories. The proximity of the ACT to Sydney means that many of the trends and patterns of illicit drug use that commence in Sydney are mirrored over time in the ACT.

TOBACCO

Tobacco is the leading cause of preventable and premature drug-related death and disease in Australia. The National Health Survey 1995 (ABS) reported that in the ACT, 21 percent of adults were smokers, 29 percent were ex-smokers and 49 percent had never smoked. These results compare favourably with the rest of Australia, which were 24 percent, 27 percent and 49 percent respectively.

The following graph shows that a higher proportion of the younger age groups are current smokers and with the exception of females in the 55-64 years group, people in the ACT smoke less than those nationally. As a general rule, males smoke at higher rates than females.

Age and sex specific smoking rates per 1,000 population, ACT and Australia, 1995



Note: Excludes people less than 18 years old.

The short-term health effects of tobacco use can include shortness of breath and increased susceptibility to colds and influenza. The longer-term health effects can include numerous types of cancer, atherosclerosis, ischaemic heart disease, heart failure, stroke, pneumonia, chronic obstructive pulmonary disease, peptic ulcer, and Crohn's disease (English et al 1995 in MCDS 1998). Smoking causes illness and death amongst those who smoke and others who involuntarily inhale tobacco fumes (known as passive smokers). There is ever-mounting evidence linking environmental tobacco smoke with ill-health among adults and children (MCDS 1998).

According to *Drug Related Health in the ACT* (Epidemiology 1999), in Australia, approximately 84% of male and 77% of female lung cancers can be attributed to cigarette smoking. Between 1993 and 1997, an average of 56 people died per year in the ACT due to malignant neoplasm (cancer) of trachea, bronchus and lung. Nearly all the malignant neoplasms were located in the bronchus and lung. Most of these were for males (63%) and 87% of them were for people aged 55 years and over.

Of particular concern is the rate of uptake and maintenance of cigarette smoking amongst young people, and in particular, young women. It is essential that the uptake of tobacco use among young people be reduced to decrease the long-term health risks. In the ACT in 1996, the last year for which information is available, 26 percent of secondary school students were smokers. It is estimated that in 1998/99, ACT children smoked more than $2.7 million worth of cigarettes.

Comparison of the different age groups shows that across the ACT and Australia, more younger women are smoking than older women, and they are not giving up at the same rate as are men (Drug Strategy Household Survey 1995 in Epidemiology Unit (b) 1998). The disproportionate numbers of Indigenous people who smoke compared with non-Indigenous people is also an area of concern.

With the last phase of the *Smoke-free Areas (Enclosed Public Places) Act 1994* now being implemented, community exposure to environmental tobacco smoke is being minimised in public places in the ACT. It is now important to further educate the community about the effects of passive smoking. It is also important to develop and implement effective education programs with a view to reducing non-smokers' exposure to environmental tobacco smoke within homes and non-public enclosed areas.

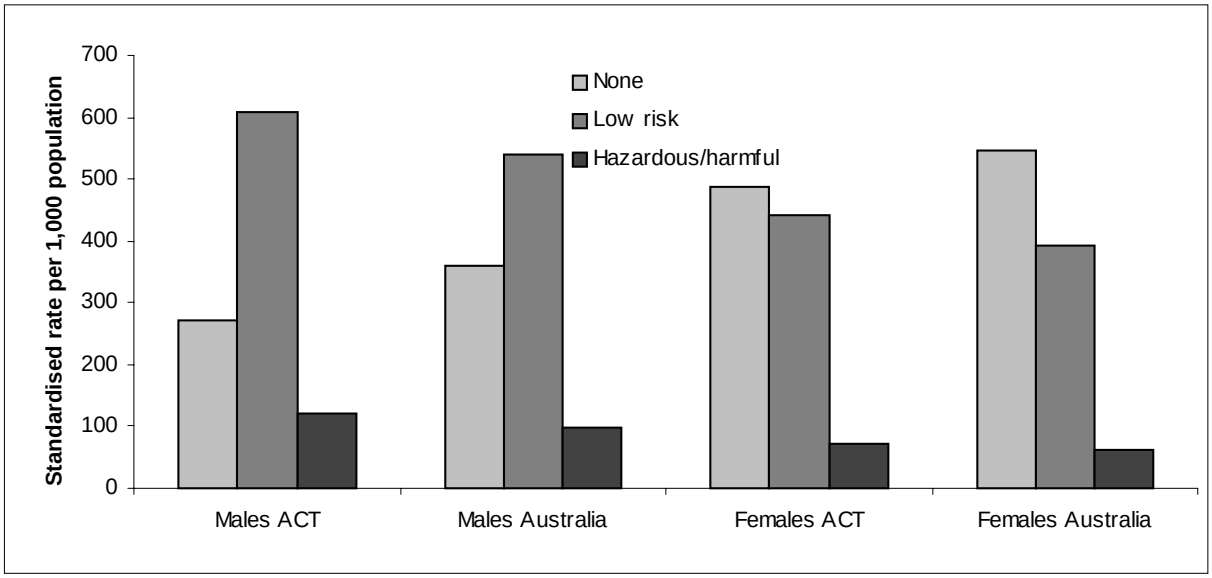
A SUPPLEMENTARY PAPER ON TOBACCO USE MAY BE FOUND AT PAGE 43.

ALCOHOL

Alcohol is the most commonly used drug in Australia and is second only to tobacco as a preventable cause of death and hospitalisation in Australia (Holman et al 1990, English et al 1995 in MCDS 1998).

Unlike the trend for smoking, a larger proportion of people in the ACT tend to drink at higher levels than people nationally. Overall, males tend to be heavier drinkers than females, although females in the 18-24 age group, both in the ACT and nationally, and males in the 25-34 age group, represent the highest percentage of hazardous or harmful drinkers (Drug Related Health in the ACT Epidemiology 1999).

Alcohol consumption level rates by sex, ACT and Australia, 1995



Note: Excludes people less than 18 years old.
For definitions of low risk and hazardous/harmful risk refer to Section 9.6 Definitions
Source: ABS, *National Health Survey, 1995,* unpublished data

Alcohol affects co-ordination and judgement and can also bring on feelings of aggression or depression (there is a high correlation between suicide/self-harm and intoxication). Alcohol is responsible for a multitude of short-term and long-term conditions including liver damage, heart and blood disorders, hypertension, stroke and brain injury. Other severe effects related to the use of alcohol are alcoholic gastritis, pancreatitis, pneumonia, peptic ulcer and alcohol withdrawal seizures.

Additionally, foetal alcohol effects are directly linked to excessive ingestion of alcohol in pregnancy. Combining alcohol with other drugs can be dangerous. Mixing over-the-counter or prescribed medications with alcohol can reduce their effectiveness. Mixing alcohol with minor tranquillisers or cannabis can affect judgement and co-ordination and even cause breathing failure.

Alcohol may also be implicated in a number of risky behaviours that may lead to accidental injury to self or others including motor vehicle injuries and fatalities. It has been estimated that approximately 39 per cent of alcohol-related deaths were attributable to either injury or violence (English et al 1995 in MCDS 1998). Of all the drugs, alcohol presents the most serious threat to public safety, being implicated in many incidents of violence and property loss or damage. The link between alcohol and injury is also well established for falls, drowning, burns and assault. (Hingson and Howland, 1993a and English et al, 1995 in MCDS 1998).

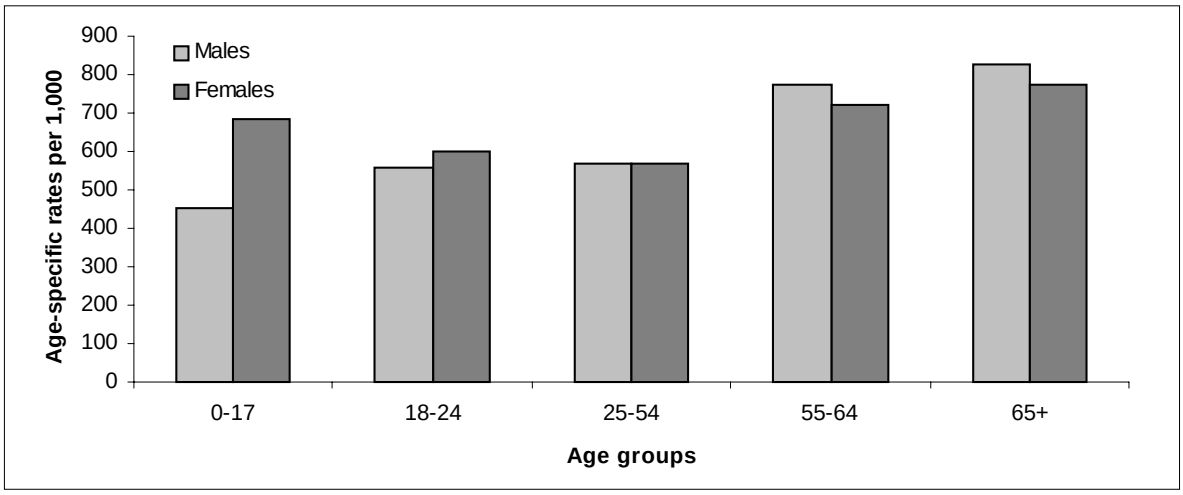
Emotional problems related to alcohol can include depression or relationship and family problems. Poor work performance, financial difficulties and legal problems may also be experienced. Damage and disruption to family and work relationships is an immeasurable social cost resulting from the use and misuse of alcohol. Parents affected by alcohol may not be adequately caring for their children and the effect of being parented by an alcohol dependent parent is cause for concern.

OVER-THE-COUNTER AND PRESCRIPTION DRUGS

The unnecessary, inappropriate or excessive use of prescribed and 'over-the-counter' medication has implications in terms of health, social and economic costs to both the individual and the broader community. The risk of long-term dependency and associated decline in quality of life is also of concern. Illicit and recreational use of prescribed medications may lead to complications through combining pharmaceuticals with alcohol and other drugs. Sharing of prescription medicines among friends and family is also of concern.

Older people are the major users of prescription and over-the-counter medicines in Australia. This can be partially explained as older people are more likely to be prescribed a number of medicines due to multiple health problems. However the use of multiple medicines by older people leaves them vulnerable to adverse effects of medicines and inappropriate use (Purcell J 1999).

Age specific rates of those who took medications, ACT, 1995



Source: ABS, *National Health Survey, 1995,* unpublished data

With the increasing numbers of older people maintaining independence, living alone, continuing to drive and providing assistance to families, the consequences of inappropriate drug use can be harmful. However, many falls, motor vehicle accidents and hospitalisations can be avoided by appropriate management of medication (Purcell J 1999). Education, understanding and support will assist in the wise use of medicines so that the consequences of inappropriate drug use by older people are minimised.

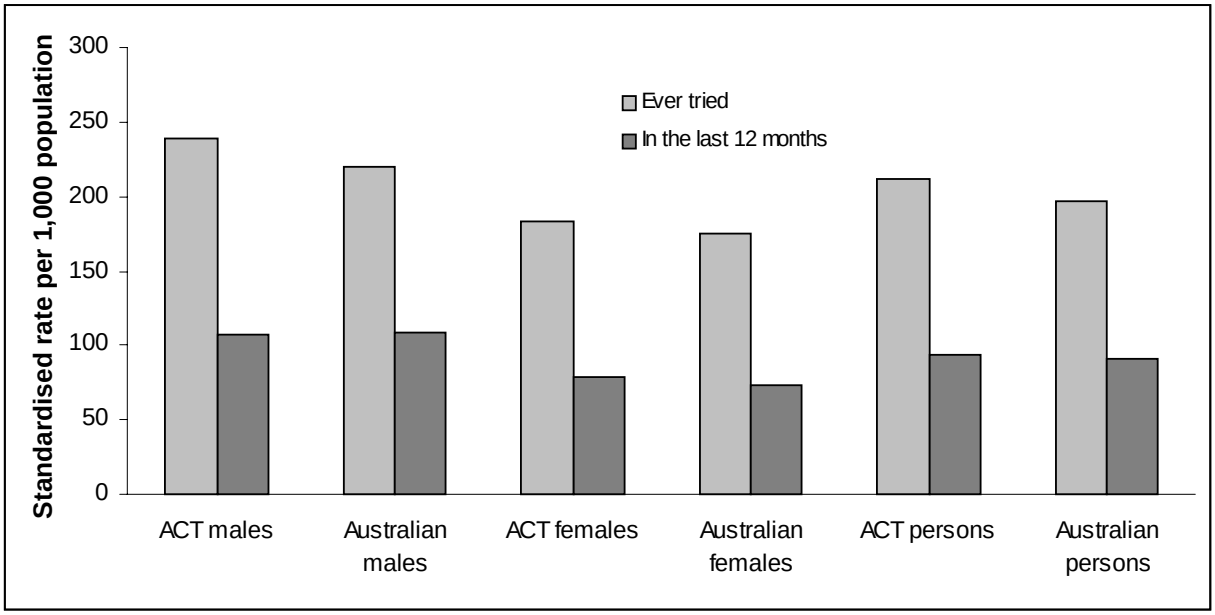
In addition to providing funding to deliver education, resources and information and support for people with problematic benzodiazepine and anti-depressant use, the Department of Health and Community Care is keen to increase awareness and accountability among doctors in their prescribing of benzodiazepines and to address issues around inappropriate use of benzodiazepines. The Department is currently undertaking a needs analysis in respect of benzodiazepine use in the ACT to:

- Identify gaps in current service provision
- Identify barriers to clients; and
- Inform the development of future services.

CANNABIS

Cannabis is the most commonly used illicit drug, although its use is less common than both alcohol and tobacco. The National Drug Strategy Household Survey 1995 (Epidemiology Unit (b) 1998), showed that 42 percent of ACT people have at some time tried cannabis and 16 percent of those had used the drug in the last 12 months. The ACT Secondary Schools Survey 1995 (Epidemiology Unit (b) 1998), showed an increase in the cannabis use of years seven to twelve students between 1991 and 1996.

Use of cannabis by sex, ACT and Australia, 1998



Note: Standardised to 1991 Australian population.
Includes respondents aged 14 years and over.
Source: Commonwealth Dept of Health and Aged Care, *National Drug Strategy Household Survey, 1998*, unpublished data

The immediate harmful health effects of cannabis use can include anxiety, panic, paranoia, difficulty concentrating, memory loss, and impairment of motor skills. The long term-harmful health effects can include an increased risk of experiencing psychotic symptoms for some people, an inability to abstain from or to control use, and subtle forms of cognitive impairment, particularly difficulty concentrating and memory loss, which may continue after use stops (Hall et al 1994 in MCDS 1998).

Considerable research has been undertaken in the areas of the health and psychological effects of cannabis use. An extensive review of existing literature was most recently undertaken in the context of the National Task Force on Cannabis that was established on 25 May 1992.

The Task Force commissioned a review of the evidence on the health and psychological effects of cannabis use. A new and independent review was thought necessary because there had not been any major international review of the literature on the health and psychological effects of cannabis since 1981, when the Addiction Research Foundation and World Health Organisation jointly reviewed the literature.

The resulting paper *"The Health and psychological consequences of cannabis use",* (National Drug Strategy, Monograph Series No.25, 1994) provided a useful summary of the nature of cannabis in addition to a range of relevant findings about the health effects of cannabis.

The study identified a range of key findings in respect of the health effects of cannabis, in particular

- respiratory diseases associated with smoking as the method of administration, such as chronic bronchitis, and the occurrence of histopathological changes that may be precursors to the development of malignancy;
- development of a cannabis dependence syndrome, characterised by an inability to abstain from or to control cannabis use; and
- subtle forms of cognitive impairment, most particularly of attention and memory, which persist while the user remains chronically intoxicated, and may or may not be reversible after prolonged abstinence from cannabis.

The study was also useful in identifying high risk groups for cannabis induced harm including youth, women of child-bearing age and people with specific pre-existing conditions.

The ACT Government policy on the management of personal cannabis use acknowledges these findings and seeks to minimise harms through appropriate education and treatment intervention. These treatments and interventions are made more accessible to the community through the Simple Cannabis Offence Notice system.

USE OF OTHER DRUGS

Illicit drugs such as designer drugs, cocaine and opioids have been used by less than 3 percent of the Australian population and used in the last 12 months by less than one percent of the Australian population.

While only a small proportion of the Australian population inject drugs, the social and economic cost to the community is huge. *The National Drug Strategy Household Survey* estimated that in 1998 there were about 4,400 people and up to 6,700 people in the ACT had ever tried heroin. A significantly higher proportion of Australian males had ever tried it when compared to their female counterparts (Australian males 3.0%, Australian females 1.4%).

The immediate harmful health effects of heroin can include difficulty concentrating and the risk of overdose. Long-term harmful health effects can include the build-up of tolerance (which increases the risk of overdose) and withdrawal symptoms associated with stopping or reducing use. The nature of injecting drug use associated with heroin dramatically increases the risk of exposure to bloodborne diseases such as Hepatitis C.

Anecdotal evidence suggests an increase in the practice of injecting cocaine, both in the Sydney region and in the ACT. As the purity and strength of the dose may vary greatly, the risk of overdose is increased, and as it is a short-acting drug, more daily injections are required. This greatly increases the risk of exposure to blood-borne viruses through the increased likelihood of reusing or sharing injecting equipment.

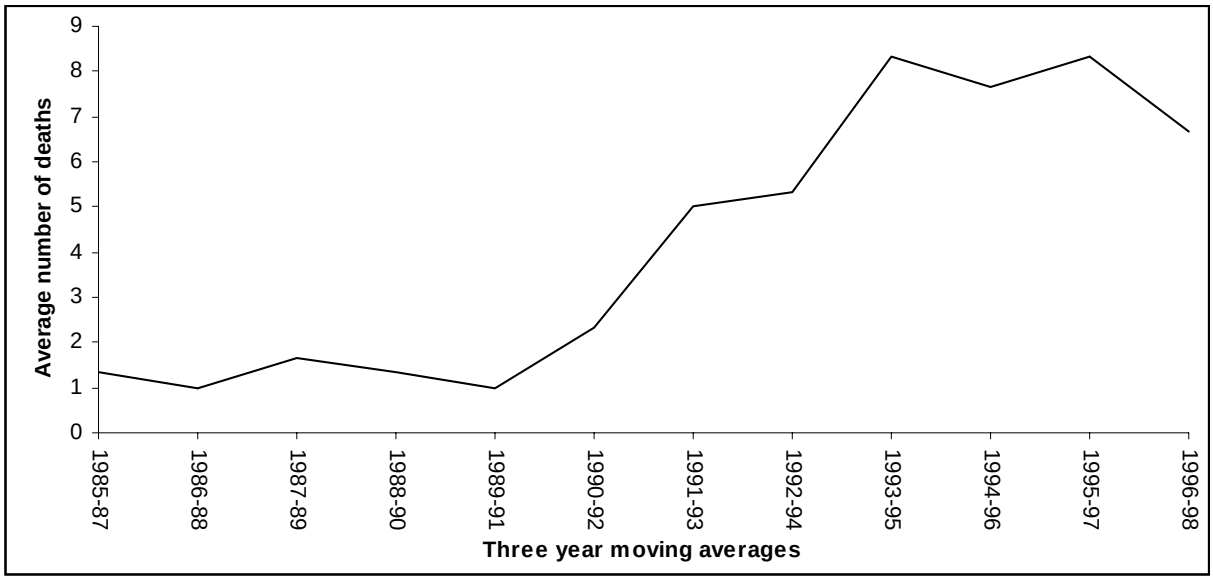
OVERDOSE ISSUES

Since 1995, there have been 52 deaths as a result of a drug overdose in the ACT. Opiates (heroin, methadone and opium) and their combination with other drugs predominated as a cause of these deaths.

Due to the high fluctuations in the number of heroin related overdose deaths, three year moving averages have been used in the following graph. This graph shows an increase in the number of heroin related overdose deaths from 1992 onwards. Very few of these deaths, however, can be attributed to heroin only and in a majority of cases, other drugs such as alcohol and benzodiazepines had also been consumed.

In 1997 when data for multiple cause of death were first collected, besides the underlying cause of death, a further 3 people died in the ACT from causes that were related to other drug dependence.

Heroin related overdose deaths, three year moving averages, ACT and region, 1985 - 1998



Note: Some deaths from the ACT region may be included.
Source: *ACT Government Analytical Laboratory, 1985-98*

NEEDLE AND SYRINGE PROGRAM

The Needle and Syringe Program in the ACT has increased the availability of sterile syringes to injecting drug users and has reduced unsafe injecting practices such as needle sharing, thus reducing levels of the blood-borne virus HIV. Due in significant measure to the widespread establishment of Needle and Syringe Programs, Australia is fortunate enough to be experiencing decreased rates of HIV infection compared with other countries.

The Needle and Syringe Program in the ACT is not only about providing access to sterile syringes for injecting drug users in order to prevent the transmission of blood borne diseases. The program allows clients to access counselling, drug information and detoxification programs; and treatment modalities such as methadone program and abstinence-based programs.

Over a 12 month period in 1998, 3371 injecting drug users registered with the ACT Needle and Syringe Program. Because of the transient nature of the IDU population, a more realistic estimate of injecting drug users who access the Needle and Syringe Program would be approximately 1,250. This figure does not include IDUs who purchase their needles, share codenames, reuse needles or access equipment by some other means.

According to the statistics collected from the Needle and Syringe Program in the ACT, the distribution of needles increased significantly and continuously over the last 7 years

Assisting Drug Dependents Incorporated, a non-government organisation that administers the Needle and Syringe Program in the ACT, conducted a survey in August 1999 and found that injecting drug users engaged in risk-taking behaviours for reasons both practical and cultural. Seventy-four per cent of respondents gave lack of availability of clean equipment as the main reason for sharing needles. Of major concern was the finding that most respondents knew little or nothing about the risk of contracting a blood borne disease when they commenced injecting.

ACT needle distribution and return rates

Needle distribution in the ACT has increased markedly over recent years.

1996/97	**1997/98**	**1998/99**
480,000	541,590	612,103

The ACT has excellent return rates for needles and syringes. In 1998-99 there was a 74% drop in the number of sharps found in public toilets across Canberra and a 31% drop in the number of sharps found discarded in public places.

Based on 1998/99 figures, approximately half of all sharps are returned to the needle exchange. Only a small proportion of sharps were collected by the Department of Urban Services (1.5%) from public places. Again, half of these were collected from appropriate disposal chutes in public toilets.

There was only, therefore, a very tiny proportion of needles discarded inappropriately. Most of the remainder of needles were collected and destroyed by Totalcare, private waste disposal contractors and pharmacies. A small number will end up in landfill.

Injecting drug users are at higher risk of contracting blood borne disease such as Hepatits C and HIV/AIDS than the general population, primarily through injecting under unhygienic circumstances. Such injection also risks a variety of other forms of infection and disease. It is estimated that 60-70% of all injecting drug users are infected with a blood borne virus.

BLOOD BORNE VIRUSES

The practice of injecting illegal drugs is associated with a range of risk factors and harms. Some of these include a risk of overdose and other health complications, and exposure to blood borne viruses. In particular the sharing of needles and syringes and injecting equipment for the injection of drugs carries with it the risk of transmission of

HIV, Hepatitis B and C and other communicable diseases. As outlined earlier, Hepatitis C is now the most commonly notified infectious disease in the ACT.

HIV

The cumulative total HIV diagnoses for the ACT to 31 March 1999 is 211, with a further 103 cases that have been diagnosed interstate but have moved to or sought treatment in the ACT, giving a total cumulative figure of 314. Of the total 314 cases, 5.4% report IDU exposure (4.5% for Australia). To 31 March 1999, a total of 93 cases of AIDS have been notified in the ACT (Australian HIV Surveillance Report July 1999).

HEPATITIS C

People with injecting drug behaviour are at high risk of contracting Hepatitis C (HCV). It has been estimated that at least 100,000 Australians are currently infected with the Hepatitis C virus (HCV) as a result of injecting drug use (IDU) since 1970 and that 8,000 to 10,000 more are becoming infected each year. (Crofts, N et al 1993 in Brown, K et al, 1998). All the former and around 80% of the latter are at risk of long term disease associated with its chronic carriage. The natural history of chronic HCV infection is still poorly understood, but at least a proportion of those infected will go on to develop severe end-stage liver disease. (Strasser, EI et al 1995 in Brown, K et al 1998).

HCV was first reported as a virus in 1989. Since July 1991, 2,207 cases of hepatitis C have been notified. The true prevalence of HCV in the ACT is likely to be much higher than this since many people with HCV do not have symptoms and/or have not been tested.

Researchers conclude that efforts to prevent HIV transmission amongst injecting drug users have been shown to be clearly cost-effective. These data imply that there is a pressing need to halt or slow the current epidemic of HCV infection among injecting drug users. The cost associated with the ongoing treatment/hospitalisation of people infected with these diseases is a major consideration.

HEPATITIS A

There has also been a recent increase in the numbers of injecting drug users contracting Hepatitis A in the ACT. Evidence suggests that a bout of Hepatitis A can exacerbate the symptoms in someone already infected with Hepatitis C.

Hepatitis A is an acute viral infection with a worldwide distribution. Risk factors relevant to injecting drug users include blood to blood contact (eg. needle sharing);

faecal-oral contact (eg. poor hygiene when sharing food, drinks, cigarettes, bongs); and faecal to blood contact (contaminated hands pass infection when injecting drugs).

Clearly, if injecting drug users are injecting in unsanitary conditions, the risk of acquiring Hepatitis A can only increase. A clean injecting environment and supply of sterile injecting equipment is necessary in order to reduce Hepatitis A infection.

According to a study conducted by Dr Nicole Gilroy in 1998, prior to 1996 there were fewer than 25 reports per year of HAV in the ACT. By June 1998, 42 cases of HAV infection had been reported to the ACT Department of Health and Community Care. The most frequently reported risk factors for both 1997 and 1998 were contact with a known case of HAV infection and intravenous drug use.

The ACT has sought Federal assistance for a program of vaccination for Hepatitis A which, to date, has been rejected by the Federal Government. This program, linking into other programs for injecting drug users, would have, on advice received by the Sexual Health and Blood Borne Diseases Advisory Committee, been quite effective in reaching a large number of otherwise inaccessible people, thus making a significant impact in control of the disease.

METHADONE

The ACT currently has three streams for the provision of methadone. These streams include a combination of public clinic assessment and stabilisation, with public clinic prescribing and dosing; General Practitioner prescribing and community pharmacy dosing after stabilisation in the public system; and public clinic assessment and stabilisation, with public prescribing and community pharmacy dosing.

Through implementation of these three streams, the methadone program in the ACT has been able to reach 600 places, and will be further increased to 700 during 2000. There is potential for further expansion of the methadone program through the development of a fourth private stream. The Department of Health and Community Care has been working with the Methadone Advisory Committee to develop a private stream of methadone provision in the ACT. This project will investigate, develop and implement a proposed fourth private stream as an alternative option for members of the community seeking access to private methadone treatment.

The proposed fourth stream will see a limited number of General Practitioners appropriately trained to deliver a full methadone service, from assessment to prescribing, to clients in the context of their own health needs. Induction onto

methadone will be by a specialist General Practitioner and dosing will take place in a non-subsidised pharmacy place. The fourth stream will not include the establishment of a private methadone clinic.

ALTERNATIVE PHARMACOTHERAPY TRIALS

The ACT Government recognises the importance of providing a range of treatments for people with opioid dependency. The government is funding a trial of buprenorphine as a pharmacotherapy leading to detoxification from heroin, with or without access to methadone. This trial complements similar trials being undertaken in Sydney and Melbourne.

A second trial, involving detoxification from methadone using naltrexone, is currently being undertaken. This trial aims to establish the best clinical procedures for a process of rapid withdrawal from methadone.

INDIGENOUS HEALTH

The ACT has approximately 3,000 people identifying as Aboriginal and Torres Strait Islanders living mainly in South Canberra and Tuggeranong. The population consists of a diverse range of cultures, but in the main comprise the Ngunnawal people, who are the traditional owners of the land in the ACT and of Wiradjuri people from surrounding NSW towns who come to the Territory for education and employment. In addition, there are a further (approx) 3,000 Aboriginal and Torres Strait Islander people in the surrounding region who may access the health resources of the ACT.

The substantial increase in Indigenous population in the ACT since the 1991 consensus is probably due to a personal willingness to self-identify rather than an influx of Indigenous people. Of those identified, there are approximate even numbers of males and females.

Included in the population figures is the Jervis Bay community, consisting of 14%. This presents a problem with indicators of health status because those living in the Jervis Bay area are less likely to be admitted to hospitals or use health services in the ACT.

The draft Australian Capital Territory Aboriginal and Torres Strait Islander Health Plan 1999-2004 notes that the health status of Aboriginal and Torres Strait Islander people across Australia is much lower than that of non-indigenous people.

Aboriginal and Torres Strait Islander people in the ACT in 1995 had an average age at death of 40.6 years whereas the average age for all ACT deaths was 68.4 in the same year. Indigenous people are more likely to be affected by lifestyle related conditions including diabetes, the use of alcohol, tobacco or other drugs, and injuries or medical conditions relating to hypertension and mental illness than the non indigenous population (Department of Health and Community Care Monograph Series).

Three key documents - *The National Aboriginal Health Strategy* (1989), the *Royal Commission into Aboriginal Deaths In Custody* (1991) report, and the "*Bringing Them Home" National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families Report*, link this poor health status to a range of socio-economic factors in which indigenous people fare less well than non-indigenous people. In the ACT, these factors include housing, employment and educational opportunities.

The data available on the health needs of indigenous service users in the ACT is poor and therefore cannot be relied upon for informed decision making about service design or priorities. This is partly due to a lack of consistent data collection mechanisms, including indigenous identifiers across all service providers. In addition, a reluctance of Aboriginal and Torres Strait Islander people in identifying their indigenous status (anecdotally: for fear of reduced services or reduced quality of care) has contributed to this difficulty.

The 1994 survey of drug use among Aboriginal and Torres Strait Islander peoples was part of the *National Drug Strategy 1993 Household Survey*. It involved face-to-face interviews with 2,993 Aboriginal and Torres Strait Islander peoples living in urban areas nationally. The major findings are summarised below:

- A smaller proportion of Aboriginal and Torres Strait Islander peoples drink alcohol (62%) compared to the general population living in urban areas (72% from 1993 survey).

- Those who do drink alcohol, however, consume higher quantities of alcohol than the general population, with 68% of current drinkers consuming harmful quantities of alcohol (ie. more than four standard drinks if female, more than six if male) on occasions when they do drink, compared with 13% of the general population.

- Males tend to have more hazardous drinking patterns than females, as with the general population. However, hazardous drinking was more prevalent in the 25-34 years age group, compared to 14-24 years age group in the general population.

- More than half (54%) of urban Aboriginal and Torres Strait Islander peoples are current or regular smokers, compared to only 29% of the general population.

- The majority of smokers (88%) are regular smokers.

- Alcohol and tobacco use are closely correlated, with 77% of current smokers also being current drinkers, and 56% of current smokers consuming alcohol at hazardous levels at least weekly.

- Illicit drug experimentation and use is more widespread among the Aboriginal and Torres Strait Islander urban community than in the general urban population, with 50% having tried at least one illicit drug, compared with 38% in the general community, and 24% being current users, compared to 15% in the general community.

- Nearly half (48%) have tried marijuana, compared with 16% in the general community, and 22% are current users.

- There also appears to be slightly higher rates of experimentation and usage of other illicit drugs, with 19% of the Aboriginal and Torres Strait Islander urban community having tried at least one illicit drug other than marijuana, compared to

16% in the general community, and 6% being current users of at least one other illicit drug (compared with 5% in the general community).

Alcohol and tobacco use is strongly linked to the four main causes of death and morbidity amongst Aboriginal and Torres Strait Islanders. The complex links between substance abuse, mental health and primary health care within the Aboriginal and Torres Strait Islander population make effective coordination of services even more crucial than amongst other populations.

Illicit drug use is higher in the Aboriginal and Torres Strait Islander community, with almost twice as many experimenting and using illicit drugs than the non-indigenous community.

The use of alcohol and other drugs has long been closely linked to the deep levels of emotional and physical harm that has been suffered by the indigenous community since the arrival of European settlers (Commonwealth Department of Health and Family Services, 1998b).

In 1990-92 more than 60% of deaths in the indigenous community were caused by cardiovascular diseases, external causes (accidents, poisoning and violence), respiratory problems, neoplasms and endocrine disorders (Australian Bureau of Statistics, 1997c). Each of these causes of death is strongly related to the use of alcohol, tobacco and other drugs. Alcohol is the single biggest concern, with the proportion of deaths related to alcohol misuse three to five times higher than among the non-indigenous community (Commonwealth Department of Health and Family Services, 1998b).

Tobacco related diseases are responsible for between 1.5 and 8 times more deaths in the indigenous community than could be expected in the non-indigenous community (Cunningham, 1995). A study examining the effect of tobacco and alcohol consumption in Western Australian Indigenous people found a similar differential. If Western Australian Indigenous people consumed drugs at a similar rate to non-Indigenous people, over 10,000 hospital admissions by Aboriginal and Torres Strait Islanders would have been avoided, preventing over 65,000 hospital bed days, saving an estimated $4.2 million per year (Unwin, Thomson & Gracey, 1994).

SUPPLEMENTARY PAPER

SOCIAL AND ECONOMIC COSTS OF TOBACCO USE

SOCIAL AND ECONOMIC COSTS OF TOBACCO USE

Tobacco Control Program, Health Protection Service,

ACT Department of Health and Community Care

Overview

Although the terms of reference to this inquiry refer to substance abuse, it should be noted from the outset that, when discussing tobacco use, the detrimental health consequences and associated costs relate to the *use* (not the *abuse*) of the product. This is because tobacco is the only legally available product which kills when used exactly as intended.

A perspective on the numbers of tobacco-related deaths can be gained through the realisation that tobacco kills more people in Australia each year than the total number killed by alcohol, illicit drugs, AIDS, murder, suicide, road crashes, rail crashes, air crashes, poisoning, drowning, fires, falls, lightning, electrocutions, snakes, spiders and sharks.[1] Of all drug-related deaths in Australia, more than three-quarters are attributable to tobacco use.[2]

Studies that have followed smokers and nonsmokers for many years have found that smoking-related deaths are not just deaths which occur in 'old age': smokers are three times more likely to die between the ages of 45 and 64 than those who have never smoked, and only 12 percent of smokers live to age 85, compared to 33 percent of nonsmokers[3].

World-wide, tobacco remains the largest single preventable agent of illness and death in developed countries. The extent of the tobacco epidemic is such that it is expected to kill 3 million people a year in developed countries by the year 2025, with the total

[1]Australian Council on Smoking and Health, submission to Senate Community Affairs References Committee Inquiry into the Tobacco Industry and the Costs of Tobacco-Related Illness, December 1995, Committee Report p. 1

[2] K Higgins, M Cooper-Stanbury and P. Williams, *Statistics on Drug Use in Australia*, Australian Institute of Health and Welfare, Drug Statistics Series, No. 2, April 2000.

[3] Michael P. Eriksen, Director, Office of Smoking and Health, US National Center for Chronic Disease Prevention and Health Promotion, personal communication to M. Goodin, ACT Health Protection Service, 18 May 1999; see also individual studies including R. Doll, R. Peto, K Wheatley, R Gray, and I Sutherland, 1994, Mortality in relation to smoking: 40 years' observations on male British doctors, British Medical Journal 309:901-911].

number of deaths from tobacco use world-wide increasing to more than 10 million over the next 30 years.[4] Smoking already kills one in 10 adults world-wide; by 2030, this will be one in 6, or 10 million deaths per year.[5]

The December 1995 Report of the Senate Community Affairs References Committee, *The Tobacco Industry and the Costs of Tobacco-Related Illness*, contains a substantial collection of information about tobacco use and its costs. We commend this report and its findings, and will not reiterate the information presented in it.

However, it is important to note that, even after the publication of more than 57,000 scientific articles examining the link between tobacco smoking and disease, continued investigations have provided ever-increasing evidence of the harmful effects of tobacco use. This includes valuable information about issues that had been previously under-investigated -- such as cigar smoking, and the relationship between smoking and breast cancer, smoking and strokes, and smoking and eye diseases – as well as methodologically complex areas of research, such as passive smoking. Growing evidence in these and other areas has contributed significantly to our understanding of the detrimental consequences of tobacco use on individuals and on the community.

Despite the difficulties in quantifying the range of costs, the trends are worrying. It now appears that tobacco imposes considerably greater social costs than does alcohol.[6] In the four years from 1988 to 1992, the real costs attributable to alcohol rose by 1 percent while those attributable to tobacco rose by 17 percent.

It has been noted that the estimated health consequences and total costs of tobacco use would certainly be higher if there were accurate measures of the impact of passive smoking and its costs.[7] Even based on existing estimates, tobacco use is responsible for more than 65 percent of the total economic costs of drug abuse.[8]

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[4] R. Peto, Smoking and death: the past 40 years and the next 40, *British Medical Journal*, vol. 309, 8 October 1994, p. 937.

[5] World Bank, *Curbing the epidemic: governments and the economics of tobacco control.* Washington, DC: The World Bank, 1999

[6] DJ Collins and HM Lapsley, *The social costs of drug abuse in Australia in 1988 and 1992*, National Drug Strategy Monograph 30, February 1996, p. 63.

[7] Collins and Lapsley 1996, p. 64; National Health and Medical Research Council, *The health effects of passive smoking: a scientific information paper*, Commonwealth Dept of Health and Family Services, 1995.

[8] Collins and Lapsley 1996.

In the five years since the Senate Community Affairs References Committee issued its report, important evidence has come to light in another crucial area: the tobacco industry itself. Largely as a result of litigation in the United States, millions of tobacco company documents have become publicly available.

These documents provide a wealth of information about what the industry knew about the effects of tobacco use, when it had this information, what it did with this information, and how its marketing strategies have been consistently and deliberately designed to mislead and to confuse the decision-makers, the media and the public. These strategies include on-going programs in Australia.

It has long been acknowledged that a comprehensive, multi-faceted tobacco control program is the only effective way to reduce the harms and associated costs of tobacco use. This approach was first formally reflected in the *National Health Policy on Tobacco in Australia*, which was adopted in 1991. Subsequent documents, such as *National Drug Strategies* and *Better Health for Australians*, also reflected this approach.

The need for a comprehensive set of strategies to address the problem of juvenile smoking was recognised by the Senate Community Affairs References Committee in its 1995 Report.[9] The recent report of the World Bank[10] recommends a multi-pronged strategy to 'curb the tobacco epidemic.'

Most recently, the *National Tobacco Strategy*, which was endorsed by all Australian jurisdictions in 1999, provides a blueprint to aid jurisdictions in identifying and acting on key areas of tobacco control and carries the clear message that action in all of these areas is necessary if substantial gains are to be achieved.

The inequalities in the disease and cost burden from tobacco use should also be noted. Within Australia and world-wide, smoking is more prevalent among those who can least afford the product and its disease burden. Numerous studies have shown that smoking prevalence in higher educational and occupational groups is only a fraction of that in lower socio-economic groups.

[9] Senate Community Affairs References Committee Report, p. 62.
[10] World Bank 1999.

In Australia, an informal analysis of ABS Household Expenditure Survey data from 1993-94 found that, overall, 35 percent of households purchased tobacco, but in families where unemployment and sickness benefit were the principal source of income, over 60 percent were 'tobacco households'.[11] Of households headed by someone under 25 years of age, more than 50 percent purchased tobacco.

Leading commentators have also claimed that conventional attributable risk methodology considerably underestimates the burden that smoking places on the health care system by virtue of the failure to consider how smoking complicates the course of many illnesses not themselves directly associated with smoking (including diabetes and AIDS). Smokers recover more slowly from surgery of all types than do nonsmokers, thus extending post-surgical hospital stays. Inclusion of such costs could result in an increase in estimates of 50 percent or more of smoking-related health care costs.

It is also the case that most cost-of-smoking studies do not include a range of direct costs – for example, costs of transporting patients to and from health care services, costs of home modifications to accommodate smoking-related disabilities, and smoking-related maintenance and ventilation costs in buildings.

Intangible costs, such as the pain and suffering of smoking-related disease victims and their families, may exceed costs which are more readily quantifiable.

Policies which establish non-smoking as the norm represent a community-based approach to reducing the harmful effects and costs of tobacco use. Studies have shown that these policies, if implemented consistently and effectively, provide health benefits to nonsmokers by reducing ETS exposure and make a major contribution to an environment which supports health.

In the ACT, where legislation has formalised 'non-smoking as the norm', there are substantially fewer smokers who smoke inside the home compared to Australia as a whole (18% in the ACT vs 24% Australia-wide).[12]

[11] G Spencer, 'What do tobacco households go without?', Canberra ASH Inc, 18 November 1996.
[12] J Barac, P Luke and O Phongkham, Drug related health in the ACT, 1999, Health Status Monitoring Epidemiology Unit, ACT Department of Health and Community Care.

Current service provision in the ACT

The ACT actively supports a comprehensive tobacco control strategy. A range of initiatives has been designed to discourage the uptake of tobacco use through demand reduction and supply control.

Implementation of the ACT's landmark *Smokefree Areas (Enclosed Public Places) Act 1994* is continuing. Recent changes to the *Tobacco Act 1927* have seen the elimination of in-store tobacco advertising and the reduction in tobacco product displays, as well as measures to minimise the sale and supply of tobacco products to children.

The ACT's health promotion fund, Healthpact, promotes a smokefree lifestyle in the community through sponsorships and other programs. Assistance with smoking cessation is provided by agencies such as the Alcohol and Drug Service and the QUIT program of the ACT Cancer Society.

Future directions

Crucial to reducing the social and economic costs of tobacco use is the availability of appropriate data. The fact that such data have been lacking in Australia, and tobacco cost figures are more reliable and more accessible for other countries, is a matter which needs to be urgently addressed.

The ACT's tobacco control strategy will continue to focus on demand reduction and supply control. It is the ACT's view that a combination of community-based approaches and targeted approaches will be most effective in reducing tobacco use over the long term.

While we support the directions mapped out in the *National Tobacco Strategy*, we believe that there are also opportunities for further Commonwealth initiatives, particularly in the areas of tobacco product regulation and tobacco marketing, and in relation to encouraging the adoption of minimum standards in the areas of tobacco sales to minors, in-store tobacco advertising, and passive smoking protection.

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ATTACHMENT A

FROM HARM TO HOPE - ACT DRUG STRATEGY 1999

ATTACHMENT B

SETTING THE AGENDA

ATTACHMENT C

CURRENT ALCOHOL & DRUG SERVICE PROVISION IN THE ACT

NON GOVERNMENT ALCOHOL & DRUG SERVICES

ACT Cancer Society	• Smoking cessation programs
Alcohol and Drug Foundation	• Residential rehabilitation and half way houses
Assisting Drug Dependents Incorporated	• Detoxification (Arcadia House) • Therapy and counselling • Needle exchange • Late Night DRIC for young people • Skillsplus program
Gugan Gulwan Aboriginal Youth Group	• Support, counselling and outreach
Salvation Army - Mancare	• Residential rehabilitation
Toora (WIREDD)	• Information and Support
Canberra Injectors Network	• Support and advocacy
Ted Noffs Foundation	• Residential Rehabilitation

ACT COMMUNITY CARE ALCOHOL AND DRUG PROGRAM

- Drugs of Dependence Treatment Referral Program including Court reports and Treatment Panels
- 24 hour Alcohol and Drug Helpline
- Counselling and Therapy to aid cessation or harm minimisation
- Training for community workers in alcohol and other drugs
- Needle and Syringe Program
- Methadone Treatment Program
- Supervised alcohol and/or other drug withdrawal (Medicated Detoxification)
- Professional consultations
- Alcohol and Drug client interventions
- Representation on relevant panels including Dual Diagnosis Project.

OTHER GOVERNMENT SERVICES

Department of Education	• Alcohol and Drug education/curriculum development
Law Enforcement funding	• Alcohol and drug treatment for offenders in contact with the criminal justice system