Whole-of-government Victorian alcohol and drug strategy

Anex submission to the Whole-of-government Victorian alcohol and drug strategy - September 2011

Our vision is a society in which all individuals and communities enjoy good health and wellbeing, free from drug–related harm

About Anex

Anex is a leading national voice in the public health sector. Since our inception as an independent, non-profit organisation in the 1990s, we have worked to increase understanding and improve responses to the problems arising from the use of illicit drugs, pharmaceuticals and alcohol.

Anex does not condone drug use, but strives to protect people from drug-related harm when at their most vulnerable.

Our mission

To employ the best available evidence and compassion to improve individual and community health and wellbeing by supporting and strengthening policies and programs that reduce drug-related harm in Australia.

Our Patrons

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Overview

Anex welcomes the opportunity to contribute to the development of this important strategy and commends the government for initiating the development of a whole of government approach and the associated community consultation. Anex understands a strategic approach to reform across multiple portfolio areas, together with private and community based stakeholders, represents a rare opportunity to achieve long term improvements in the efficiency and effectiveness with which existing and potential additional resources are deployed in this state.

Anex is committed to the promotion of public health and harm reduction, particularly in relation to alcohol and drug misuse in the Australian Community.

Its priority areas include the promotion and development of the capability of the harm prevention and reduction workforce and the completion of high quality research that will continue to increase the evidence base for harm prevention and reduction and inform best practice for the sector.

The work of Anex is set in the context of the social determinants of health, which the World Health Organisation defines as:

"The conditions in which people are born, grown, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequalities – the unfair and avoidable differences in health status seen within and between countries"

Anex strongly supports a client centred approach across all aspects of multi-lateral government and other involvement. A client centred approach is one that meaningfully engages clients in planning, implementation, delivery, review and evaluation of interventions and services with recognition of the importance of family and community in client outcomes.

Overarching harm minimisation approach

Such an approach should reinforce the three policy pillars that have underpinned activity in this field in Australia for many years and made us a world leader in drug and alcohol policy:

- reduction in supply of illicit drugs and the inappropriate and harmful supply of licit drugs
- reduction in demand through an integrated approach across all sectors, including health, justice and harm reduction elements
- reduction in the harm caused to both individuals, their families, workplace colleagues and the wider community

It has been a number of years since there has been a thorough analysis of how government expenditure on illicit drug harm minimisation measures is divided. Even the most recent publication on the matter, (Moore 2008), refers to 2002-2003 data. Of "proactive" expenditure, the largest amount was on law enforcement (55%), followed by prevention (23%), treatment (17%), harm reduction (3%) and other (1%). [1]

However, judging by commercially conducted public attitudes research commissioned by Anex in 2009,[2] Victorians are in favour of greater balance between taxpayer funding on law enforcement measures to address illicit drug-related issues and harm reduction interventions. When asked the

[1] Moore, T. (2005). Monograph No. 01: What is Australia's "drug budget"? The policy mix of illicit drug-related government spending in Australia. Drug Policy Modelling Project Monograph Series. Fitzroy, Turning Point Drug and Alcohol Centre.

[2] Anex. **Anex Community Research Project - Summary of Findings**. In. Melbourne: Anex; 2009.

question "*if the government had $100 to spend on addressing problems associated with illegal drugs, how much do you think they should spend on each of the following?",* results analysis found that the preferred division for a majority of respondents was as follows:

- Police, courts and imprisonment for people who use or produce illegal drugs: $20
- Educating people to prevent commencement of illegal drug use: $30
- Treatment programs that aim to reduce or end use in people using illegal drugs: $20
- Programs to reduce harms to individuals and the community resulting from illegal drugs use: $20

The 2010 National Drugs Household Survey found that 68.5 percent of Australians (14 years old and older) supported NSPs to reduce harms associated with heroin.[3]

Harm Reduction needs emphasis

Anex supports the strong harm minimisation focus evident in the consultation paper, but submits that an equally strong emphasis on harm reduction is required. Such an emphasis should address shortcomings in:

- the connections between service sectors, including the primary health sector, mental health sector, and harm reduction services such as Needle and Syringe Programs (NSPs);

- inter-sectoral referral pathways;

- improved resourcing of the various sectors to better support people misusing drugs and alcohol by more effective linking to a comprehensive range of services and supports which may increase the prospects of effective recovery interventions in the future;

- Leverage of the community health services (CHS's) in particular to ensure the size and pervasive distribution (100 CHS's across Victoria) of the resources devoted to the sector are applied to provide harm reduction and provide pathways to other appropriate services and interventions more effectively and more evenly than is currently the case.

What Does a Whole of Government Approach Mean?

As the government has noted, a need for greater cohesion and coordination in relation to alcohol and drug policy and services has been identified. What should this mean in practice?

Over many decades governments at both state and federal level, and of all political persuasions, have from time to time set out to integrate and harmonise policy and practice across multiple areas of government interest and activity. Sometimes this has simply been challenge enough to achieve within a single portfolio. In other cases more ambitious inter-portfolio agendas have been pursued.

Results have, it must be said, generally been mixed, particularly when cross portfolio agendas have been pursued. This underscores the challenge the government has set itself in seeking to put in place, and then implement, an alcohol and drug strategy across the whole Victorian government.

It is submitted that, as well as embracing the best ideas which come forward through the external focus inherent in the community consultation process, attention must also be directed internally in regard to the operations of government and the cultures which are dominant within various agencies. A whole of government strategy in any area cannot be expected to succeed where:

- different elements of government are in competition with each other for scarce budgetary resources

[3] AIHW (2011). 2010 National Drug Strategy Household Survey report. Canberra, Australian Institute of Health and Welfare. **Drug statistics series no. 25. Cat. no. PHE**.

- fundamental differences in values and perspective exist, whether overtly or not, between different areas of government

A simple, if blunt, example can be taken of an overall system in which drug taking behaviour is regarded by the law enforcement system as primarily a crime. This leads to custodial punishment in an environment where continued drug taking is possible but treatment and meaningful prevention of the transmission of blood borne viruses is not. Upon release the wider community is exposed to transmission risks, leading to a demand on health resources as well as a range of societal harms. This could not be considered an integrated client and community centred approach.

Conversely, an overall system in which the law enforcement system approached drug taking as a health issue and sought to connect the individual with appropriate health interventions, thereby reducing harm, generating increased potential for effective treatment while reducing demands on the justice and penal systems, could be seen as a more effective use of scarce resources.

The values and culture of any element of the overall system are therefore paramount and must be harmonised across the system from the top down. This is a challenge the government will have to rise to for a whole of government alcohol and drug strategy to be judged by history to have been successful.

It is suggested that the government give consideration to how traditional government processes and portfolio arrangements should be reviewed and revised to ensure the implementation of specific programs and initiatives is not undermined by conventional intra government norms.

Outline of areas emphasised in Submission

This submission seeks to bring 10 main areas to the attention of the Expert Advisory Group and the Inter-Departmental Committee formulating the Strategy. These are:

1. Criminal justice;
2. Alcohol and drug issues in the workplace.
3. Improving capacity for referral to other services;
4. Improving the resourcing of secondary outlets;
5. Diversified availability of equipment – syringe vending machines;
6. Enabling outreach through peer networks to young injectors;
7. Workforce development;
8. Funding for Secondary NSPs;
9. Rural growth in needle and syringe provision;
10. Pharmacotherapy.

The submission will also discuss four particular subject matters that warrant consideration. These are:

1. Increased pharmaceutical misuse;
2. Prison-based needle and syringe programs;
3. Take-home naloxone to reduce overdose deaths and injuries;
4. Improved data collection.

Anex submits that formulation of this Strategy should also be undertaken with reference and recommendations pertaining to the on-going development of an updated Victorian Alcohol and Other Drug Workforce Development Strategy 2012-2015.[4]

[4] DoH (2011). AOD Workforce Development Strategy, 2012-2015 - Consultation Paper (prepared by KPMG, August 2011). Melbourne, Victorian Department of Health.

Criminal justice

Prevention and early intervention

Recognising that involvement in the criminal justice system at an early age is correlated with ongoing contact and engagement in later life, the importance of prevention and early intervention programs has long been recognised by the Victorian Government. There is clear evidence of the positive outcomes of such an emphasis on early intervention in Victoria, when comparing the adult imprisonment rates between that State and New South Wales over many decades.

This submission recommends a continuation and expansion of the preventative and early intervention social policies that have been part of the Victorian Government's approach over successive governments, including both Liberal/Coalition and Labor governments for more than 40 years.

The most significant point of contact that the Victorian Government has with young people is through the education system, both the government system and, indirectly, through the religious and independent school systems.

Victorian secondary schools, and increasingly primary schools, are called upon to respond to the impact of alcohol use and illicit drug use by students. Further, most secondary schools and some primary schools have found it necessary to formulate school drug policies, in response to incidents of unauthorised alcohol use and illicit drug use by students.

National policies in these areas have been set over the past decade by the 1999 drug education policy document of the Department of Education, Training and Youth Affairs (DETYA) *"National School Drug Education Strategy"* and the subsequent policy document dealing with drug incidents: "*National framework for protocols for managing the possession, use and/or distribution of illicit and other unsanctioned drugs in schools"*.[5]

During the last decade, there has been increased understanding and knowledge of the close link existing between young people's drug misuse and mental health needs, and the need to carefully assess drug incidents in relation to the absence of youth friendly and accessible mental health services.

This submission would argue for an emphasis on a more holistic response to incidents of unsanctioned alcohol use and illicit drug use by school students, leading to a substantial social assessment following such an incident, so that appropriate considerations can be given to other than criminal justice interventions.

All schools within Australia are expected to work within the national framework (DETYA 2000), which while maintaining the goal of no illicit drugs in schools, incorporates three integrated approaches to drug use in schools, including supply reduction strategies; demand reduction strategies; and harm reduction strategies.

The Catholic Education System, which is responsible for over 600,000 students nationally, representing more than 20 percent of all students in primary and secondary schools in Australia, also works within this National Framework, but has largely through its local offices built policies of assessment and social inclusion, in response to the report *"Keeping Them Connected"*.[6]

Keeping students connected to their local environment, using the resources of the school community and associated professional services from within the education system, and involving the instrumentalities of the juvenile justice and criminal justice system only when it is deemed necessary or required by law has proven to be an effective response.

- **Recommendation 1 -** That departmental strategies and intervention programs be established between the Department of Education and Early Childhood Development, the Department of Human Services and the Department of Justice to ensure that a coordinated response is established with recognised protocols ensuring that interventions that occur in

[5] DEST. National framework for protocols for managing the possession, use and/or distribution of illicit and other unsanctioned drugs in schools. In. Canberra: Departement of Education, Science and Training, Commonwealth of Australia; 2000.

[6] Norden P. Keeping them connected: A national study examining how Catholic Schools can best respond to incidents of illicit drug use. In. Melbourne: The Ignatius Centre for Social Policy and Research: A program of Jesuit Social Services 2005.

response to drug incidents in Victorian schools are focused on harm reduction and positive outcomes for the students concerned.

Juvenile Justice

Only a small percentage of young people have formal contact with the Victorian juvenile justice system. This percentage is only a fraction of the percentage of our New South Wales counterparts, and even less when compared with Western Australia, or Queensland. This is because over the decades Victoria has got the balance right. We manage to divert many of those who otherwise would come under the jurisdiction of the Children's Court, and the outcome for most is far more positive for the child, the child's family, and equally importantly for the wider Victorian community.

For those who really do need to come before the Children's Court, it is important to ensure that positive outcomes are also forthcoming. Only a small percentage actually requires a custodial sentence. Generally, they are a group who have had their chances, or who have been convicted of a very serious offence. The greater the penetration young people have into the juvenile justice system, the greater the likelihood of their graduating to a further involvement with the adult system in later years.

Those young people who appear with substantial involvement with misuse of alcohol or illicit substances generally exhibit complex needs, a clear indication that a carefully managed treatment plan is required. A period of placement within a juvenile justice facility will not teach them a good lesson. What is required, generally, are substantial interventions that provide the young person with the opportunity to once again access educational, training and employment opportunities. The alternative is the development of an anti-social, or even criminal, identity that will cause untold distress to the lives of those they come into contact with.

This perspective points to the need for closer liaison to be established between the Department of Human Services, the Department of Premier and Cabinet and the Victorian Multicultural Commission. A disproportionate number of young people with complex social needs coming under the attention of the juvenile justice system need pathways back into further training and education to increase their chances of gaining access to the employment market. In addition, many are second generation Australians, with a disproportionate number with experiences of refugee resettlement or trauma from their countries of origin. Cross departmental co-operation and skilled workers are required to ensure positive outcomes from state interventions with such young people. The Department of Justice also needs to be involved, to ensure that the future generation of police officers are trained with an awareness of cultural diversity and the ability to engage with ethnic and religious differences that are now part of our Australian society.

Victoria has available a specialised youth drug treatment service in YSAS, established more than a decade ago after the findings of the Pennington Drug Inquiry. In addition, as a result of a long tradition of creative partnerships between government and the community sector, there are a broad range of diverse community support programs that can effectively respond to young people with complex needs.

This submission argues that this structure needs to be sustained and supported in the coming decade, despite the political pressure mounted by some media outlets and partisan interest groups that would move our community to a more punitive approach by the state in response to problematic juvenile behaviour.

We need to recognise that behaviours which attract such media attention are largely episodic, not chronic, and largely is in response to serious social or economic disadvantage and a sense of social isolation or exclusion. If we can continue to find the solution early we avoid the damage that inevitably results from a deeper incursion by the instrumentalities of the juvenile justice system.

- **Recommendation 2 -** That an Interdepartmental Task Force be established to ensure that the complex needs presented by that small group of young Victorians that have substantial contact with the Victorian Juvenile Justice System are better responded to with an intensive case management plan for each individual.

Community Corrections

The vast majority of adults who come into contact with the criminal justice system in this state receive fines, bonds, or some form of community based orders. For the most part, their engagement with the criminal justice system is incidental, resulting from a bad decision or episode of behaviour that is not reflective of consistent behaviour responses. For those who receive community based orders, there is either a need for some form of compensation to the community, expressed through unpaid community work, or they have been identified as in need of a more complex form of intervention or treatment, in response to their behaviour.

It is important that the courts retain the capacity to mould sentencing options according to the circumstances identified through the court process. This has been the strength of the practice of judicial sentencing in this State over many decades.

The recent report of the Victorian Government's Sentencing Advisory Council found that 59 percent of respondents indicated they were fairly confident or very confident in the courts and the legal system in Victoria.[7] This confidence should be a strong indication that despite some misgivings about the courts not always "getting it right" there is general support for the institution and role of the judiciary in this State.

Many of those who appear before the courts come with more complex behaviours for which there is not a speedy or single dimensional response. As in the juvenile justice system, there is an over-representation of persons from disadvantaged areas: both metropolitan, rural and remote. The recent social investigations completed by Professor Tony Vinson of the University of Sydney found that 25 percent of the Victorian prison population came from just 14 out of 623 postcode areas.[8] Vinson also found that court convictions, measured from Victorian magistrates records, were highly correlated with low income families, early school leaving, no post-school qualifications, low work skills, and being on disability or sickness benefits. This national research indicates an increasing level of concentration of disadvantage in particular communities throughout the nation. Vinson found that 3 percent of the postcodes measured nationally had three times the number of persons convicted of criminal convictions, compared to the national average. He warned of the danger of the Australian criminal justice system "mining" such disadvantaged communities more and more deeply in the coming years. It is perhaps this trend that gives some explanation to the fact that the Australian prison population has been increasing by 3.7 percent per year over the last 15 years, more than 3 times the rate of the national population increase.[9]

For this reason, it is important that community corrections has the capacity to respond not only to the particular offence that brings the offender to court, but also the underlying factors that influence or shape the offender's behaviour.

Where serious difficulties in relation to alcohol or illicit drug misuse are identified, treatment interventions must be broader than single dimensional, reflecting these social determinants that lead to appearance before the courts. The new division of Mental Health, Drugs and Regions within the Department of Health must continue to devise programs that reflect the prevalence of dual disability in many of those appearing before the courts. Alcohol and drug misuse is a clear indicator of mental health concerns and the intervention focused on substance misuse must also take into account the co-occurring mental health needs of the person.

- **Recommendation 3 -** Stronger coordination between mental health services and alcohol and drug treatment programs be established to more effectively respond to the needs of those persons coming into contact with the community corrections system.

[7] Gelb K. Predictors of Confidence: Community Views in Victoria In. Sentencing Advisory Council; 2011.
[8] Vinson T. Dropping off the Edge: the distribution of disadvantage in Australia In. Melbourne: Jesuit Social Services and Catholic Social Services Australia; 2007.
[9] ABS. Prisoners in Australia, 2009. In. Canberra: Australian Bureau of Statistics; 2010.

Custodial Services

The recent report of the Victorian Ombudsman identified the challenges facing Victorian correctional services in providing health services within their facilities at a level even approximating those services readily available in the community.[10] This issue becomes particularly stark, when the rate of Hepatitis C among Victorian prisoners (43 percent) is compared with the general rate within the wider community (1 percent). Despite this disparity and the presence of a classic "captive audience" for medical intervention, only three of Victoria's prisons enable prisoners to access hepatitis C health treatment programs.

As the Ombudsman's Report found:

"Prisoner rights are legislated in the Corrections Act 1986 which states that prisoners have the right to access reasonable medical care and treatment necessary for the preservation of health. The Charter of Human Rights and Responsibilities Act 2006 states that 'all persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person'."

There is clearly a serious obligation on state government authorities to respond more effectively to the complex health and mental health needs of the Victorian prison population. Given that 49 percent of current inmates had previously served an earlier period of imprisonment (ABS, November 2010) and that the death rate of those recently released from prison has been found to be 10 times the rate of those incarcerated in prison (Burnet Institute, Medical Journal of Australia, July 2011), one could suggest that the provision of health services to those in our correctional facilities needs to be seriously reviewed.[11]

This submission would suggest that the administration of health services to those in Victorian prisons should be managed directly by the Department of Health, instead of Corrections Health, as is presently the situation. Many of the personal health concerns applicable to individual inmates have public health implications for the whole community. The compromises and delays identified in the recent Victorian Ombudsman's Report make it clear that the present management of health services has not been effective and should not be continued. The transfer of these responsibilities directly to the Department of Health would recognise that prisoners' health has direct implications on public health and the level of health services available within custody should not be determined by management and security barriers placed by prison administrators or obstructions from prison officer unions.

The Victorian Ombudsman used the example of the delays in implementing his 2006 recommendation on the availability of condoms and opioid substitution therapy. The fact that since that report in 2006, there still is no comprehensive communicable disease policy within Victorian prisons is further evidence of the need for a new approach and a new model of managing prisoners' health.

This issue has been addressed in the recent "Consensus Statement: Addressing Hepatitis C in Australian Custodial Settings".[12] That report found that: "custodial settings provide a unique opportunity to protect and enhance the health of marginalised individuals and populations through prevention and treatment programs". It concluded that: "Given the inability of custodial authorities to achieve and maintain the unrealistic expectation of a drug-free prison environment, prevention strategies using proven harm reduction measures including prison-based Needle and Syringe Programs should be introduced in the interests of public health, duty of care and human rights obligations".

The case for controlled NSPs in Australian prisons has been clearly outlined in the recent publication "With Conviction" by Anex which is based on the understanding that "prisoner health is community health".[13] In recognising the efforts prison administrators have made in harm minimisation programs around supply and demand reduction, the report calls for a more significant commitment to

[10] Victorian Ombudsman. Investigation into prisoner access to health care (August 2011). Melbourne: Ombudsman 2011.
[11] Stuart A Kinner, David B Preen, et al. (2011). "Counting the cost: estimating the number of deaths among recently released prisoners in Australia." Medical Journal of Australia 195(2): 64-68.
[12] Hepatitis Australia. Consensus Statement: Addressing Hepatitis C in Australian Custodial Settings. In. Canberra: Hepatitis Australia; 2011.
[13] Anex. With Conviction: the case for controlled needle and syringe programs in Australian prisons. In. Melbourne, Australia: Association for Prevention and Harm Reduction Programs Australia Inc. (Anex); 2010.

institutionalised prison management practices in the area of harm reduction and efforts to ensure that prisoners be entitled to health services comparable to those available to the general community.

The case to introduce NSPs within Australian prisons is not based around condoning the use of illicit drugs within prison, but rather is founded on the public health imperative that leads to the minimisation of harm when people continue to use drugs, be it inside prison or beyond.

- **Recommendation 4 -** Harm Reduction strategies, including prison based needle syringe exchange programs be established in Victorian prisons, recognising that the Victorian prison population represents a community with complex and serious general health needs and that their release back into the community has serious public health implications.

Post Release Services

The experience of imprisonment impacts not only on the offender, but also the offender's family and the community to which he or she returns, if in fact such exists. There is recent evidence that the return to the community is not always a smooth transition, to say the least.

A recent study by the Burnet Institute found that the death rate of those recently released from prison around Australia was ten times the mortality rate of those actually incarcerated.[14] The deaths reflected high rates of drug overdoses, suicides and death by accident or reckless behaviour. Such dramatic and disproportionate figures indicate a serious problem and raises questions about the connection, if any, between prison based interventions and the impact of "the prison experience" on the inmate's capacity to resettle after release.

Many of those returning to the community after a period of imprisonment in fact have no community to return to. The social dislocation of prison life, and the increased fragmentation of significant relationships that occurs as a result of the separation involved, results in many of the 50,000 individuals released from prison around Australia each year facing a major crisis that is life-threatening.

The challenge facing many individuals in the twelve months following release has been evidenced in a recent report by the Australian Housing and Urban Research Institute,[15] which showed the significance of housing instability on the lives of many released offenders and the significance of changes of residence during the first six months on the likelihood of return to custody. The report also found ex-prisoners were more likely to return to prison if they had an increase in the severity of alcohol and other drug problems in the months following release. The policy implications of these findings point to the need for drug and alcohol services to be delivered in conjunction with housing support services, rather than separate from them, for "when stable housing is combined with helpful support that assists in addressing issues such as drug problems, family relations and employment, the evidence from this study is that ex-prisoners are much less likely to return to prison".

In reference to this Whole of Government Inquiry relating to alcohol and drug use, the findings highlighted the importance of a multi-agency team approach to housing, mental health and employment, that includes ex-prisoners' views and knowledge. The study concluded that the "allocation of a trained caseworker to each and every prisoner pre-release could be a way to aid this integration".

- **Recommendation 5 -** In keeping with the Victorian Government's commitment to ensuring community safety and social cohesion, a post release program be developed for every person released from custody, including ensuring access to affordable housing, mental health services, drug treatment programs and harm reduction programs.

Whole of Government approach in relation to criminal justice services

The nature of the recommendations contained in the above studies, suggesting multi agency teams and integrated responses covering different areas of social need will never be possible, much less

[14] Stuart A Kinner, David B Preen, et al. (2011). "Counting the cost: estimating the number of deaths among recently released prisoners in Australia." Medical Journal of Australia 195(2): 64-68.

[15] Baldry E, McDonnell D, Maplestone P, Peeters M. The role of housing in preventing re-offending. *Australian Housing and Urban Research Institute - Research & Policy Bulletin* 2004,36.

successfully implemented, without a substantial shift in thinking and operational management across a range of government authorities.

At present there appears to be an inherent conflict of values and priorities in developing a more effective whole of government response to alcohol and drug services in relation to the operation and responsibilities of the criminal justice system in Australia.

It is not just a matter of organisational structure, but includes different ethical and value approaches that reflect judgements about the causes of criminal behaviour and interventions that are appropriate in response.

It is perhaps best illustrated by the practice common across the country in the loss of "privileges" in relation to contact visiting rights imposed on all prisoners who breach prison regulations. This is seen by prison authorities as an effective punishment, but it is widely recognised that the fractured family relationships that could result are one of the strongest correlates to further re-offending behaviour and returns to prison.

Before a whole of government response can be considered in relation to drug and alcohol services in the context of the operation of the criminal justice system, State and Territory Governments across the country need to come to terms with such inherent contradictions in goals and strategies if true co-operation and a greater level of complementary programs could be considered across government authorities.

- **Recommendation 6 -** That the Victorian Government recognises that single dimensional interventions will not be effective in responding to the needs of the Victorian population that becomes substantially involved in the criminal justice system, but that cross departmental interventions are required for more effective outcomes that are intended to protect the safety of the wider community

Prison-based needle and syringe programs

More than 10 nations, including Spain, Switzerland and Germany, have established NSPs in prisons. These programs have been implemented without a single case of a needle/syringe being used a weapon against prison staff.

National health strategies, including the Third National Hepatitis C Strategy 2010-2013, recommend that Victoria and other jurisdictions identify correctional facilities to trial needle and syringe distribution for prisoners. It states:

> "In view of the well documented return on investment and effectiveness of Australian community-based needle and syringe programs, combined with the international evidence demonstrating the effectiveness of prison needle and syringe programs, it is appropriate throughout the life of this strategy for State and Territory Governments to identify opportunities for trialling the intervention in Australian custodial settings." [16]

The Victorian Ombudsman in 2006 recommended that a communicable diseases prevention strategy be developed for the State's correctional system. The Ombudsman has more recently repeated this recommendation.[17]

Hepatitis and HIV are the primary diseases communicable through needle sharing. A communicable diseases prevention strategy for the correctional system that did not respond to risks of hepatitis and HIV transmission amongst prisoners whilst they were in custody would be negligent.

Anex supports trialling of prison-based needle and syringe exchange within the Victorian correctional system.

- **Recommendation 7 -** That for the forthcoming Strategy to be silent on this recommended public health intervention would be a major failure. Furthermore, the Strategy should state

[16] DoHA (2010). Third National Hepatitis C Strategy 2010-2013. Canberra Australian Government Department of Health and Ageing.

[17] Victorian Ombudsman. Investigation into prisoner access to health care (August 2011). Melbourne: Ombudsman 2011.

that a goal of public health policy in Victoria be the establishment of NSP within the correctional system where appropriate.

- **Recommendation 8 -** That the forthcoming alcohol and drug Strategy be developed in such a way as to 'feed into' any forthcoming communicable diseases strategy for the correctional system. The Strategy should seek to:
    - a) identify potential sites for NSP implementation as either a pilot or trial,
    - b) develop guidelines and protocols for operations of such an NSP, and
    - c) identify barriers to implementation and possible means to overcome those barriers. As a minimum there should be strong collaboration in the development and implementation of such as system between the Departments of Health and Justice, with overall responsibility vested in the former.

Drug and Alcohol Issues in the Workplace

A comprehensive whole of government strategy should include policies and programs directed towards issues associated with alcohol and drug use in, or associated with, employment and workplaces. Resources should be directed towards assisting employers to establish drug and alcohol policies and programs to ensure that misuse of alcohol or drugs in a workplace context can be dealt with ethically, legally and to the benefit of both the company and the employee.

Of the total social cost of drug abuse in 2004/05 of $55.2 billion, alcohol accounted for $15.3 billion (27.3 per cent of the unadjusted total), tobacco for $31.5 billion (56.2 per cent), and illicit drugs $8.2 billion (14.6 per cent). Alcohol and illicit drugs acting together accounted for another $1.1 billion (1.9 per cent).[18]

The International Labour Organisation (ILO) estimates that:

• 20-25 percent of all occupational injuries are a result of drug and alcohol use
• 62 percent of harmful drug and alcohol users are in full time employment, which amounts to about 300,000 workers in Australia
• 3-15 percent of fatal injuries are related to drug and alcohol use.

The House of Representatives Standing Committee on Family and Community Affairs noted that tangible costs associated with drug use in the workplace was second only to the costs impacting on home and family.[19]

Harmful drug and alcohol use can create a range of problems in the workplace. Employees with drug and alcohol problems can cause injury to themselves and others can lose their job or family and damage their physical and mental health. Workmates of a drug or alcohol user can be faced with an increased risk of injury and disputes, covering for colleagues poor work performance and the need to "dob in" a mate for their own good.

Consequences which employers are faced with include lateness and absenteeism, lost time and reduced production and work quality as a result of incidents and injuries. There may also be losses associated with inefficiency and damage to plant, equipment and other property. The workplace is an ideal place to run effective drug and alcohol prevention programs because the peer support network in a workplace can be used to shape behaviour. Workers have a better chance of recovery from drug and alcohol problems if they are still working. Notably, the sanction for drug use is more severe in the workplace than it is in the criminal justice system.

[18]Collins D, Lapsley H. The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05. In. Canberra: Department of Health and Ageing (Australia); 2008.
[19] Australian Parliament House of Representatives. Road to recovery: Report on the inquiry into substance abuse in Australian communities. Canberra; 2003.

Initiatives to address workplace alcohol and drug issues

Anex is introducing a new program called Lucid to address this serious problem in the absence of other effective initiatives available to employers, employees and their families. Lucid aims to de-stigmatise addiction and improve organisational and individual capacity to prevent and reduce harm from drug problems through policy training and referral. Lucid will reduce organisational, individual, community and economic harm arising from workplace drug and alcohol issues.

Occupations and alcohol

The harmful use of alcohol can be found at all levels in organisations from the boardroom to the shopfloor, in community service, manufacturing, retail and business sectors. Harmful alcohol use is more prevalent in some industries than others, indicating environmental and cultural influences in addition to workplace stressors as possible contributing factors.

The highest rate of alcohol consumption is among administrative and executive staff. Other heavy drinking occupations include mine workers, salespersons, clerical staff, professionals, transport workers, tradespeople and labourers.

Causes

Genetic factors, unemployment and boredom have been linked to the harmful use of drugs and alcohol. Stressors at home and at work can also contribute to the extent to which drugs and alcohol are used. These may include:

- shiftwork
- high risk of personal injury or illness at work
- dirty, noisy work environment
- poorly designed, difficult to use equipment
- tight deadlines (e.g., transport industry)
- fear of losing job
- conflict with peers or supervisor
- discrimination or prejudice
- peer pressure
- marital or personal relationship problems
- financial problems.

Extent of drug use

Illegal drug use is not a major factor in Australian workplaces with the exception of the transport industry where amphetamine use has been reported by some drivers. A survey conducted by the Victorian Occupational Health and Safety Commission found cannabis use was reported by seven percent of workers. The 2010 National Drug Strategy Household Survey report indicates that 35.4% of the population 14 years and over had tried cannabis; 10.3% had tried ecstasy; 7% had tried meth/amphetamines; 8.8% had tried hallucinogens; 3.2% tranquillisers/sleeping pills; 3.8% had tried inhalants in their lifetime. 11.7% of those surveyed went to work while under the influence of illicit drugs in the previous 12 months while 15.8% of people currently employed reported using an illicit drug in the previous 12 months.[20]

There is also a range of medications which can affect performance as seriously as illegal drugs or alcohol. These include pain relievers, sleeping pills, tranquillisers, cough medicine and anti histamines. Many of these commonly used medications can have an adverse effect on performance, particularly when mixed with alcohol. Chemicals used in workplaces, such as solvents and pesticides, can also

[20] AIHW. **2010 National Drug Strategy Household Survey report**. In. Canberra: Australian Institute of Health and Welfare; 2011.

have a negative effect on performance, which may be worsened if the employee has used alcohol or other drugs. Information and training needs to be provided so any adverse effects which may result are considered.

Statutory Obligations and Responsibilities

Workplace health and safety is currently regulated by a number of pieces of Victorian legislation. Victoria is party to a Council of Australian Governments (COAG) initiative to bring about harmonisation of such legislation across all jurisdictions. When completed, this is expected to, *inter alia*, provide for the following responsibilities:

Employers

In general terms, occupational health and safety legislation requires an employer to ensure, so far as is reasonably practicable, the health and safety of the workers engaged, or caused to be engaged by the employer, and those workers whose activities in carrying out work are influenced or directed by the employer, while the workers are at work in the business or undertaking.

A person conducting a business or undertaking must ensure, so far as is reasonably practicable, that the health and safety of other persons is not put at risk from work carried out as part of the conduct of the business or undertaking.

Without limiting subsections to the above, a person conducting a business or undertaking must ensure, so far as is reasonably practicable:

- The provision and maintenance of a work environment without risks to health to safety.
- The provision and maintenance of safe plant and structures.
- The provision and maintenance of safe systems of work.
- The safe use, handling and storage of plant, structures and substances.
- The provision of adequate facilities for the welfare at work of workers in carrying out work for the business or undertaking, including ensuring access to those facilities.
- The provision of any information, training, instruction or supervision that is necessary to protect all persons from risks to their health and safety arising from work carried out as part of the conduct of the business or undertaking.
- That the health of workers and the conditions at the workplace are monitored for the purpose of preventing illness or injury of workers arising from the conduct of the business or undertaking.
- If a worker occupies accommodation that is owned by or under the management or control of the person conducting the business or undertaking.
- The occupancy is necessary for the purposes of the worker's engagement because other accommodation is not reasonably available, the person conducting the business or undertaking must, so far as is reasonably practicable, maintain the premises so that the worker occupying the premises is not exposed to risks to health and safety.

A self-employed person must ensure, so far as is reasonably practicable, his or her own health and safety while at work.

Employees

While at work, a worker must:

- Take reasonable care for his or her own health and safety;

- Take reasonable care that his or her acts or omissions do not adversely affect the health and safety of other persons;

- Comply, so far as the worker is reasonably able, with any reasonable instruction that is given by the person conducting the business or undertaking to allow the person to comply with this Act;

- Cooperate with any reasonable policy or procedure of the person conducting the business or undertaking relating to health or safety at the workplace that has been notified to workers.

Other Persons at a Workplace

A person at a workplace (whether or not the person has another duty under this Part) must:

- Take reasonable care for his or her own health and safety;

- Take reasonable care that his or her acts or omissions do not adversely affect the health and safety of other persons;

- Comply, so far as the person is reasonably able, with any reasonable instruction that is given by the person conducting the business or undertaking to allow the person conducting the business or undertaking to comply with this Act.

Although drugs and alcohol are not specifically mentioned in the new national OH&S Act, they are covered under the general statement of the employer's responsibility to manage risk in relation to the employee's health and safety. The employer is required to eliminate or reduce risk as far is practically possible, and to provide any information, training, or instruction that is necessary to protect all persons from risks to their health and safety arising from work carried out as part of the conduct of the business or undertaking.

In addition, employees and other persons at the workplace (e.g. contractors, casuals, volunteers and visitors) have a responsibility to take reasonable care for their own health and safety; and to comply, so far as the person is reasonably able, with any reasonable instruction that is given by the employer.

Remediating the harm arising from workplace alcohol and drug use issues

Clearly, employment by one or more members of a household may be considered the "normal state" in Victorian communities. Time spent in employment or travelling to and from or in the course of employment necessarily accounts for a significant component of a typical lifestyle.

A strong relationship between health issues in the workplace and overall community wellbeing and functioning therefore exists, in terms of both economic impact on businesses, families, communities and the State and the social effects thereon. Where health issues arising from alcohol and drug usage are present in the workplace, the effect is felt throughout the Victorian economy and community.

It is therefore argued that a whole of government alcohol and drug strategy must include policies and initiatives directed at remediating the individual, family, community and economic harm arising from health issues related to alcohol and drug usage in the workplace.

- **Recommendation 9 -** That a whole of government alcohol and drug strategy include mechanisms designed to:

- strengthen a focus on the development of an appropriate culture in all workplaces regarding alcohol and drug issues through collaboration between the Department of Health and Worksafe Victoria;

- ensure that Worksafe arrangements for the determination of workers compensation premiums provide an appropriate incentive to employers to address these issues pro-actively and preventatively and not be limited to *post hoc* action or reactive postures on their part;

- engage with unions, employer and industry groups and other workplace stakeholders to build a consensus and culture around the prevention of harm arising from alcohol and drug usage in the workplace through collaboration between the Departments of Health and Business and Innovation, and Worksafe;

- Ensure that the education sector, in particular that part of the sector focussed on vocational education, includes in curricula coverage of "healthy workplace" issues, particularly as regards alcohol and drugs in the workplace, through collaboration between the Departments of Education and Early Childhood Development and Business and Innovation.

- Fund advertising and other promotional activity in regard to workplace health and safety relevant messages in relation to the use of alcohol and drugs in the workplace or impacting on the workplace, through collaboration between the Department of Health and Worksafe.

- Create and/or reinforce connections between workplace health and other sectors such as primary health, community health, alcohol and drug treatment services, the employment sector etc. to provide a more integrated government and community approach to the addressing of relevant issues, through collaboration between the Departments of Health and Business and Innovation and Worksafe.

Harm Reduction Programs

This section provides an introduction and background regarding harm reduction programs and the proven social, health and economic benefits it contributes for all Victorians.

As the Terms of Reference for the Strategy state, harm reduction can be considered as measures which contribute to "reduction of adverse health, social and economic consequences of the use of alcohol and drugs, for community safety and amenity, families and individuals".

Anex's work in the area of drug harm reduction is situated within the broader debate about how to promote community public health, ways in which the Victorian Government can respond to concerns about community safety and continuing efforts to bring about an integrated government approach to complex social problems in our society. Harm reduction services should be seen as an important front line element in an overall whole of government system which integrates initiatives directed towards the promotion of public health, community safety and efficient use of taxpayer funds.

Harm Reduction Services – What Are They?

- Needle and Syringe Programs
- Primary Health Care Centres for Injecting Drug Users
- Mobile Drug Safety/Mobile Overdose Response Services
- Opioid Replacement Therapy service providers including GPs and Specialist Pharmacotherapy Services

Harm reduction services – while sharing areas of commonality and overlap – are not primarily drug treatment services as their first priority is not the reduction and cessation of drug use. Rather, they are committed to preventing and reducing the harms associated with drug use. In relation to NSPs the prevention of infection through obviating needle sharing practices has far reaching positive impacts beyond the individual drug user to the wider community, and therefore to the public purse in terms of health expenditures, economic productivity, social cohesion and functioning. Better

resourcing of this sector can be seen to provide enhanced opportunities for future treatment and recovery.

In relation to injecting drug users, NSPs are often the first point of contact they have with any element of the overall "health" system, at least in relation to their drug use. Many will, however, have had contact with some element of the criminal justice system.

As discussed below, the NSP workforce should be formally considered part of the Victorian Alcohol and Other Drugs (AOD) workforce. In addition, as previously mentioned the Ombudsman has recommended creation of a communicable diseases strategy for the corrections system. The Whole-of-government alcohol and drug strategy should establish guiding principles that would feed into that corrections policy, particularly with regard to blood borne virus prevention and treatment.

The development of a Whole-of-government alcohol and drug strategy for Victoria provides an opportunity to lay the foundations for the next generation of NSPs by building on and extending the success the sector has demonstrated. Equally importantly there is an opportunity for education of the community regarding the valuable role NSPs in reducing the harm associated with injecting drug use.

Without community awareness of the benefits of NSPs and an improved understanding of their performance, NSPs may be vulnerable to community backlash and resistance, particularly at the crucially important local level. This could result in the closure of services, leading to decreased availability of and access to clean needles and syringes, potentially resulting in increased sharing of used injecting equipment with the concomitant increased risk of transmission of blood borne viruses. Additionally, if local communities are hostile to NSPs, attempts to increase and improve access to these services for people most vulnerable to drug-related harms would continue to be hampered. The net effect would be less effective NSP services and increased harms to injecting drug users and the community.

Needle and Syringe Program

The investment in Victoria's NSP generates a net positive for taxpayers and the Victorian economy. It saves money by preventing disease.

While the Victorian Auditor General did not examine the NSP, his report in March noted that numerous reviews into the sector had been commissioned, but were often subsumed by further reviews. The Auditor General further noted that additional reviews were underway.[21] One such review is the evaluation of the Victorian NSP commissioned by the Department of Health.[22] Anex concurs with the recommendations in the draft report and recommends the forthcoming Strategy reflect these findings which are reproduced in Appendix II.

Having a qualified workforce is a major step towards guaranteeing service quality. However, no minimum training requirements applies to workers within the NSP. Additional and much-improved workforce development strategies are required.

The NSP workforce can potentially play a much more important and effective role in the area of demand reduction, which is one element of prevention. The NSP workforce, whether full time or as part of a person's overall work duties, should be formally considered part of the Victorian Alcohol and Other Drug workforce. At the moment this is not the case.

Secondary NSPs operate without direct and specific public funding yet account for more than half of the sterile injecting equipment distributed in Victoria under the Program, and therefore the benefit they provide can be seen to be immeasurably positive. Additional support is required for secondary NSPs so that they may play a far greater role in brief counselling interventions and referral to other services, particularly drug counselling and treatment.

Additional resources for the NSP sector should not be viewed as a cost to government, as the NSP sector effectively pays for itself by way of preventing disease and therefore significantly reducing cost burdens upon the public and private health systems as well as public and private enterprises.

[21] Victorian Auditor General Report in Drug and Alcohol Prevention. In. Melbourne: Victorian Auditor General; 2011.

[22] Health Outcomes International. **Department of Health Evaluation of Needle and Syringe Programs in Victoria and the Role of the Council of Australian Governments (COAG) supporting measures (Final Draft), April 2011** In. Melbourne: Report by Health Outcomes International to Victorian Department of Health; 2011.

Additional resources for the NSP should be viewed as 'reinvesting' proven cost savings in order to enhance the capacity of the sector's workforce to play a greater role in harm minimisation more generally.

Value of Needle and Syringe Programs

Beginning with Australia's enlightened and world leading response to the emerging AIDS issue in the 1980's, the contribution harm reduction programs make to an integrated and multi-faceted policy and practice landscape has been well established. By reducing the harm caused by drugs lives are saved, the negative impact on the rest of the community is reduced, and the prospects for future treatment and recovery are enhanced. Public health, community safety and the economy benefit as a result.

As part of our commitment to promoting community safety and to promoting increased levels of public health in Victoria, Anex is engaged in policy development, research and support of programs that lead to a reduction in harm emanating from alcohol and drug misuse in our community. It is within this context that our work in promoting effective NSPs is located.

Indisputably, Victoria's NSP is a highly cost effective, evidence-based health intervention. The program saves millions in Government revenue each year. There is a strong business case to support maintaining, expanding and further improving NSPs, in particular to achieve a more even coverage across Victoria than is presently the case.

The second Return on Investment report published in 2009 identified that in Australia, an estimated 32,050 HIV infections and 96,667 HCV infections have been directly averted over the period 2000-2009.

The analysis found that for each dollar invested, NSPs have (effectively) saved $27 in health and productivity costs. It saves both the public and private sector millions. Put simply, the NSP program overall does not just pay for itself, but contributes a very positive and exponential benefit to the overall health economy.

The NSP was introduced in Victoria in 1987 via four pilot programs to prevent the transmission of HIV/AIDS and other blood-borne viruses (BBVs). The program has since expanded to include almost 300 registered NSP outlets, which have been provided through four distinct service model types:

- Primary NSPs;
- Enhanced Secondary NSPs;
- Secondary NSPs; and
- Pharmacy NSPs.

In Victoria, outlays totalling $71m had resulted in a saving of $224m in healthcare costs across the 10 years from 2000 to 2009, yielding estimated net financial savings of $153m. It is also estimated that during that period, more than 5500 HIV infections and almost 19,000 hepatitis C infections were averted through the provision of sterile injecting equipment through the Victorian program.[23]

To obtain a rough picture of the geographic spread of health and productivity-related cost savings attributable to the NSP across the Victoria, state-wide needle distribution data by region can be drawn upon to 'regionalise' the spatial distribution of the estimated total $153 million dollars in net savings from 2000-2009.

[23] Wilson D, Kwon A, Anderson J, Thein R, Law M, Maher L, *et al.* Return on investment 2: evaluating the cost-effectiveness of needle and syringe programs in Australia. In. Sydney: Australian Government Department of Health and Ageing, National Centre in HIV epidemiology and clinical research (University of NSW). 2009.

Table: Estimates of regional division of healthcare cost savings attributed to the Victorian NSP program 2000-2009. Source: Anex, based on data from Department of Health 2009.

Region	% of total	Cost savings
Barwon-South West Region	6.1%	$9,378,601
Gippsland	5.1%	$7,729,781
Grampians	2.7%	$4,204,374
Hume	2.7%	$4,134,271
Loddon Mallee	2.3%	$3,574,004
Metropolitan Eastern	7.5%	$11,501,526
Metropolitan North & West	40.7%	$62,207,056
Metropolitan Southern	32.9%	$50,270,387
Total	**100.0%**	**$153,000,000**

As the above cuttings from Victorian newspapers shows, there are excellent public communications opportunities presented by the outstanding return on investment and health outcomes that the NSP clearly provides.

In Victoria, the level of support for the NSP was measured as 71 percent by the 2010 National Household Drugs Survey. Clearly then, NSPs are supported by the vast majority of the Victorian public.

Operationalisation of existing related health policies

In its *Victorian Health Priorities Framework 2012-2022: Metropolitan Health Plan (May 2011*) the Victorian Government articulates a commitment to empowering people to maintain their health and to make informed choices about the most appropriate health care for their needs.[24] It notes that better connections between all parts of the system, whether public, private or not for profit would help to maximise the benefits to be gained from available resources. One of the priorities established for the coming decade is to develop a comprehensive health system that is responsive to people's needs.

The overall policy and strategic framework in relation to NSP service delivery is contained in, and guided by, a number of fundamental documents released at both State (Victoria) and Federal levels. These policy documents include:

[24] Department of Health, Victoria. Victorian Health Priorities Framework 2012-2022: Metropolitan Health Plan. In. Melbourne: Department of Health, Government of Victoria; 2011.

- National NSP Programs Strategic Framework 2010-2014.
- Third National Hepatitis C Strategy 2010-2013.
- The National Hepatitis B Strategy 2010-2013.
- Sixth National HIV Strategy 2010-2013.
- Second National Sexually Transmissible Infections Strategy 2010-2013.
- Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010-2013.
- The National Drug Strategy 2010-2015.

It is clear that NSP policy and strategy is an integral component of the broader harm minimisation strategy. These policies and strategies are clear in policy direction, and identify a number of related issues in relation to harm minimisation.

- **Recommendation 10 –** The Strategy under consideration at present should not only reflect the National Drugs Strategy, as has been foreshadowed by Minister Wooldridge. It should be based on the aforementioned related strategies in totality. In particular, in so far NSPs are concerned, the forthcoming Victorian Strategy should emphasise the need for, and forecast sufficient resources for, operationalising the significant number of recommendations outlined in the National NSP Programs Strategic Framework 2010-2014.

Improving capacity for referral to other services

Those who misuse alcohol and drugs in our community largely represent a group with complex health and mental health needs. Generally they fail to access general health services and as their general health condition deteriorates come into contact with the criminal justice system and specialist services such as NSPs, and in some cases specialist alcohol and drug treatment services.

There is a major need for greater coordination of services between mental health and drug treatment services, those with the greatest health needs presenting a challenge to the service delivery system as they are by virtue of their circumstances inherently less likely to access general health services.

Under the Howard Government's Illicit Drug Diversion Initiative (IDDI), additional funding was provided to Victoria through Council of Australian Governments (COAG) processes with the specific intention of increasing the NSP sector's capacity to better counsel drug injectors and play a role in referring them to other social services if required.

This is recognition that for many injecting drug users, but not all, NSPs are the most common and often only health services they access on a sufficiently regular basis. Appropriate and prompt referral to the full range of other available services is a central task for the Program. These services include drug treatment, HIV and hepatitis C treatment, mental health services, general practice, dental care, counselling, social work, housing services and other NSP outlets.

Key areas for linkages with harm reduction services include early intervention, case management, primary care, allied health professionals, as well as counselling, consultancy and continuing care services within the specialist AOD treatment system.

However, evaluations of the Victorian NSP point to inconsistent practice regarding referrals and counselling, particularly with regards to non-primary services.

The National NSP Strategic Framework released by the Commonwealth Department of Health and Ageing, notes that significant workforce capacity development is required to further improve frontline staff ability and propensity to conduct counselling and referrals.[25] Additional resourcing is required to ensure that harm reduction services are better able to identify and respond to client needs, to link clients into appropriate specialist and generalist services, and to support those who may fall through the gaps.

[25] DoHA. **National Needle and Syringe Programs Strategic Framework 2010-2014**. In. Canberra: Australian Government Department of Health and Ageing, 2010.

There is an opportunity to inject resources into high-client contact NSPs (funded and unfunded) to give priority to the development and maintenance of partnerships and linkages with a range of organisations, and to support clients through the health and welfare service system.

- **Recommendation 11 -** The Strategy recognise the important role that NSP staff have in referrals and counselling. Further, the Strategy should provide for, consistent with the National NSP Strategic Framework, greater resourcing for workforce development, including curriculum development, E-learning and for regularised experience sharing through support for state-wide/national networking events.

Please note Recommendation 8 and Recommendation 10 in Appendix II.

Improving the resourcing of secondary outlets

The most comprehensive analysis of the Victorian NSP services conducted to date is that by Anex, completed for the Victorian Government in 2008. The report, released in 2011, found that more than 85 percent of NSP services are unfunded for this particular intervention.[26]

For example, hospital Emergency Departments do not receive any government funding to provide the service (apart from the supply of equipment including needles and syringes). Resources provided by hospitals in this context are therefore essentially diverted from other priorities, to the cost of the overall health system.

Funded services have capacity to undertake referrals and counselling, thereby contributing to demand reduction as well as harm reduction. Unfunded services have very limited capacity for enabling confidentiality, opportunistic interventions and for referrals to treatment. As such, they are vastly under-utilised.

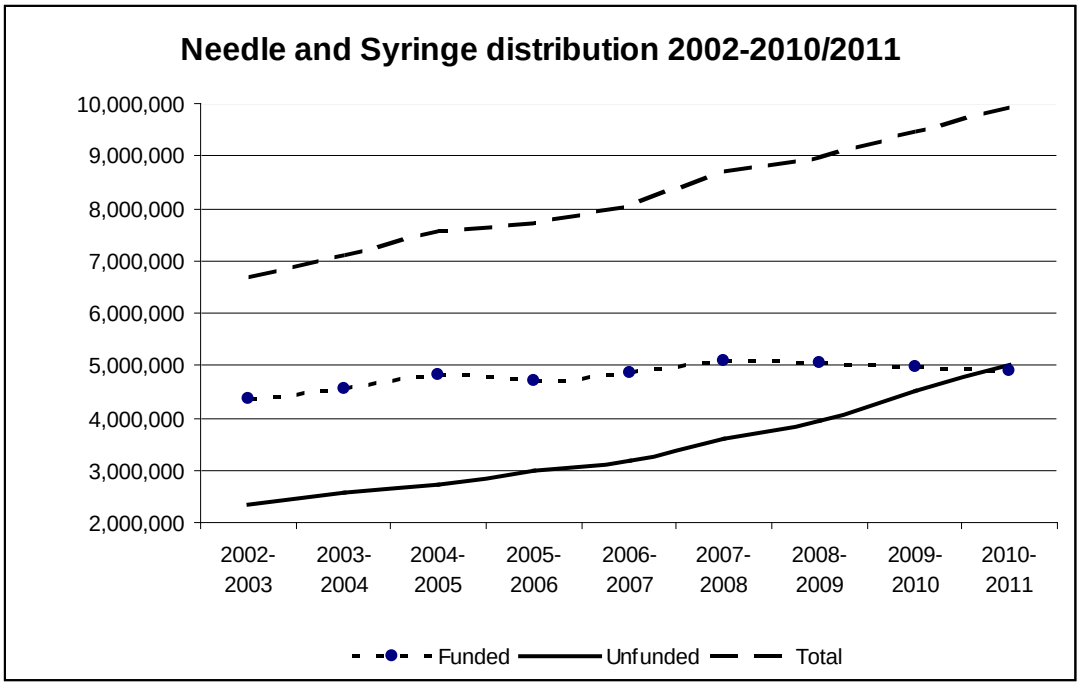
It is important to understand the significance of the secondary NSPs sector to the overall savings that the Victorian program has achieved. As discussed earlier, it is estimated that net savings from the NSP over the 10 year period to 2009 was $153 million.

NSP data indicates that secondary outlets accounted for 39 percent of the equipment distributed through the program during that period. However, these outlets receive no specific funding for the service, not even for data collection and dissemination to the Department.

It can therefore be argued that given that secondary outlets accounted for 39 percent of product throughput across the decade to 2009, and savings across the state were $153 million, more than $59 million in healthcare cost savings were achieved via an unfunded health intervention.

That breakdown pertains to the 10 year period examined for the Return on Investment Study. The share of distribution through unfunded services has become even more pronounced in recent years.

[26] Ryan, J., D. Voon, et al. (2008). Integrating Care: Victoria's needle and syringe program. Anex. Melbourne, Prepared for the Drugs Policy and Services Branch, Department of Human Services (Victoria). (released 2011).



Data source: Department of Health, 2011.

Whereas unfunded NSPs accounted for 35 percent of distribution in 2002/2003, by 2010/2011 secondary NSPs accounted for 50.6 percent of distribution. In other words, more than half the health care cost savings accrued through the Victorian NSP is potentially being delivered by services that receive no specific funding support whatsoever to achieve that return on investment.

Such a situation, in which more than a half of the financial benefits (cost savings) are derived from unfunded activities, that is without investment, is uncommon to say the least, and represents and opportunity to exponentially increase that benefit with appropriate and targeted investment of funding.

In addition, the desired objective of having the NSP services contribute to a more holistic prevention and treatment strategy is not attainable for around 50 percent of the service workload, because staff distributing more than half the annual equipment throughput are not able to commit sufficient face-to-face client time required for effective referrals, including to treatment or ORT. As such, the NSP unfunded sector is a health resource that delivers an incredibly high return on investment in terms of blood borne virus prevention, but has enormous untapped latent potential when it comes to referrals to services that can assist people contemplate and enter drug treatment including ORT.

Annual percentage growth in distribution through Funded and Unfunded NSP services								
Year	**03-04**	**04-05**	**05-06**	**06-07**	**07-08**	**08-09**	**09-10**	**10-11**
Funded	4.1	6.2	-2.3	3.4	4.8	-0.9	-1.8	-1.4
Unfunded	9.2	7.2	9.6	6.0	13.5	9	14.7	11.1

Source: Victorian Department of Health, 2011.

This state of affairs, in which a high-performing service is scarcely resourced, contributes to inconsistencies in service provision, inconsistencies in data collection, inconsistencies in organisational commitment to the program, and in many instances, reluctance by some staff/management to even provide the program. For example, Bendigo Base Hospital does not provide an NSP service despite it being one of the largest hospitals and populations outside of Melbourne. In recent times, some services have cut back hours of access (e.g.: Maryborough and Healesville).

It is recognised that the lack of any funding whatsoever for secondary NSPs to administer the program is a constraint upon service quality improvement and therefore, the program as a whole.

Until it is possible to have NSP-specific staffing permanently located at every NSP outlet, some level of dedicated NSP-trained support is needed at every NSP outlet across the system, commensurate with the level of NSP activity. We need a network of NSP workers across the sector, rostered to spend time at unfunded outlets, so that all NSP clients have access to the education, information and referral that needs to be available to this neglected population. Furthermore, there is opportunity for productivity and effectiveness gains by combining forces, remodelling a work force appropriately trained to assist injecting drug users and people addicted to opioids across the full range of services they need on their journeys out of their injecting drug using careers.

These practitioners could be seen as outreach primary health service providers, delivering primary health services across larger catchments, where the concentration warranting fixed-site primary health services is not present. Such an approach clearly lends itself to supporting pharmacotherapy and referrals to other health services, particularly mental health.

There is evidence that adds weight to the argument that investing resources in building capacity for staff to engage clients in meaningful discussions in a trustworthy manner is associated with positive health-seeking behaviour change. Data from the Health Department compares needle sharing routes, as measured through client surveys, of primary NSPs with secondaries. The sharing rates reported by clients in services without staff able to develop client relations are far higher than in those that do.

- **Recommendation 12 -** The Strategy should make particular note that secondary NSP services receive no specific funding for NSP services, thereby constraining quality improvement and limiting the potential for the NSP to assist through referrals.
- **Recommendation 13 -** The Strategy should signal Government intention to commit additional resources to secondary NSPs, either directly on a service-by-service basis or through additional means such as resourcing support workers who could help tap the latent potential for the unfunded services to enhance their 'all of government' role through referral to other services. Such an investment strategy should ensure that population distribution is factored in so as to reduce eliminate existing regional disparities in service availability.
- **Recommendation 14 –** The Strategy should ensure that existing and future resources are deployed for maximum return to the community by encompassing and recognising the return on investment potential of all service modalities, noting that unfunded services currently account for more than half the State's NSP throughput and hence return on investment.

Diversified availability of equipment

Maintaining and expanding access to sterile equipment as well as behaviour change interventions that promote non-sharing are essential to maintaining low HIV rates amongst injectors, and particularly important to reducing the still high rates of hepatitis C transmission.

Australia has one of the highest per person (IDU) rates of average needle access in the world, which is reflective of Victoria's service growth over more than two decades.[27]

However, as has been discussed elsewhere, there is much scope to enable greater access, particularly in under-serviced parts of metropolitan Melbourne, rural areas (towns, regional cities) where clients have greater practical concerns over anonymity, distance and access outside normal business working hours.

One way that after-hours access has been addressed in parts of metropolitan Melbourne and in Bendigo and Geelong has been through "mobile services" whereby two staff deliver equipment to people's homes or other locations. This is the most expensive service modality with quite possibly the lowest return on investment.

- **Recommendation 15 -** Two priority areas need to be supported in order to further expand hours of access. These are through supporting the currently unfunded Secondary services, and by encouraging and supporting the introduction of Syringe Vending Machines.

[27] Mathers BM, Degenhardt L, Ali H, Wiessing L, Hickman M, Mattick RP*, et al.* HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. *The Lancet* 2010,375:1014-1028.

Syringe Vending Machines

Sterile needles and syringes can be dispensed via mechanical or electronic vending machines, in most cases for a small fee. These machines may operate outside NSP staffed service hours or provide 24-hour access to sterile injecting equipment. They are co-located with disposal facilities.

Vending machines operate successfully in Queensland, NSW, Tasmania, South Australia, the Australian Capital Territory and Western Australia. SVMs account for approximately 10 percent of equipment distribution in Queensland.

Victoria is now the only state that does not currently have any SVMs as part of its public health and drug harm reduction programs. It has been determined that there are no current legislative barriers to the operation of SVM's in Victoria by existing NSP outlets.

In the case of the most recent State to introduce SVMs, South Australia, "distribution figures demonstrate that the introduction of machines had no adverse impact on distribution of equipment from staffed CNP services. Rather, distribution from staffed sites has increased substantially in the evaluation period following SVM installation".[28]

Anex has investigated the possibility of trialling SVMs in Victoria. Anex has consulted with a number of Victorian health services that wish to add syringe vending machines to complement their existing service. Anex proposes that as an element of this strategy an appropriate trial proceed.

Endorsing introduction of SVMs is particularly important, as a small but growing number of secondary NSP outlets, such as Healesville District Hospital and Maryborough District Hospital have reduced their hours of operations to Monday-Friday, 9am-5pm. This means that clients cannot access sterile equipment after hours during the week or at any time on the weekend.

The provision of such facilities in appropriate locations such as hospitals and community health centres should be considered.

- **Recommendation 16 -** The Strategy should state clearly that, as is the case in other States, SVMs have a role within the Victorian NSP and that the support for their introduction as part of the funded Program also be noted and foreshadowed in the Strategy.

Enabling reach through peer networks to young injectors

There is ample evidence that people starting out as drug injectors do not begin by attending NSPs for accurate health advice. Rather, it may be some time before individuals stop relying on others to source injecting equipment for them and begin visiting NSPs themselves. In that time, they may well have learned high-risk injecting practices and already have contracted hepatitis C.

Currently, it is not possible to formally implement a peer education program training NSP clients who are collecting equipment for others to impart safer-injecting advice to those others. This is because a client is not authorised under the Drugs, Poisons and Controlled Substances Act 1981 to give injecting equipment to another person. In reality, vast numbers of sterile injecting equipment are received by people who then provide them to other injectors, thereby contributing to disease prevention.

The anomaly could easily be remedied by authorising NSP clients as a class of person eligible to give other people sterile needles and syringes. There is already provision for this to happen under the Act; it would only need a change in administrative practice.

- **Recommendation 17** - barriers to facilitating client-to-non client distribution of sterile injecting equipment provided through an NSP be removed through necessary administrative procedures, thereby by formally allowing NSPs to provide accurate and frank advice to picking-up clients about how to encourage third parties to reduce risks of blood borne viruses and other injecting-related health risks.

[28] South Australia. Syringe Vending Machine Trial, 30 November 2009-30 November 2010, Evaluation Report. In. Adelaide: Clean Needle Program, Drug and Alcohol Services South Australia, Department of Health; 2011.

Workforce Development

This pertains to Key Results Area 5 of the National NSP Strategic Framework which states: "Implementation of national core training for NSP workers".[29]

For most of the workforce, NSP service provision is not the primary focus. As discussed earlier, for most agencies NSP service provision is not funded. This significantly constrains the ability of many staff to access workforce development and training opportunities. This is further exacerbated by there being no minimum training requirements for providing NSP services.

The Victorian Alcohol and Other Drugs Workforce Development Strategy 2004-2006 outlined five strategic directions, and minimum qualification standards. However, the accompanying "Minimum Qualifications Strategy" notes (Page 18) that even for *Primary* NSPs, let alone *Secondaries*:

> "Needle Syringe Program Workers are not required to meet the Minimum Qualification Strategy as they do not fall within the definition of an AOD Drug Treatment Services Worker. However, Primary Needle Syringe Program Workers are able to access any of the free training offered under the Victorian AOD Workforce Development Strategy."[30]

A review of the AOD workforce requirements, standards and training is currently underway. The preliminary discussion paper by KPMG and commissioned by the Department of Health mentions staff performing NSP duties as being part of the AOD workforce, citing the 2009 Victorian Alcohol and Other Drug Workforce Census. However, the census, which was also conducted by the Department of Health, specifically states that "Non-clinical service providers, such as employees of the Victorian Needle and Syringe Program, were excluded from this project".

Therefore, it should be assumed for the purposes of the development of the Strategy, that NSP workers (Primary and Secondary) still remain outside the formal definition of the AOD workforce.

- **Recommendation 18 -** The Strategy should categorically state that all people working in an NSP role in Victoria, whether full or part time, should be considered part of the AOD workforce. In addition, the Strategy should recommend that all future workforce development planning and support for the AOD sector specifically recognise the unique role that NSP frontline staff play – and can potentially increasingly play – in counselling and referral as envisaged through funding allocations under the Illicit Drugs Diversion Initiative. As such, the Strategy should foreshadow development of appropriate minimum standards and qualifications for people performing duties in accordance with the Victorian NSP.

The 2004-2006 Alcohol and Other Drugs Workforce Development Strategy does state that despite not being required to have minimum standards, NSP workers can access the training funded by the Department. Anex is the sole specialist provider of this training for NSP workers in the secondary, unfunded sector. The training has received favourable reviews through the Victorian NSP evaluation.

Workforce development capacity needs to be enhanced, including consideration of introducing minimum stands in line with the sentiment of the National NSP Strategic Framework. In Tasmania, training for NSP workers is compulsory. This should be replicated in Victoria.

Staff need to understand the full range of client needs and have the confidence, skills and time to be able to respond to the needs of their clients in the most effective and appropriate way. Staff should know what services are available, and staff (or at least line managers) should be able to maintain effective relationships with those services.

Sufficiently qualified and/or experienced workforce development and support staff should be deployed to cover particular areas and/or networks, with particular emphasis on supporting secondary NSPs in population growth corridors, regional centres and in rural communities.

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[29] DoHA. National Needle and Syringe Programs Strategic Framework 2010-2014. In. Canberra: Australian Government Department of Health and Ageing, 2010.

[30] Victorian Government. 2009 Victorian Alcohol and Other Drug Workforce Census. In. Melbourne: Victorian Department of Health; 2011.

- **Recommendation 19 -** That the Department of Health require all staff involved with client contact to be trained, and to provide increased resources in the annual funding allocation for this purpose. This training should be crafted in such a way as the potential for inter-linkages across needs/service areas is emphasised, particularly with regard to drug treatment, law enforcement, mental health services and social welfare services such as housing and family services.
- **Recommendation 20 -** In addition, workforce development improvement must be implemented in the context of the National Drugs Strategy and the National NSP Strategic Framework which emphasises the need to strive for higher quality and more uniform training and service delivery standards.

It has been demonstrated in Canada that setting 'best practice' standards and operationalising them organisationally is feasible and leads to better client outcomes.

- **Recommendation 21 -** That as a matter of urgency Victoria work with other jurisdictions to establish feasible, flexible best practice standards and have necessary training systems, data collection and monitoring and evaluation systems in place to implement best practice and draw from learnt experiences for on-going systems improvement and policy development. This should be a co-ordinated exercise involving all relevant government agencies including general and mental health, police, justice and communities.

Rural growth in needle and syringe provision

This submission has already demonstrated that sterile needle demand through secondary services is increasing at a far faster rate than through funded primary services. It should be noted that no rural NSP, and only two (Geelong and Bendigo) regional city services, are funded for this service.

It should also be noted that demand for sterile injecting equipment in rural areas has risen substantially in the past decade. According to data from the Department of Health, NSP outlets in rural areas accounted for 15.3 percent of state-wide demand in 2002-2003. This had risen to 23.7 percent in 2010-2011.

As shown in Appendix III, there has been a 55.8 percent increase in the numbers of needles/syringes distributed through rural NSPs in the past five years, compared with 22 percent in metropolitan areas.

This is further evidence that additional investments in resources for secondary NSPs are warranted if service encounters between staff and clients are to be more oriented toward brief counselling interventions and referrals.

Pharmacotherapy

Pharmacotherapy assists in the reduction of harm by reducing blood borne virus transmission, overdoses and offender recidivism. Pharmacotherapy also assists people participate in the vocational training system and the workforce. As such, pharmacotherapy is a prime example of an addiction intervention at the heart of whole of government drug prevention and treatment strategies, as well as enhancing the prospects of future treatment and recovery

The on-going expansion of the Opioid Replacement Therapy (ORT) system in Victoria is to be applauded.

The percentage of Victorian NSP clients who reported that they had ever been on a methadone program, for example, has increased from 36 percent in 1995 to 66 percent in 2010.[31]

However, as with other jurisdictions, Victoria is facing a pharmacotherapy crisis as the need and demand for places on the Opioid Replacement Therapy program far outstrips the structural supply of

[31] NCHECR. Australian NSP Survey: national data report 2005-2009. Prevalence of HIV, HCV and injecting and sexual behaviour among IDUs at needle and syringe programs. In. Sydney: National Centre in HIV epidemiology and Clinical Research, University of New South Wales; 2010.

a) prescribing doctors, and b) dispensing pharmacists. While there are approximately 21,000 people for whom ORT permits have been issued, only about 13,000 are reported as having their ORT dispensed to them. This indicates a 'missing' population of 8000 people who have began ORT, but were not continuing ORT at the time of the annual 'census'.[32]

More than 55 percent of Victorian NSP clients surveyed through the annual Australian NSP survey report that they are on ORT. For many years now Anex has highlighted that the consistently high rates of NSP clients who are also ORT clients points to the need for on-going and outcome-oriented enhancement of the ORT system.

The recent review into the Victorian pharmacotherapy system identified that long-standing inadequacies remain unsolved, particularly regarding the need to improve services in regional and rural areas.

Improving pharmacotherapy services should be viewed as one component of the overall Strategy, and must be seen in the context of the emergent shift toward recovery oriented systems. Therefore, far greater investment and capacity is required to create linkages between health-related services and other psychosocial services more generally.

One area that the Strategy should note is that approximately 8,000 of the 21,000 people who are registered as having a 'permit' to be on ORT are not actually collecting their prescription. The reasons for people moving in and out of ORT are complex and will not be discussed in this submission. However, the "missing 8000" represents a shortfall in the latent potential of the treatment system to fulfil its objectives.

Little, if anything, is known (institutionally) about the 8000 cohort. This highlights a need for better data collection and health records systems. It is further evidence that more client-oriented networking between treatment and other services is required.

Without understanding the missing 8000, it will be difficult for the government to measure success or failure of a recovery-oriented policy. Under the current system, a person may go onto ORT and reduce dosage until becoming abstinent and therefore no longer pick up – a successful outcome that would not necessarily be recorded under current arrangements.

The potential for the CHS sector to play a larger role in the area of pharmacotherapy, if necessary as a condition of the funding provided to that sector, should be given close consideration. At present, involvement by this sector varies dramatically, and yet all are subject to the same funding source and conditions.

- **Recommendation 22 -** That the funding and associated conditions for the CHS sector be reviewed as an element of a whole of government alcohol and drug strategy to ensure that the resources available in this sector and the community context in which they operate is leveraged to maximise their positive contribution to harm minimisation, harm reduction, referral, counselling and treatment, and that service provision is consistent across the sector.

Other areas of importance

Prescription Drug Misuse – challenge of "harmaceuticals"

Judging by trends abroad, including the United Kingdom, the United States and Canada, Victoria can expect to see increasing numbers of people misusing prescription medicines. The increased availability of prescription opioids and other pharmaceuticals will almost certainly challenge perceptions and realities of drug misuse, and will present critical new challenges to an already stretched and under-resourced drug treatment sector.

The increased misuse of prescription drugs has direct implications for NSP services. In particular, staff need regular and updated training on the specifics of pharmaceutical misuse, including the emergence of a new clientele with mismanaged chronic pain. Addressing this need should be done in the context of workforce development overall, discussed elsewhere in this submission.

[32] AIHW. National Opioid Pharmacotherapy Statistics Annual Data collection: 2010 report. In: *Drug Treatment Series*. Canberra: Australian Institute of Health and Welfare; 2011.

- **Recommendation 23 -** The Strategy should recognise that pharmaceutical drug injection requires additional equipment (wheel filters), which are currently not funded through the Program. The Program therefore should provide additional resources to enable service to provide additional equipment.
- **Recommendation 24 -** In addition, investment is required to create informational and behaviour change educative programs targeted at both NSP staff, but more importantly, NSP clients.
- **Recommendation 25 -** Demand and supply reduction strategies will remain hamstrung until such time as reform of health records and pharmaceutical dispensing data is better synchronised. This is an urgent matter that the State Government must address through negotiations with the Australian Government and related stakeholders.

Take home Naloxone to reduce opioid overdose fatalities and injuries

Naloxone Hydrochloride (Narcan®) is a prescription-only drug which reverses the effects of opioids including heroin and prescription drugs such as MS Contin®. It can be injected or administered as a nasal spray. Trials of the nasal spray in Victoria confirm that it is effective in overdose reversal.

International experience demonstrates that non-medical personnel can be trained to safely administer Naloxone Hydrochloride to reverse opioid overdoses, thereby saving lives.

There are dozens of programs overseas, including in the US and UK, under which Naloxone is provided to potential overdose witnesses (including drug users). They have saved thousands of lives. As yet, no such program has existed in Australia.

- **Recommendation 26 -** The Strategy should recommend that a program for Naloxone distribution to potential overdose witnesses be permitted and supported in Victoria. Consideration should be given to incorporating Naloxone training and provision to at-risk prisoners prior to their release.
- **Recommendation 27 -** The Strategy should envisage minor legislative change necessary to remove any ambiguities regarding potential liabilities for prescribers, dispensers and administrators of Naloxone.

For example, 'Good Samaritan' legislative amendments could be passed, as is the case throughout the US. It would enable a prescription of an opioid antagonist in conjunction with an overdose prevention and treatment training program without the prescriber and/or dispenser being subject to civil liability or criminal prosecution even if the antagonist is administered by someone other than the person to whom it is prescribed. An extract from Californian legislation is reproduced below and services as an example of what may be considered in Victoria:

> The bill would authorize a person who is not otherwise licensed to administer an opioid antagonist in an emergency without fee if the person has received specified training information and believes in good faith that the other person is experiencing a drug overdose. The bill would prohibit that person, as a result of his or her acts or omissions, from being liable for any violation of any professional licensing statute, or subject to any criminal prosecution arising from or related to the unauthorized practice of medicine or the possession of an opioid antagonist.

UK legislation permits parenteral administration in an emergency to human beings of certain prescription only medicines, including naloxone. If such law was passed in Victoria, it would enable a person who is not otherwise licensed to administer it permission to do so in an emergency if the person has been given information regarding its use and believes in good faith that the other person is experiencing a drug overdose.

Improved Data Collection

There are serious inconsistencies and shortcomings in the collection, delivery, analysis and dissemination of data relating to NSP clients and service delivery. Problems with data collection throughout the drug and alcohol sector have been noted by the Auditor General.

Anex submits that data collection could be improved through better resourcing and support to secondary NSPs, which currently receive no funding to collect and/or provide data to the Department.

For additional commentary on the need to strengthen data collection, note the "missing 8000" discussion in the section concerning Pharmacotherapy.

The harm reduction sector, and therefore both its clientele and the wider community, would benefit greatly if Anex were able to access program data on a timely basis. This would significantly enhance Anex's support to the harm reduction service sector if it was able to respond rapidly to the dynamic drug market.

Smoking cessation during alcohol or illicit drug treatment

The relationship between smoking and substance use presents questions for harm reduction more broadly, but for drug treatment in particular. It is common for Australian residential withdrawal and rehabilitation services to not address nicotine addiction simultaneously, and for clients' 'smoko' privileges have been known to be used a disciplinary tool. In such scenarios, the threat to take away one drug (cigarettes) is used as a means to facilitate treatment of another. It has been argued that not dealing with tobacco dependence can be seen as a form of harm reduction in that tobacco use is viewed as a lesser evil compared with alcohol or illicit drug use and/or other self-harm behaviours.

Three prevalent assumptions undermining nicotine cessation being included in other drug treatment are: (1) clients are not interested in cessation; (2) staff are not interested in helping clients quit; and (3) quitting smoking may hinder abstinence from alcohol or illicit drug use.

However, a recently published review in the journal, *Drug and Alcohol Dependence*, argued that in fact, treating tobacco addiction during other addictions treatment "appear to enhance rather than compromise long-term abstinence".[33]

As with other high risk groups, including people who use drugs, people who are incarcerated and people of Aboriginal and Torres Strait Islander background and people with mental health issues not only have a greater prevalence of smoking, but also greater potential for associated physical, psychological and social hardship. Each of these factors needs to be addressed should smoking cessation or reduction be achieved.

Permitting alternatives to cigarette smoking

New forms of nicotine delivery may now provide means for uncoupling nicotine use from smoked tobacco, thereby removing most of the harms of smoking tobacco. There is increasing interest within some public health circles in the harm reduction potential of smoke-free nicotine-providing products, of which Swedish-style snus and electronic cigarettes are two examples.[34] They do not expose the user or others to tobacco smoke, and there is epidemiological evidence to suggest they are significantly less harmful than cigarettes. Insufficient harm reduction measures toward smoking is indicative of the need to foster a more holistic regulatory framework based on a continuum of risk and including all nicotine providing products such as pharmaceutical nicotine replacement therapies.

Anex appreciates that these matters fall within Commonwealth responsibilities, but contends that there is scope for the Victorian Whole of Government Drug and Alcohol Strategy to be cognisant of emerging evidence that alternatives to cigarettes may be a legitimate part of programs to reduce smoking-related harms.

For example, in the United Kingdom, the Behavioural Insights Unit within the Cabinet Office has recently raised the possibility of allowing sale and promotion of e-cigarettes based on the potential to

[33] Prochaska JJ. Failure to treat tobacco use in mental health and addiction treatment settings: A form of harm reduction? *Drug and Alcohol Dependence* 2010,110:177-182.
[34] Gartner CE, Hall WD, Vos T, Bertram MY, Wallace AL, Lim SS. Assessment of Swedish snus for tobacco harm reduction: an epidemiological modelling study. *The Lancet* 2007,369:2010-2014.

reduce incidence of lung-cancer. Its annual report, published in September 2011, states: "products that deliver nicotine quickly in a fine vapour instead of as harmful smoke could prove an effective substitute for 'conventional smoking'. It will be important to get the regulatory framework for these products right, to encourage new products, which smokers can use as safer nicotine alternatives, to be made available in the UK."[35]

- **Recommendation 28 -** That Victorian regulatory frameworks amenable to such approaches be developed through the on-going discussions with Local Government regarding banning of cigarette smoking in far more, or all, public spaces. Consideration should be given to including exemptions for e-cigarettes, which may currently be legally consumed in Australia (but not sold).

[35] Government of the United Kingdom. Behavioural Insights Team Annual update 2010–11. In. London: Cabinet Office, 2011.

Appendices

Appendix I – Recommendations from this Submission

- **Recommendation 1 -** That departmental strategies and intervention programs be established between the Department of Education, the Department of Human Services and the Department of Justice to ensure that a coordinated response is established with recognised protocols ensuring that interventions that occur in response to drug incidents in Victorian schools are focused on harm reduction and positive outcomes for the students concerned.
- **Recommendation 2 -** That an Interdepartmental Task Force be established to ensure that the complex needs presented by that small group of young Victorians that have substantial contact with the Victorian Juvenile Justice System are better responded to with an intensive case management plan for each individual.
- **Recommendation 3 -** Stronger coordination between mental health services and alcohol and drug treatment programs be established to more effectively respond to the needs of those persons coming into contact with the community corrections system.
- **Recommendation 4 -** Harm Reduction strategies, including prison based needle syringe exchange programs be established in Victorian prisons, recognising that the Victorian prison population represents a community with complex and serious general health needs and that their release back into the community has serious public health implications
- **Recommendation 5 -** In keeping with the Victorian Government's commitment to ensuring community safety and social cohesion, a post release program be developed for every person released from custody, including ensuring access to affordable housing, mental health services, drug treatment programs and harm reduction programs.
- **Recommendation 6 -** That the Victorian Government recognises that single dimensional interventions will not be effective in responding to the needs of the Victorian population that becomes substantially involved in the criminal justice system, but that cross departmental interventions are required for more effective outcomes that are intended to protect the safety of the wider community.
- **Recommendation 7 -** That for the forthcoming Strategy to be silent on this recommended public health intervention would be a major failure. Furthermore, the Strategy should state that a goal of public health policy in Victoria be the establishment of NSP within the correctional system where appropriate.

- **Recommendation 8 -** That the forthcoming alcohol and drug Strategy be developed in such a way as to 'feed into' any forthcoming communicable diseases strategy for the correctional system. The Strategy should seek to:
    - a) identify potential sites for NSP implementation as either a pilot or trial,
    - b) develop guidelines and protocols for operations of such an NSP, and
    - c) identify barriers to implementation and possible means to overcome those barriers. As a minimum there should be strong collaboration in the development and implementation of such as system between the Departments of Health and Justice, with overall responsibility vested in the former.

- **Recommendation 9 -** That a whole of government alcohol and drug strategy include mechanisms designed to:

- strengthen a focus on the development of an appropriate culture in all workplaces regarding alcohol and drug issues through collaboration between the Department of Health and Worksafe Victoria;

- ensure that Worksafe arrangements for the determination of workers compensation premiums provide an appropriate incentive to employers to address these issues pro-actively

and preventatively and not be limited to *post hoc* action or self protective postures on their part;

- engage with unions, employer and industry groups and other workplace stakeholders to build a consensus and culture around the prevention of harm arising from alcohol and drug usage in the workplace through collaboration between the Departments of Health and Employment and Industrial Relations, and Worksafe;

- Ensure that the education sector, in particular that part of the sector focussed on vocational education, includes in curricula coverage of "healthy workplace" issues, particularly as regards alcohol and drugs in the workplace, through collaboration between the Departments of Education and Employment and Workplace Relations.

- Fund advertising and other promotional activity in regard to workplace health and safety relevant messages in relation to the use of alcohol and drugs in the workplace or impacting on the workplace, through collaboration between the Department of Health and Worksafe.

- Create and/or reinforce connections between workplace health and other sectors such as primary health, community health, alcohol and drug treatment services, the employment sector etc. to provide a more integrated government and community approach to the addressing of relevant issues, through collaboration between the Departments of Health and Employment and Industrial Relations and Worksafe.

- **Recommendation 10 –** The Strategy under consideration at present should not only reflect the National Drugs Strategy, as has been foreshadowed by Minister Wooldridge. It should be based on the aforementioned related strategies in totality. In particular, in so far NSPs are concerned, the forthcoming Victorian Strategy should emphasise the need for, and forecast sufficient resources for, operationalising the significant number of recommendations outlined in the National NSP Programs Strategic Framework 2010-2014.
- **Recommendation 11 -** The Strategy recognise the important role that NSP staff have in referrals and counselling. Further, the Strategy should provide for, consistent with the National NSP Strategic Framework, greater resourcing for workforce development, including curriculum development, E-learning and for regularised experience sharing through support for state-wide/national networking events.
- **Recommendation 12 -** The Strategy should make particular note that secondary NSP services receive no specific funding for NSP services, thereby constraining quality improvement and limiting the potential for the NSP to assist through referrals.
- **Recommendation 13 -** The Strategy should signal Government intention to commit additional resources to secondary NSPs, either directly on a service-by-service basis or through additional means such as resourcing support workers who could help tap the latent potential for the unfunded services to enhance their 'all of government' role through referral to other services. Such an investment strategy should ensure that population distribution is factored in so as to reduce eliminate existing regional disparities in service availability.
- **Recommendation 14 –** The Strategy should ensure that existing and future resources are deployed for maximum return to the community by encompassing and recognising the return on investment potential of all service modalities, noting that unfunded services currently account for more than half the State's NSP throughput and hence return on investment.
- **Recommendation 15 -** Two priority areas need to be supported in order to further expand hours of access. These are through supporting the currently unfunded Secondary services, and by encouraging and supporting the introduction of Syringe Vending Machines.
- **Recommendation 16 -** The Strategy should state clearly that, as is the case in other States, SVMs have a role within the Victorian NSP and that the support for their introduction as part of the funded Program also be noted and foreshadowed in the Strategy.
- **Recommendation 17** - barriers to facilitating client-to-non client distribution of sterile injecting equipment provided through an NSP be removed through necessary administrative procedures, thereby by formally allowing NSPs to provide accurate and frank advice to

picking-up clients about how to encourage third parties to reduce risks of blood borne viruses and other injecting-related health risks.

- **Recommendation 18 -** The Strategy should categorically state that all people working in an NSP role in Victoria, whether full or part time, should be considered part of the AOD workforce. In addition, the Strategy should recommend that all future workforce development planning and support for the AOD sector specifically recognise the unique role that NSP frontline staff play – and can potentially increasingly play – in counselling and referral as envisaged through funding allocations under the Illicit Drugs Diversion Initiative. As such, the Strategy should foreshadow development of appropriate minimum standards and qualifications for people performing duties in accordance with the Victorian NSP.
- **Recommendation 19 -** That the Department of Health require all staff involved with client contact to be trained, and to provide increased resources in the annual funding allocation for this purpose. This training should be crafted in such a way as the potential for inter-linkages across needs/service areas is emphasised, particularly with regard to drug treatment, law enforcement, mental health services and social welfare services such as housing and family services.
- **Recommendation 20 -** In addition, workforce development improvement must be implemented in the context of the National Drugs Strategy and the National NSP Strategic Framework which emphasises the need to strive for higher quality and more uniform training and service delivery standards.
- **Recommendation 21 -** That as a matter of urgency Victoria work with other jurisdictions to establish feasible, flexible best practice standards and have necessary training systems, data collection and monitoring and evaluation systems in place to implement best practice and draw from learnt experiences for on-going systems improvement and policy development. This should be a co-ordinated exercise involving all relevant government agencies including general and mental health, police, justice and communities.
- **Recommendation 22 -** That the funding and associated conditions for the CHS sector be reviewed as an element of a whole of government alcohol and drug strategy to ensure that the resources available in this sector and the community context in which they operate is leveraged to maximise their positive contribution to harm minimisation, harm reduction, referral, counselling and treatment, and that service provision is consistent across the sector
- **Recommendation 23 -** The Strategy should recognise that pharmaceutical drug injection requires additional equipment (wheel filters), which are currently not funded through the Program. The Program therefore should provide additional resources to enable service to provide additional equipment.
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- **Recommendation 27 -** The Strategy should envisage minor legislative change necessary to remove any ambiguities regarding potential liabilities for prescribers, dispensers and administrators of Naloxone
- **Recommendation 28 -** That Victorian regulatory frameworks amenable to such approaches be developed through the on-going discussions with Local Government regarding banning of cigarette smoking in far more, or all, public spaces. Consideration should be given to including exemptions for e-cigarettes, which may currently be legally consumed in Australia (but not sold).

Appendix II - Recommendations from Victorian NSP evaluation (2011)

Recommendations from the draft report on the Evaluation of the Victorian Needle and Syringe Programs, by Health Outcomes International (2011).

The evaluation has presented a number of recommendations to assist in improving the planning, appropriateness, effectiveness and/or efficiency of the program.

R1

NSP service providers are meant to submit a specified data set to the Department on a monthly basis. The data set contains information in relation to distribution volumes, collection and disposal, and certain other demographic data. A number of stakeholders (both service provider and some policy stakeholders) highlighted the need for regular program reporting to be provided. Further, it was noted that the data collected by the Department of Health to support the NSP policy making and service planning has remained relatively unchanged, although services have evolved. Service providers, in particular, suggested that this information (and benchmark data) would be very useful to support service planning and identifying geographic locations requiring greater access to services and better targeting of interventions and related workforce development. It was noted that new services were generally initiated by an applicant, through the licensing process, rather than being a centrally co-ordinated response to a supply and demand analysis. In many ways, this supports the stakeholder view that data is not influencing policy or the sector response as effectively as it could.

It is recommended that the current data reporting arrangements be reviewed to ensure that relevant information is systematically reported by the Department to stakeholders for purposes of service improvement. It is recommended that the Department of Health review the current data collected, define an appropriate data set, and provide instructions to the NSP to report the data on a regular basis. It is recommended that this data be shared with Anex to ensure timely and tailored training interventions.

R2

There is a requirement to have NSPs licensed. A number of stakeholders identified this as a barrier to improving accessibility to sterile equipment, and in particular to utilising (and supporting) the development of social distribution networks in Victoria. Our assessment is that service providers support the establishment of social distribution networks, both in principle, but also in practise (through the distribution of volumes of needles to an individual that are clearly more than that individual's needs).

It is recommended legislation and policy in relation to NSP licensing be amended to maximise participation and minimise barriers to NSP participation for organisations and individuals.

R3

Syringe vending machines operate in all jurisdictions except the Northern Territory and Victoria. There was significant stakeholder support for the introduction of syringe vending machines in Victoria. Given the significant support in the sector, the comparatively high cost of out-of-hours mobile outreach, and the successful adoption of vending machines in other states, it is appropriate that steps be taken to enable their introduction in Victoria.

It is recommended that introduction of SVMs (similar to other states, including South Australia which successfully completed a 12-month trial of four machines in November 2010) be piloted to demonstrate the impacts of introducing vending machines in Victoria.

R4

It is currently policy to provide syringes and needles free of charge to service providers. IDU will, in addition to the equipment supplied at no cost, use other equipment that is necessary to complete safe and sterile injection episode. Items that are most commonly used are sterile water ampoules, tourniquets and wheel filters. There was broad support in the sector for equipment to be supplied at no cost.

It is recommended that consistent with harm minimisation principles, the Department of Health considers expanding the types of equipment that are provided free of charge.

R5 Based upon our analysis of the data and stakeholder feedback there is a need to improve service planning activities and to introduce financial support to particularly busy secondary NSPs. This should include the mapping and identification of both geographic and demographic service gaps in relation to NSP service delivery. Importantly, the planning should propose a strategic response to any gaps identified, including the preparation of an implementation plan with specified timeframes. This type of co-ordinated planning approach to the identification of new NSP sites and services, should ultimately replace the "applicant-driven" approach currently adopted in relation to the establishment of new services, and provide a greater equity of distribution. Such planning should be aimed at increasing the number of Aboriginal Controlled Community Health Organisations which actively participate in the program.

It is recommended that the Department of Health conduct a review of NSP service planning approaches including a gap assessment with the aim of providing a coordinated planning approach to improve service delivery and access.

R6 The evaluation noted that young IDU are under-represented in the age profile of people attending NSPs. The National NSP surveys indicate that this may be a feature of the Australian NSP system more generally. There is a paucity of data and published reports on the issue of young Victorian illicit drug injectors and their willingness to engage established NSP services.

It is recommended that investigation be conducted into young people's transition to illicit drug injection, access to injecting equipment and ways in which NSP services can be improved to serve young injectors, not just in provision of BBV prevention but in also assisting them engage alcohol and drug treatment services.

R7 The IDU survey and stakeholder consultation identified the need for increased access to sterile equipment outside of office hours. It is considered that a number of optional approaches warrant consideration via cost-benefit analysis, such as extended fixed site hours, expanded out-reach, financial support to hospital-based overnight Emergency Departments and syringe vending machines. This would provide a greater breadth of options to meet the different needs of IDUs.

It is recommended that following gap analysis the Department of Health, as part of the NSP strategic planning processes, address the provision of increased access to sterile equipment outside normal business hours.

R8 The evaluation noted that many secondary NSP staff insufficiently engage with NSP clients. It also noted that there was limited time and resources available to support effective training of NSP staff. In general, secondary and pharmacy outlets provided their own orientation training, and little more. Primary and some Secondary sites had accessed Anex training and provided favourable feedback.

Consistent with the intentions of the National NSP Strategic Framework, including improving capacity to engage with clients, it is recommended that the Department of Health require all staff involved with client contact to be trained, and to provide increased resources in the annual funding allocation process.

R9 The evaluation noted that hepatitis C prevalence rates among IDU presenting in Victorian NSP services have remained high. In order to further improve public health outcomes through reduced hepatitis C transmission, increased distribution of sterile injecting equipment and improved health promotion should be a stated and funded aim of the Victorian program.

It is recommended that steps be taken to prioritise hepatitis C prevention and treatment by significantly expanding coverage of and access to the Program and to strengthen the capacity of the NSP workforce to provide clients with evidence-based prevention advise as well as people with hepatitis C how to access and maintain treatment.

R10 The evaluation has identified there are opportunities to improve the current NSP partnership and support arrangements including networking, advocacy and crisis management. The design, development and implementation of a state-wide support network has been identified as an initiative that warrants consideration by the Department. This is particularly the case regarding outer Melbourne-metropolitan areas undergoing rapid expansion, and in regional and rural areas which have little opportunity for practical skills sharing on a regular basis. Such an approach should be modelled on the intent of the National NSP Strategic Framework. Sufficiently qualified and/or experienced workforce development and support staff should be deployed to cover particular areas and/or networks.

It is recommended that the Department of Health review the model/s by which NSPs are currently supported. Consideration should be given to creating additional workforce development capacity to improve the effectiveness of NSP service delivery, with particular consideration given to the needs of Secondary NSPs in non-metropolitan areas.

R11 The evaluation identified that there were opportunities to improve the NSP from a policy and governance perspective:

- NSP services and systems have been in place for 20 years and to a large extent remain relatively unchanged. During that time there have been demographic changes, drug-use changes and to some extent changes in research into NSPs and drug treatments (e.g. pharmacotherapy services).
- The data collected by the Department of Health to support policy development and governance of the NSP had remained relatively unchanged.

It is recommended that the Department of Health undertake a systematic review of the appropriateness of the policy and governance framework in relation to NSPs in Victoria to ensure that it is consistent with evidence-based best practice.

R12 The evaluation identified that there is a requirement to have more sophisticated and nuanced approaches to working across the diversity of NSP client profiles. This applies to ethnicity, culture, gender, sexuality and age which is a particularly cross-cutting issue of importance.

It is recommended that program planning and implementation, particularly as it pertains to recommendations 1, 6, 7 and 11, increase attention to sub-population specific research and interventions.

Appendix III - Needle and Syringe distribution (units) in Victoria by health region and local government area.

Source: Department of Health, 2011.

REGION	Local Govt Area	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	5-year % increase in Syringes (05-06 to 10-11)
Barwon-SW	Colac-Otway (S)	32,950	30,350	38,650	48,900	63,650	55,100	67.2%
	Corangamite (S)	4,500	12,100	7,450	8,700	7,000	15,950	254.4%
	Glenelg (S)	46,000	37,450	51,300	62,650	60,500	98,750	114.7%
	Greater Geelong (C)	359,100	363,000	312,800	368,600	382,000	434,850	21.1%
	Moyne (S)	2,750	1,250	2,250		1,500	0	-100.0%
	Queenscliffe (B)					0		
	South'n Grampians (S)	19,650	23,350	18,800	17,100	14,500	3,750	-80.9%
	Surf Coast (S)			6,950	300	750	750	
	Warrnambool (C)	44,450	67,500	48,450	64,000	54,500	69,200	55.7%
Barwon-SW Total		**509,400**	**535,000**	**486,650**	**570,250**	**584,400**	**678,350**	**33.2%**
Gippsland	Bass Coast (S)	16,200	15,000	15,500	20,800	24,050	25,350	56.5%
	Baw Baw (S)	17,950	23,050	25,250	29,600	30,900	53,200	196.4%
	East Gippsland (S)	23,200	29,300	37,200	50,200	61,000	55,300	138.4%
	Latrobe (C)	279,650	328,800	349,050	408,350	403,450	405,850	45.1%
	South Gippsland (S)	8,250	9,000	3,750	3,000	8,250	3,750	-54.5%
	Wellington (S)	21,500	28,100	31,900	42,350	49,900	84,800	294.4%
Gippsland Total		**366,750**	**433,250**	**462,650**	**554,300**	**577,550**	**628,250**	**71.3%**
Grampians	Ararat (RC)	6,000	7,700	4,750	8,750	3,500	8,750	45.8%
	Ballarat (C)	161,500	163,650	193,950	193,650	212,600	228,250	41.3%
	Hepburn (S)	3,750	8,500	7,000	6,500	5,750	5,500	46.7%
	Hindmarsh (S)						1,250	
	Horsham (RC)	41,250	22,900	37,250	41,900	58,250	61,600	49.3%
	Moorabool (S)	10,500	7,950	11,700	15,700	8,500	8,250	-21.4%

REGION	Local Govt Area	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	5-year % increase in Syringes (05-06 to 10-11)
	Northern Grampians (S)	5,000	4,000	14,000	7,900	19,250	7,500	50.0%
	West Wimmera (s)						1,600	
	Yarriambiack (S)			2,750		3,000	500	
Grampians Total		**228,000**	**214,700**	**271,400**	**274,400**	**310,850**	**323,200**	**41.8%**
Hume	Alpine (S)			1,800	2,300	6,350	8,150	
	Benalla (RC)	8,000	9,000	8,000	10,000	16,000	20,750	159.4%
	Greater Shepparton (C)	104,300	104,800	108,700	115,950	119,450	127,400	22.1%
	Indigo (S)					750	0	
	Mansfield (S)	2,000	3,750	1,600	1,800	1,750	2,100	5.0%
	Mitchell (S)	14,200	12,750	9,750	10,500	7,500	9,000	-36.6%
	Moira (S)	15,050	13,250	18,600	17,500	23,250	23,000	52.8%
	Murrindindi (S)	1,250	2,750	1,750	2,100	750	2,250	80.0%
	Towong (S)					750		
	Wangaratta (RC)	10,850	8,300	10,750	7,500	11,400	11,250	3.7%
	Wodonga (RC)	68,900	67,300	108,850	102,500	99,550	117,350	70.3%
Hume Total		**224,550**	**221,900**	**269,800**	**270,150**	**287,500**	**321,250**	**43.1%**
Loddon Mallee	Buloke (S)					0	600	
	Campaspe (S)	16,600	22,300	21,450	25,600	28,800	26,850	61.7%
	Central Goldfields (S)	12,450	16,900	13,600	16,800	26,550	39,650	218.5%
	Gannawarra (S)	3,500	750	1,750	4,250	3,500	2,750	-21.4%
	Greater Bendigo (C)	80,850	108,000	92,750	95,250	128,000	131,100	62.2%
	Loddon (S)		2,250	1,000	0	1,000	0	
	Macedon Ranges (S)	3,050	5,000	4,500	5,350	12,850	3,900	27.9%
	Mildura (RC)	44,000	52,900	35,500	59,900	89,300	131,600	199.1%
	Mount Alexander (S)	12,450	10,300	8,300	27,150	31,450	26,650	114.1%
	Swan Hill (RC)	8,000	10,500	10,100	14,000	27,500	37,700	371.3%
Loddon Mallee Total		**180,900**	**228,900**	**188,950**	**248,300**	**348,950**	**400,800**	**121.6%**

REGION	Local Govt Area	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	5-year % increase in Syringes (05-06 to 10-11)
M_Eastern	Boroondara (C)	0	1,500	4,000	4,700	13,100	7,550	
	Knox (C)	0		1,000	1,000	6,000	7,850	
	Mannigham (S)					2,000	1,250	
	Maroondah (C)	97,450	112,250	104,850	111,250	127,300	131,850	35.3%
	Monash (C)	44,200	41,950	81,550	42,750	73,600	72,900	64.9%
	Whitehorse (C)	321,950	358,850	380,850	344,500	378,300	380,400	18.2%
	Yarra Ranges (S)	134,200	118,950	145,050	144,950	130,900	107,500	-19.9%
M_Eastern Total		**597,800**	**633,500**	**717,300**	**649,150**	**731,200**	**709,300**	**18.7%**
M_North&West	Banyule (C)	78,150	65,850	62,050	75,150	84,800	95,250	21.9%
	Brimbank (C)	80,400	110,850	216,600	290,700	436,850	535,850	566.5%
	Darebin (C)	294,150	320,200	317,500	349,300	361,350	394,000	33.9%
	Hobsons Bay (C)	18,650	29,900	30,700	10,750	11,750	14,550	-22.0%
	Hume (C)	145,700	141,100	159,250	142,550	142,500	149,000	2.3%
	Maribyrnong (C)	383,500	400,300	475,200	395,750	375,250	417,300	8.8%
	Melbourne (C)	330,900	219,450	193,800	151,450	186,500	183,600	-44.5%
	Melton (S)	34,250	14,550	22,000	31,950	41,200	51,450	50.2%
	Moonee Valley (C)	10,600	14,700	23,650	35,850	24,750	39,150	269.3%
	Moreland (C)	493,100	546,350	554,350	617,900	614,450	655,950	33.0%
	Nillumbik (S)	19,050	15,400	11,100	3,350	12,150	20,600	8.1%
	Whittlesea (C)	18,150	20,500	22,950	24,450	30,200	37,700	107.7%
	Wyndham (C)	108,700	136,250	145,800	157,350	152,000	153,950	41.6%
	Yarra (C)	1,042,250	1,048,250	1,220,600	1,155,200	1,121,100	962,400	-7.7%
M_North&West Total		**3,057,550**	**3,083,650**	**3,455,550**	**3,441,700**	**3,594,850**	**3,710,750**	**21.4%**
M_Southern	Bayside (C)			750	100	1,250	500	
	Cardinia (S)	42,650	45,500	55,950	47,250	41,350	44,750	4.9%
	Casey (C)	61,300	138,050	119,250	117,400	143,550	138,100	125.3%
	Frankston (C)	574,450	584,600	632,350	629,700	629,400	641,050	11.6%

REGION	Local Govt Area	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	5-year % increase in Syringes (05-06 to 10-11)
	Glen Eira (C)	39,850	26,900	36,600	40,750	43,200	37,750	-5.3%
	Greater Dandenong (C)	516,700	570,900	571,550	622,550	690,600	767,650	48.6%
	Kingston (C)	22,900	31,750	33,100	35,450	29,000	39,250	71.4%
	Mornington Peninsula (S)	70,550	71,300	101,850	83,750	108,750	96,350	36.6%
	Port Phillip (C)	1,101,350	1,118,700	1,196,600	1,276,250	1,249,300	1,248,950	13.4%
	Stonnington (C)	111,700	108,100	108,800	128,850	107,150	127,000	13.7%
M_Southern Total		**2,541,450**	**2,695,800**	**2,856,800**	**2,982,050**	**3,043,550**	**3,141,350**	**23.6%**
Grand Total		**7,706,400**	**8,046,700**	**8,709,100**	**8,990,300**	**9,478,850**	**9,913,250**	**28.6%**

	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	Change
Metropolitan	6,196,800	6,412,950	7,029,650	7,072,900	7,369,600	7,561,400	22%
Rural	1,509,600	1,633,750	1,679,450	1,917,400	2,109,250	2,351,850	55.8%
TOTAL	7,706,400	8,046,700	8,709,100	8,990,300	9,478,850	9,913,250	28.6%