Submission to the
Standing Committee on Family and Community Affairs
for the Inquiry into
Substance Abuse in Australian Communities

by the
Public Health Association of Australia

The Public Health Association of Australia (PHAA) is the national peak body of the public health sector in Australia. The PHAA is the principal organisation for public health in Australia and is the major forum for advocacy for public health, policy development, research and training and for the exchange of ideas, knowledge and information on public health. Through representation by PHAA members on external committees and task forces, the Association contributes to evidence based decision-making processes relevant to public health issues.

TERMS OF REFERENCE

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

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

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

SUMMARY OF RECOMMENDATIONS

Part 1 Tobacco

Recommendations:

1.0 Implement a National Plan of Action Against Tobacco in 11 areas of action:

1.1 Passive smoking
1.2 Price of tobacco products
1.3 Promotion of tobacco products
1.4 Points of sale
1.5 Public education (including school education)
1.6 Proven aids to cessation
1.7 Poisons Act
1.8 Packaging
1.9 Probity in public pronouncements
1.10 Prosecution
1.11 Government responsibilities

PART 2 ALCOHOL

2.1 Intensification of harm minimisation responses appropriately directed at population groups.
2.2 Development of intersectoral collaboration especially using a settings approach
2.3 Increase excise and other taxes on alcohol in proportion to the alcohol content of beverages.
2.4 Enforce legislation about the responsibilities of those serving alcohol in public environments.
2.5 Greater incentives for manufacturers to produce and market lower alcohol beverages.
2.6 Introduce drink-safe education programs that link alcohol abuse with violence especially violence against women and children.
2.7 Programs to prevent children ‘inheriting’ violent behaviours.
2.8 Increased revenue from increased taxes be directed to fund living with alcohol programs.
2.9 Increased research into relationships between alcohol abuse, anxiety, depression and affective disorders.
2.10 Referral of alcohol and problematic drug use issues to the National Public Health Partnership particularly in terms of chronic disease, cancer, injury, which are all National Health Goals and Targets.
2.11 Funding for systematic rigorous evaluation of local and State-wide campaigns to determine their impact and cost-effectiveness.

2.12 Strengthening of alcohol counselling skills of GPs and community health nurses, including school nurses.

Summary of Recommendations cont'd

PART 3 ILLICIT DRUGS

3.1 It is preferable to fund treatment because good treatment programs work and are more effective than the current over-emphasis on law enforcement.

3.2 Expand pharmacotherapy treatment options.

3.3 Increase funding for community based counselling options and social support together with funding for community action to address the drug problem. There is real need for a diversity of treatment options and decentralised treatment availability in community health, general practice and community hospitals;

3.4 Rehabilitation programs need to be multifaceted and include skill training for long time drug users trying to re-enter society;

3.5 Programs must have the capacity to deal with the social determinants of drug use including violent experiences, poverty and unemployment and not just in terms of disadvantage.

3.6 All jurisdictions including the Commonwealth should adopt forthwith the Cannabis Expiation Notice System modelled on South Australia and the ACT but with substantially reduced penalties.

3.7 All jurisdictions should ensure forthwith that sterile needles and syringes are readily available at no or minimal cost at all times and places where there is demand for their use with particular attention to correctional facilities and safe injecting rooms.

3.8 All jurisdictions should ensure that heroin injectors who wish to enter methadone maintenance programs and other pharmacotherapy treatments can be assessed within days, that entry criteria are minimal, that programs are attractive and economical and high retention rates. Currently, there is limited access to public methadone programs. In one Gold Coast study, more than half of users who said they would definitely or probably start treatment tomorrow if they could, 56% said it was the waiting list that was stopping them[1]. Access should be facilitated to treatment options and people should not be thrown off a program for minor misdemeanours.

3.9 All jurisdictions should review the process under which police officers apprehend drug users for personal possession. In some instances, it may

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[1] Weatherburn, D & Lind, B. 1999. 'Heroin harm minimisation: do we really have to choose between law enforcement and treatment?' *Crime and Justice Bulletin*, NSW Bureau of Crime Statistics and Research. No 46, November.

be appropriate to refer drug users to agencies for health and welfare assistance. This may require educational processes within the police force.

3.10 In light of the cost-effectiveness data, funding should be redirected from law enforcement restriction of drug supplies to health and welfare assistance for drug users.

3.11 All jurisdictions should ensure that rigorous scientific trials which evaluate innovative forms of treatment, including the distribution of currently illicit substances to drug dependent persons, should be allowed to proceed subject to usual ethical and research review as would any other scientific trial.

3.12 If scientific trials of controlled availability of illicit substances show greater benefits and fewer costs that present policies, persons shown to be using drugs hazardously should be able to obtain sterile heroin, and other substances of known concentration at costs which are below those of the illegal market. Nonetheless unsanctioned cultivation, production, transport, distribution, sale, possession, or use of illicit drugs above quantities consistent with personal use would continue to be regarded as offences.

INTRODUCTION

A growing body of evidence demonstrates the health impact of problematic drug use with strong links drawn between problematic drug use and economic and social conditions. Income levels and distribution, conditions of employment, unemployment, low levels of education and poor social support are structural factors that contribute to environments where problematic drug use is prevalent. Drug-related problems affect not only the health of individuals but also the health status of populations. The degree of problematic drug use in Australia is a strong indicator of our nation's health as is the quality of our response to the problems engendered by it.

Public health is an approach that seeks solutions to health problems that have social, political and environmental causes. This submission is focused on the intensifying of healthy public policy for the **prevention of harms** associated with tobacco, alcohol and illicit drugs. Where these substances are already being used, public health seeks to **minimise the harms** associated with their use and to **restore the health of people** who wish to withdraw from them.

Harm minimisation refers to policies and programs directed at individuals and particular sub-population groups as well as communities in terms of health, social and economic outcomes. Harm minimisation approaches must be adaptable and responsive to particular contexts and people.

Detailed data about tobacco, alcohol and other drug use will be contained in submissions to the Inquiry from the network of Drug and Alcohol Research Institutes and Centres in Australia. The PHAA supports the directions of Australia's National Drug Strategy. The PHAA submission will highlight areas where progress towards safer, healthier and more supportive environments could be achieved through strengthening of healthy public policy responses to drug use.

Part 1 TOBACCO

Every reputable medical and scientific organisation that has reviewed the evidence has concluded that the use of tobacco is the leading preventable cause of ill-health and premature death in communities like our own. Cigarette smoking causes more than 19,000 avoidable deaths in Australia each year. The costs of smoking related morbidity and mortality in terms of health care costs, absenteeism and lost income from those unable to work are estimated at more than $6 billion annually.

The Public Health Association of Australia notes the success of the national response to passive smoking which developed following the November 1997 release of the NHMRC's scientific information paper on passive smoking. The PHAA recommends that AHMAC in conjunction with the National Public Health Partnership be requested to continue their pursuit of a national response to the problem of tobacco but in a broad framework, through a comprehensive National Plan of Action Against Tobacco. The Public Health Association of Australia does not support a total prohibition of tobacco, but we believe that it is entirely appropriate to regulate very strictly all aspects of the production, promotion, sale and consumption outside the home of products that kill prematurely half of the people that use them regularly. This epidemic warrants a comprehensive national response at every level of activity in the tobacco industry.

Thus, the principal policy direction for governments must be to intensify the control of tobacco markets in order to achieve the following objectives:

- to lower the prevalence of smoking in all age groups of the population;
- to ensure that non-smokers remain non-smokers, especially teenagers;
- to help smokers either to stop smoking or to reduce their exposure to the harmful components of tobacco smoke as far as possible;
- to proscribe all forms of tobacco promotion;
- to protect people from involuntary exposure to the tobacco smoke of others.

In order to achieve these objectives and drawing upon the best of international thinking and practice, we are able to identify eleven principal areas in which tobacco control activities which could be intensified in the States and Territories through a nationally coordinated effort. In order of priority, these are:

1. Passive smoking
2. Price of tobacco products

3. Promotion of tobacco products
4. Points of sale
5. Public education (including school education)
6. Proven aids to cessation
7. Poisons Act
8. Packaging
9. Probity in public pronouncements
10. Prosecution
11. Government responsibilities

This submission describes the nature, potential and long-term goal for each of these strategies. The PHAA recommends the following strategies be incorporated into a comprehensive Action Plan:

1. Passive smoking

There is ample evidence from the scientific literature to show that, aside from reducing the risk of life-threatening disease, adoption and enforcement of smoke-free policies reduces both the prevalence of smoking and daily consumption of tobacco by continuing smokers. It also strongly reinforces the message that smoking is no longer the norm in our community., It is pleasing to see jurisdictions in Australia moving towards a position where smoking is not allowed in any public place or workplace.

Assuming that AHMAC endorses the core provisions of the National Response to Passive Smoking in Enclosed Public Places and Workplaces: a background paper (NPHP 2000) at its August 2000 meeting, the process must be monitored for its implementation. Making progress towards the goal of a smoke-free environment outside the private home deserves top priority as it is simple, cheap and effective strategy that has strong support from the community.

2. Price of tobacco products

Consumption of tobacco products, especially by young people, is considerably price-sensitive. Australia should pursue all reasonable methods to ensure that the real price of tobacco products increases significantly faster than the cost of living, especially through Commonwealth excise on tobacco products.

The Australian Constitution contains a specific provision (s112) for States to raise revenues related to regulation of certain activities, provided that those revenues are used exclusively for enforcement of laws pertaining to the same activities. Increasing levies on tobacco products under this provision affords a mechanism for the State Government simultaneously to reduce demand for tobacco products and to increase resources available for other tobacco

control activities such as public and school education, and surveillance and prosecution of breaches of the tobacco control legislation.

An additional means by which State Governments could achieve a significant increase in the price of tobacco products is successful prosecution of the tobacco companies for recovery of costs related to provision of health services for patients whose medical conditions were caused by smoking. Whatever margin the tobacco companies added to the price of their products to meet an order to repay Governments would be further "magnified" by the Federal excise on tobacco.

3. Promotion of tobacco products

Cigarettes and cigars continue to be promoted in our community via at least four routes: "product placement" in film and video productions, "puff pieces" about "cigar bars" and similar establishments in the print media, sponsorship of certain sporting events and advertising at the point-of-sale. The National Plan of Action Against Tobacco should seek action by State and Territory Governments for amendments to Tobacco Control Acts to proscribe these and all other forms of promotion of tobacco products, and the amended provisions should be vigorously enforced. Until this is done, young people perceive that the community and governments are not seriously committed to ending the use of tobacco products.

A National Plan of Action Against Tobacco should use as its benchmark, those statutory and other regulatory mechanisms that have been adopted in some Australian jurisdictions. A National Plan of Action Against Tobacco should seek to *eliminate* tobacco promotion entirely and propose a range of strategies and a timeline for achieving this goal within the lifetime of the Plan. While there are several precedents for use of "sunset clauses" in tobacco control to allow vested interests to adapt to new regulatory environments, in relation to promotion of tobacco products the National Plan of Action Against Tobacco should include a "sunrise clause" relating to the introduction of a reverse onus of proof. After such a clause comes into effect, an adequate defence to a charge of promoting a tobacco product will require the defendant to show that his or her activity cannot have contributed to creation of circumstances where any member of the audience was more likely to smoke or to increase consumption of tobacco as a result of the communication in question.

Reversing the onus of proof is a very unusual legal arrangement but it is fully justified in this instance by the unique danger posed by use of tobacco. In addition, adoption of a reverse onus of proof is supported by Australian precedent in the form of provisions regarding claims against the Department of Veterans' Affairs for damage to health caused by smoking while on active service.

4. Points of sale

In regard to advertising at the point of sale, the goal should be that tobacco becomes entirely an under-the-counter product, stored out of sight of potential customers, adolescents and children, and available only on specific request. As indicated in the preceding section, there should be no point of sale advertising of any kind, save perhaps a small notice of fixed size, colour, wording, style and dimensions indicating that "tobacco products are available on these premises".

Field research in Western Australia has demonstrated that restricting vending machines for cigarettes to premises licensed to sell alcohol has been a dismal failure in terms of restricting access by children to tobacco products. The Global Tobacco Settlement in the United States includes an agreement that the tobacco companies will withdraw all vending machines. Accordingly, a National Plan of Action Against Tobacco should unambiguously identify amendment of Tobacco Control Acts to prohibit such machines entirely in Australia.

At present tobacco products are sold very widely indeed and surveys suggest that young people have to try at most two outlets before cigarettes will be sold to them. Reducing the number of outlets where tobacco is sold will contribute to a reduction in sales. A National Plan of Action Against Tobacco should require the introduction of licensing for tobacco retailers across Australia. It is a notable anomaly that while we require licences to sell milk, alcohol, cars or guns, none of which kills half of their consumers when used exactly as the manufacturer intends, there is no requirement in some jurisdictions for vendors of tobacco products to be licensed.

As noted above, State Governments have the power to levy fees on retailers of tobacco as well as on the products themselves. Part of the fees collected from licensing of existing retailers should be used systematically to "buy out" licensees, thus actively reducing the number of outlets selling tobacco products. No new licences should be issued.

A further strategy of a National Plan of Action Against Tobacco should be to amend the Tobacco Control Acts in States and Territories to require that only adults can sell tobacco products. This will increase the chances of adherence to the existing provision that such sales are only made *to* adults, particularly if the introduction of this provision is supported by training of licensees akin to training in "safe serving practices" now available to many bar staff in hotels. Such training should be made compulsory for all adults who will sell tobacco products, not just the licensee. While it could be subsidised by revenues collected from tobacco licence fees and levies on tobacco products, full cost-recovery for training is to be preferred because it would act as an additional disincentive to entering the pool of tobacco retailers.

5. Public education (including school education)

The UICC identifies education about tobacco as a central element of efforts to reduce the harm done by smoking. However, expenditure by the State and Territory Governments on public education activities about tobacco has been

declining in current-day dollars for many years. In terms of real outlays, of course, the decrease has been even sharper. For example, consecutive surveys by the Australian Council on Health, Physical Education and Recreation have demonstrated that coverage of the core health education curriculum in the K-12 syllabus in Western Australia is increasingly incomplete. Both of these trends must be reversed if we are to reduce acquisition of smoking habits by young people and use of tobacco products in all relevant age-groups (through both increased cessation of smoking and decreased consumption by continuing smokers).

Achieving these goals will require either or both commitment of a greater proportion of funds provided to the States and Territories by the Commonwealth from excise on tobacco and raising additional monies from State licence fees on tobacco (see above).

The goal should be to meet the “Californian commitment” of US$3.35 (A$5.78) per capitem per annum (3). These amounts are 1993 dollars – in the year 2000 the target level is A$7.12 per capitem.

A National Plan of Action Against Tobacco should strive to strengthen community action, and canvass the possibility of making mandatory in schools systematic education about tobacco and the tobacco industry in order to make a meaningful impact on the uptake and prevalence of smoking among teenagers.

6. Proven aids to cessation

Use of “nicotine replacement therapy” has been shown to double the chances that a considered attempt to give up smoking is successful. However, relevant products remain very expensive in Australia and certainly beyond the financial means of most young people and people on low incomes. In general, subsidising proven aids to cessation of smoking will help to reduce the prevalence of smoking in the community. The introduction of such subsidies would also strongly underline the commitment from governments to a smoke-free future for all Australians. The subsidies could be underwritten by State licence fees on tobacco retailers and State levies on tobacco products.

The National Plan of Action Against Tobacco should identify and pursue strategies that will achieve the stated goals and include all aids to cessation of smoking that are of proven efficacy.

7. Poisons Act

The National Plan of Action Against Tobacco must include a strategy and timeline for securing the goal of the removal of the exemption for nicotine under Poisons Acts. Having cigarettes and other tobacco products recognised for the deadly poisons that they are will facilitate other strategies to regulate how these products are packaged, stored and sold, and where and by whom they are sold.

8. Packaging

Making the products themselves less attractive will reduce demand for tobacco products. At present, annual reports from the tobacco companies have stated explicitly, "Our products are the best advertisement"(4, p9). In practice, countering this mode of promotion means a move to "generic" packaging. Legal advice to the World Health Organisation indicates this can be achieved without infringing international agreements on such issues as trademarks - the trademarks of tobacco companies would not be compromised, but where and how they can be used would be regulated. The National Plan of Action Against Tobacco should identify a strategy and timeline for achieving this change.

9. Probity in public pronouncements

The National Plan of Action Against Tobacco should identify strategies and timelines for achieving legislative provisions to penalise those making misleading public statements about tobacco, with the added proviso that such arrangements also cover persons making misleading statements about the tobacco industry and associated entities.

10. Prosecution

Adequate resources must be allocated by the States and Territories for the monitoring, enforcement, research and evaluation relevant to tobacco control. State Governments have the ability to levy licence fees on tobacco retailers and levies on tobacco products under s112 of the Constitution.

There is potential benefit for tobacco control of introducing a requirement that all retailers of tobacco should be licensed. With such a system in place, a first infringement of the provisions of the licence, which would include compliance with all laws and regulations under tobacco control legislation, should attract an official warning from the relevant authority. A second infringement should be prosecuted. A third infringement should also be prosecuted and, if proven, should result in permanent cancellation of the relevant tobacco retailer's licence, thus reducing the total number of licences in operation. In addition, the offender should be disqualified from holding a tobacco retailer's licence for a period of five years. The cancellation should apply to each and every address where that licence applied.

11. Government responsibilities

The Public Health Association of Australia recommends that:

> as a matter of public health ethics and as a responsible form of public education, all parliamentarians and their staff should refuse to accept

tobacco company sponsorship or hospitality for events that lend respectability;

governments should rescind all forms of policy that allow taxation concessions to tobacco companies for research or related activities.

National action is required if we are to bring to an end as quickly as possible the epidemic of death and disease that is caused by use of tobacco in Australia.

References

1. Collins DJ, Lapsley HM. Estimating the economic costs of drug abuse in Australia. National Campaign Against Drug Abuse. Monograph Series no 15. Canberra, AGPS, 1991
2. Policy Book, Public Health Association of Australia, Canberra, 2000.
3. Tobacco Education and Research Oversight Committee. Toward a tobacco-free California: Strategies for the 21st century. January 2000.
4. WD & HO Wills. Take a fresh look: Annual report, 1996.

2. ALCOHOL

The high level of social acceptability of alcohol masks the extent of social and economic costs associated with the problematic use of alcohol. The conventional focus of alcohol programs is on individual people with severe alcohol use problems. However, alcohol related harms occur on a continuum. The PHAA believes that vastly greater costs to society are incurred from the lower ends of the continuum of alcohol use (eg binge drinkers) than from the few people (problem drinkers) at the severe end of the continuum, and this is supported by epidemiological evidence.

Alcohol is one of the most fundamental causes of death and disability in Australia. Of the five priority program areas from the National Health Goals and Targets, alcohol is strongly implicated in cardiovascular disease, cancer, injury and mental illness. Alcohol remains a major cause of road traffic accidents. Alcohol programs, as for other tobacco and other drug programs, must be clustered for population group frameworks from a lifecourse perspective in terms of women's health, men's health, adolescent health and Aboriginal health.

Comorbidity is a serious problem for Australia. People suffering from mental illness and mental health problems combined with alcohol and other drugs are said to be experiencing comorbidity. Rates of comorbidity are rising steadily and require innovative, integrated approaches. Alcohol related harms have negative synergies with tobacco and other drug use that compound physical conditions such as cancer, that demonstrate the imperative for funding to be directed into integrated public health practice. The PHAA recommends a broadening of approaches to alcohol problems towards greater program coordination linking mental health and alcohol programs with tobacco and other drug programs. There is commonly a vicious cycle between poor mental health and problematic alcohol use. The development of integrated public health practice demands intersectoral collaboration from the health and social sectors with education, industry and transport sectors for example. Australia must also invest in the intensifying of secondary and tertiary prevention programs.

There are too few evaluations of campaigns conducted for harm minimisation in relation to living with alcohol. Evaluations are critical to ensure the continued development of learning about the value of investments in preventive and health promoting campaigns. This need is even more critical for programs that simultaneous address alcohol with other drugs. There are negative synergies between alcohol and tobacco. People who are trying to give up smoking often resume smoking when they are drinking. In other words, alcohol is a multiplier of risk in relation to smoking.

The National Public Health Partnership has not yet addressed issues of drug use and how a more integrated and coherent approach to harm reduction could contribute to the national public health effort. This is an opportunity lost as much value could be added to the total effort of health improvement

through such the NPHP, particularly in relation to legislation, strategy coordination, data collection and workforce development.

PHAA Recommendations

4 Intensification of harm minimisation responses appropriately directed at population groups.
5 Development of intersectoral collaboration especially using a settings approach
6 Increase excise and other taxes on alcohol in proportion to the alcohol content of beverages.
7 Enforce legislation about the responsibilities of those serving alcohol in public environments.
8 Greater incentives for manufacturers to produce and market lower alcohol beverages.
9 Introduce drink-safe education programs that link problematic alcohol use with violence especially violence against women and children.
10 Programs to prevent children 'inheriting' violent behaviours.
11 Increased revenue from increased taxes be directed to fund living with alcohol programs.
12 Increased research into relationships between problematic alcohol use, anxiety, depression and affective disorders.
13 Referral of alcohol and problematic drug use issues to the National Public Health Partnership particularly in terms of chronic disease, cancer, injury, which are all National Health Goals and Targets.
14 Funding for systematic rigorous evaluation of local and State-wide campaigns to determine their impact and cost-effectiveness.
15 Strengthening of alcohol counselling skills of GPs and community health nurses, including school nurses.

Costs to society and health care

Problematic alcohol use is the second leading cause of death and disability in Australia, second only to tobacco. The annual cost to Australia of alcohol-caused problems is estimated to be $4,494 million – about 2-6 times the cost for illicit drugs[2 3]. There is enormous collateral damage to society from the harmful consumption of alcohol.

In 1992, problematic alcohol use accounted for 71,593 hospital episodes and 731,169 hospital bed days were occasioned by harmful and hazardous alcohol consumption. Harmful and hazardous alcohol consumption is estimated to have caused 3,660 deaths and in 1992, and the loss of 55.450 person years of life before 70 years of age at an average of 15.2 years of life lost per death. In other social and economic costs, 37% of road injuries in males are attributable to hazardous and harmful consumption of alcohol (18% in women), 34% of drowning (34% in women), 12% of suicides (8% in

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[22] National Alcohol Indicators, Bulletin No 1, National Drug Research Institute, Curtin University.

women) and 47% of assaults (47% in women). About 84% of the costs ($3.8 billion in 1992) are deemed to be avoidable as well as amenable to public policy initiatives and behaviour change[3].

The National Alcohol Indicators Project (NAIP)[2] has updated some of the above 1992 data. To date, updates have been made of alcohol related deaths and hospitalisations as well as estimates of morbidity and mortality. In one twelve-month period (1997), 3,290 Australians died from injury and disease caused by high-risk alcohol use. 70% of those deaths were male. Further, males comprised 70% of the 72,302 hospitalisations and 403,795 hospital bed-days in 1996-7.

Women and their families

Problems associated with a serious alcohol problem affect at least 1% of family members among Australia's population. Collateral damage from harmful alcohol use in families includes child abuse, spousal abuse, aggression, neglect and disruption[15].

The problematic use of alcohol is increasingly an issue for women's health. Even though female alcohol-caused death rates have decreased between 1990-1997[2], morbidity rates among women who suffer from alcohol dependency remain largely invisible[4]. Women commonly abuse prescription medications together with alcohol.

Alcohol consumption during pregnancy has a direct link with teratogenicity in the fetus. However, it is not clearly established what level of alcohol consumption, if any, is safe for pregnant women. Regardless of this there are likely to be significant public health implications surrounding alcohol consumption during pregnancy. There is also a lack of empirical support regarding links between public awareness of potential dangers of alcohol use in pregnancy and alcohol consumption[5]. Longitudinal studies examining alcohol consumption among pregnant women show that the number of women who are drinking is increasing with time[6].

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[3] Collins DJ, Lapsley HM. Estimating the economic costs of drug abuse in Australia. National Campaign Against Drug Abuse. Monograph Series no 15. Canberra, AGPS, 1991

[4] Nizette D & Creedy D. 1998. Women and mental illness, in Women's health: a primary health care approach. Sydney, Maclennan & Petty.

[5] Abel, EL. 1998. Prevention of alcohol abuse-related birth affects 1. Public education efforts. *Alcohol.* July/August, 33(4), 411-6.

[6] Morbidity and Mortality Weekly Report. 1997. Alcohol consumption among pregnant and childbearing-aged-women--United States, 1991 and 1995. *Morbidity and Mortality Weekly Report. April 25, 46(16), 346-50*

Domestic violence

Alcohol is linked with abuse in between 50% of domestic violence incidents and 64% of cases of violence in the home[7]. Alcohol is linked with violence in general and marital violence in particular and child abuse[8].

There are strong links between the effects of childhood violence on harmful alcohol use among adults. In other words, children who have either witnessed or experienced violence were greatly at risk of "inheriting" violence. Husbands have were more consistent 'risk markers' for domestic violence than do women. The most common include being sexually aggressive towards partners (100%); violent towards children (100%); had witnessed violence as a child or adolescent (88%); and abused alcohol (78%). Alcohol and domestic violence are of particular concern in Koori communities[9]. The data suggests that both women and children should be better protected.

Victims of domestic violence are found to be significantly more prevalent in health services populations such as general practitioners' patient populations, than the general population. However, there is a general lack of inquiry by health professionals in antenatal clinics, accident and emergency departments about domestic violence and its relation to harmful alcohol use[10].

ATSI health

The social and economic costs of the excessive use of alcohol by indigenous Australians are massive. Alcohol abuse is linked to petrol sniffing and the use of illicit drugs. In turn all are linked to mental health issues arising from alienation, despair, unemployment and racism[11]. In remote Australia, alcohol is more easily obtainable and relatively cheaper than healthy, fresh food, impacting greatly on poor nutritional status as well as levels and severity of chronic disease[12].

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[7] Health and Community Services Victoria . New Directions in Alcohol and Drug Services. Melbourne; H&CS, March 1994.

[8] Hotaling GT, Sugerman DB. An Analysis of Risk Markers in Husband to Wife Violence: The Current State of Knowledge. Violence and Victims 1986;1 (2):101-123.
Bergman BK, Brismar BG. Can Family Violence be Prevented? A Psychosocial Study of Male Batterers and Battered Wives. Public Health 1992; 106:45-52.
Leonard KG, Blane HT. Alcohol and Marital Aggression in a National Sample of Young Men. Jnl Interpersonal Violence 1992; 7 (1): 19-30.

[9] Elliott and Shanahan Research. Summary of Background Research for the Development of a Campaign Against Domestic Violence. Conducted for the Office for the Status of Women, Department of the Prime Minister and Cabinet. Canberra, August 1988.

[10] Webster, J. Seett S. et al. Domestic violence in pregnancy: a prevalence study. Medical Journal of Australia 161(17 October) 1994: 466-470.

[11] Inquiry into Indigenous Health, Discussion Paper. House of Representatives Standing Committee on Family and Community Affairs, Commonwealth of Australia, 1999.

[12] Improving Aboriginal and Torres Strait Islander people's access to the food they need for health. PHAA Policy Book, Canberra, 2000: 10.

Alcohol was estimated by the Royal Commissioners responsible for reviewing Aboriginal deaths in custody as being a direct cause of 10% of deaths. The proportion of Aboriginal deaths considered to alcohol related among Aboriginal people is three to four times higher than the general Australian population with the highest mortality among middle-aged Aboriginal males where the proportion of deaths related to alcohol exceeds 30%[13].

Alcohol in the workplace

Given that a large proportion of people who drink at hazardous and harmful levels are employed, there is great scope to institute harm minimisation approaches towards the presence of alcohol in workplaces. The workplace has emerged as a major context for changing unhealthy lifestyle behaviours. The workplace setting is therefore, an ideal sight for addressing hazardous and harmful drinking practices.

Alcohol use compromises safety in many industries and contributes to absenteeism and reduced productivity. An approach that incorporates prevention and early intervention provides significant potential to reduce a range of alcohol-related harms. However, in order to be effective a program must both confront and operate within the established culture of the workplace.

Failure to tailor harm reduction programs and policies to the work-place culture may result in such approaches being construed as intrusive or just plainly ignored. The building trades alcohol program "Not at Work, Mate' is an example of a successful program. Developed by the CFMEU in conjunction with the building workers, the program delegated the identification and assessment of alcohol (and drug) impaired workers to the Safety Committees. Despite the success of properly constructed and implemented alcohol polices and programs, most work-places don't have policies. Moreover, many existing programs to deal with alcohol do not have a prevention focus and tend to be punitive.

Alcohol abuse occurs in all work places, including among medical practitioners. The Nurses Board of Victoria has recently raised the issue of known or suspected drug use by registered nurses[14]. Similar problems may also occur among other health care practitioners, with costs to society of patient's morbidity and mortality as well as litigation costs[15]. However, these problems remain largely invisible.

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[13] Alcohol, PHAA Policy Book 2000: 118.

[14] Nexus. Substance abuse and nursing. Nurses Board of Victoria, Vol 6, Issue 1, June 2000: 7.

[15] Tai Y, Saunders J. Celermajer D. 1998. Collateral damage from alcohol abuse: the enormous costs to Australia. MJA, vol 168 (5 January): 6-7.

Part 3. ILLICIT DRUGS

The PHAA supports a comprehensive approach to illicit drug policy that address supply and demand reduction and harm reduction. Current public policy approaches in Australia have resulted in expenditure on measures intended to control the supply of illicit drugs that far exceeds funding allocated to supply and demand reduction and harm reduction. There is considerable and continuing anxiety in Australia regarding illicit drugs and the most appropriate national response to the problems resulting from their use. To an increasing number of people, these policies seem arbitrary and punitive.

Illicit drugs are responsible for substantial adverse health, social and economic costs to the nation. Death rates from heroin are increasing exponentially. There is a six fold increase in the rate of fatal opioid overdose since 1979[16]. In 2000, Victoria is experiencing one death per day[17].

Given these alarming statistics, the PHAA advocates an intensifying of harm minimisation approaches. The PHAA supports the trials proposed in Victoria, for safe injecting rooms because it is pragmatic harm minimisation strategy for the most vulnerable users of injecting drugs and provides a supportive environment where a range of services can be co-located. Safe injecting rooms are most appropriate where heroin use is concentrated.

Partnerships between the police, health and welfare sectors are needed in order to reduce drug related harm. Law enforcement can help reduce drug related harm by adopting certain strategies but there should be funding to encourage projects that foster partnerships.

Treatment programs for users of illicit drugs should not be rationed. People seeking treatment should have immediate access to expert help if we are to turn the tide of crime and drug use in Australia. People who use drugs are very often troubled people. They are not human garbage, but real people whose need for help with their health problems is very real. Australia is struggling to come to terms with these human rights issues.

Cost-effectiveness of treatment

Harm minimisation strategies are proven to have a greater cost-benefit to society than law enforcement. The costs of crime and lost productivity are reduced by $7.46 for every dollar spent on treatment for cocaine users[18].

In the USA, it has been estimated that for every dollar invested in treatment there is a saving of seven dollars to the health care system[19] [20].

[16] Current state of research on illicit drugs in Australia. NHMRC, 2000: 10.
[17] Moodie R. VicHealth Letter, Issue no 13, Autumn 2000: 2.
[18] Rydell CP & Everingham SS (1994) Controlling cocaine: Supply versus demand programs. www.rand.org/publications/MR/MR331/mr331.html, August 1994.

Comorbidity

Mental health problems are more prevalent amongst people with drug problems than in the general population.[21] Epidemiological studies show that comorbidity rates have been increasing since the 1960s.[22] For example, a study using a large representative US sample found that the prevalence of mental health problems was as high as 65% in opioid dependent users with a risk rate that was seven times higher than in the general population.[23]

The major comorbid mental health problems found in people with problematic drug use problems are depression, anxiety disorders (e.g., panic, phobic, obsessive-compulsive, generalised anxiety, and post-traumatic stress, disorders), antisocial personality disorders, and alcohol problems.

Comorditty has significant impact on relapse prevention and long term treatment options, alcohol, illicit drugs. Most are poly drug abusers. For example, 93% abuse anti-depressants that increases the risk of overdose, many times over. Most are trying to get treatment but incorrectly or inadequately, or not with adequate backup.

The weight of evidence suggests that comorbidity leads to poorer clinical, personal, and social outcomes in comparison to either mental health or drug use problems alone.[24] These outcomes are: Increased hospitalisation;[25]

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[19] Single E. & Rohl,T. (1997). The National Drug Strategy: Mapping the Future: An evaluation of the National Drug Strategy 1993-1997. Ministerial Council on Drug Strategy. Canberra: Australian Government Publishing Service.

[20] Holder H, Longabaugh R, Miller W, & Rubonis AV. (1991). The cost-effectiveness of treatment for alcoholism: A first approximation. Journal of Studies on Alcohol, 52, 517-540.

[21] Kessler RC, Nelson CB, McGonagle KA, Edlund MJ, Frank RG, Leaf PJ. (1996). The Epidemiology of co-occurring addictive and mental disorders: implications for prevention and service utilization. *American Journal of Orthopsychiatry,* 50, 36-43.

[22] .Cuffel BJ. (1992). Prevalence estimates of substance abuse in schizophrenia and their correlates. *Journal of Nervous and Mental Disease,* 180, 589 – 592.

[23] .Reiger DA, Farmer ME, Rae DS, Locke BZ, Keith SJ, Judd LL, Goodwin FK. (1990). Comorbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiologic Catchment Area (ECA) study. *Journal of the American Medical Association,* 264, 2511- 2518.

[24] .Dixon L, McNary S, Lehman A. (1997). One-year follow-up of secondary versus primary mental disorder in persons with comorbid substance use disorders. *American Journal of Psychiatry*, 154 (11), 1610–1612. Lehman, A. F., Myers, C. P., Thompson, J. W., *et al.* (1993) Implications of mental and substance use disorders: a comparison of single and dual diagnosis patients. *Journal of Nervous and Mental Disease,* 181, 365 – 370.

[25] .Haywood T, Kravitz HM, Grossman LS, Cavanaugh JL, Davis J.M, Lewis DA. (1995). Predicting the “revolving door” phenomenon among patients with schizophrenic, schizoaffective, and affective disorders. *American Journal of Psychiatry*, 152, 856 – 861.

depression and suicide;[26] violence;[27] incarceration;[28] homelessness;[29] human immunodeficiency virus (HIV) infection;[30] reduced ability to manage life needs;[31] medication noncompliance;[32] increased family problems;[33] and higher service utilisation[34]. Economic considerations present a further justification for addressing comorbidity.

It is reported that people with comorbidity incur 60% higher treatment costs than either substance use or mental health disorders alone, although, in practice, they are less likely to complete outpatient treatment for either problem.[35] There is evidence that treatment for both drug problems and mental health disorders improves prognosis, whereas continued illicit drug use intensifies mental health problems.[36] Given the range of poor outcomes, it can be argued that benefits to both individual and public health may be gained from treatment that addresses comorbidity.

Drug use, crime and prohibition

[26] .Harris EC, Barraclough B. 1997. Suicide as an Outcome for Mental Disorders: A Meta-Analysis. *The British Journal of Psychiatry,* 170 (3), 205 - 228.

[27] .Swanson J, Holzer C, Ganju V. (1990). Violence and psychiatric disorder in the community: evidence from the Epidemiological Catchment Area Survey. *Hospital and Community Psychiatry,* 41, 761 – 770.

[28] .Abram KM, Teplin LA. (1991) Co-occurring disorders among mentally ill jail detainees: Implications for public policy. *American Psychologist*, 46, 1036 – 1045.

[29] .Drake RE, Osher FC, Wallach MA. (1991). Homelessness and dual diagnosis. *American Psychologist,* 46, 1149 – 1158.

[30] .Cournos F, Empfield M, Horwath E, McKinnon K, Meyer I, Schrage H, Currie C, Agosin B. (1991). HIV seroprevalence among patients admitted to two psychiatric hospitals. *American Journal of Psychiatry,* 148, 1225 – 1230.

[31] .Drake RE, Wallach MA (1989). Substance abuse among the chronically mentally ill. *Hospital and Community Psychiatry,* 40, 1041 – 1046.

[32] .Alterman AI, Erdlen DL, LaPorte DJ, Erdlen F.R. (1982) Effects of illicit drug use in an inpatient psychiatric population. *Addictive Behaviors,* 7, 231 – 242.

[33] .Clarke RE. (1994). Family costs associated with severe mental illness and substance use: A comparison of families with and without dual disorders. *Hospital and Community Psychiatry,* 45, 808 – 813.

[34] .Kessler RC (1995). The epidemiology of psychiatric comorbidity. In: Tsaung M, Tohen M, Zahner G. eds. Textbook of Psychiatric Epidemiology New York: Wiley, 1995.

[35] .Crome IB (1999). Substance misuse and psychiatric comorbidity: towards improved service provision. *Drugs: Education, Prevention and Policy,* 6 (2), 149 – 174.

[36] .*Ibid.*

Direct relationship between crime and drug use[37] but most of the adverse consequences of illicit drugs are the result of policies intended to minimise the harmful effects of drugs. Unintended negative consequences include overdose, the transmission of blood borne diseases, increasing crime used to general income to pay for the high cost of drugs, expanding prison populations and violence associated with the drug trade.

Prohibition is inimical to minimising HIV, HepC and the spread of other blood borne diseases. Supply control policy delayed the introduction and implementation of sterile needle and syringe programs in many countries. Stringent supply control policy is irreconcilable with efforts to minimise the spread of HIV infection among and from injecting drug users. Supply control policy in the opium growing areas of the world, including South-east Asia, has led to heroin injecting replacing opium smoking, even in remote areas. This has exposed large populations to the hazards of HIV and HepC infection associated with needle sharing. The prohibition of drugs can only effectively restrict the availability of substances if there is limited demand, little opportunity to subvert controls and if there is no similar available drug which can be substituted. In summary, Australia's policy on illicit drugs relies on measures to control supplies which are expensive, ineffective and counter-productive.

Public Health principles for action

The PHAA affirms the following principles in relation to illicit drugs:

- Illicit drug use is found in all social and economic groups but disproportionately among those most severely disadvantaged.

- Drug policy should be guided by the principle of trying to ensure the least harm for the smallest number in the community.

- Where the use of drugs has undesirable effects on the well-being of the using person, responses should be fundamentally a matter for health and welfare sectors.

- Where the use of drugs has undesirable effects on the well-being of persons other than the user, there is a clear role for the law. This includes such things as driving under the influence of drugs and intoxication in the workplace. However, the emphasis must be on impairment, not just the presence of drugs in a person's body. Drug-testing for illicit drugs is not generally appropriate because it does not accurately measure impairment[38].

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[37] Makkei T. & Feather M. 1999 Drug use monitoring in Australia. Preliminary results from the Southport site. Trends and Issues in Crime and Criminal Justice, no 142, 6Institute of Criminology, Canberra.
[38] Macdonald S. (1997). Work-place alcohol and other drug testing: A review of the scientific evidence. Drug & Alcohol Review, 16, 251-259.

- The law should also be used to regulate individuals or organisations engaged in the cultivation, production, transport, distribution and sale of illicit drugs in quantities deemed to exceed personal use.

- Policies adopted in Australia should continue to be modified according to the extent to which they minimise the adverse health, social and economic consequences of mood-altering substances including those which are presently illicit.

- The negative consequences of policies used to regulate the use of mood altering substances should not exceed the adverse consequences of the drugs themselves for individuals or communities.

- Persons who choose or consume or feel unable to cease consuming illicit drugs have human rights which may be threatened by national obligations to international drug treaties.

- As HIV and HepC infection together represent the most serious potential complication of injecting drug use for drug users and non-drug users alike, policies for illicit drugs should be at least partly considered in terms of whether they will assist or hinder efforts to control the spread of HIV, Hep C and other blood-borne infections.

- As there are no optimal solutions to the problems resulting from illicit drugs, Australia should aim to identify and adopt solutions which create the least harm in the community.

Recommendations

16 It is preferable to fund treatment because good treatment programs work and are more effective than the current over-emphasis on law enforcement.

17 Expand pharmacotherapy treatment options.

18 Increase funding for community based counselling options and social support together with funding for community action to address the drug problem. There is real need for a diversity of treatment options and decentralised treatment availability in community health, general practice and community hospitals;

19 Rehabilitation programs need to be multifaceted and include skill training for long time drug users trying to re-enter society;

20 Programs must have the capacity to deal with the social determinants of drug use including violent experiences, poverty and unemployment and not just in terms of disadvantage.

21 All jurisdictions including the Commonwealth should adopt forthwith the Cannabis Expiation Notice System modelled on South Australia and the ACT but with substantially reduced penalties.

22 All jurisdictions should ensure forthwith that sterile needles and syringes are readily available at no or minimal cost at all times and places where there is demand for their use with particular attention to correctional facilities and safe injecting rooms.

23 All jurisdictions should ensure that heroin injectors who wish to enter methadone maintenance programs and other pharmacotherapy treatments can be assessed within days, that entry criteria are minimal, that programs are attractive and economical and high retention rates. Currently, there is limited access to public methadone programs. In one Gold Coast study, more than half of users who said they would definitely or probably start treatment tomorrow if they could, 56% said it was the waiting list that was stopping them[39]. Access should be facilitated to treatment options and people should not be thrown off a program for minor misdemeanours.

24 All jurisdictions should review the process under which police officers apprehend drug users for personal possession. In some instances, it may be appropriate to refer drug users to agencies for health and welfare assistance. This may require educational processes within the police force.

25 In light of the cost-effectiveness data, funding should be redirected from law enforcement restriction of drug supplies to health and welfare assistance for drug users.

26 All jurisdictions should ensure that rigorous scientific trials which evaluate innovative forms of treatment, including the distribution of currently illicit substances to drug dependent persons, should be allowed to proceed subject to usual ethical and research review as would any other scientific trial.

27 If scientific trials of controlled availability of illicit substances show greater benefits and fewer costs that present policies, persons shown to be using drugs hazardously should be able to obtain sterile heroin, and other substances of known concentration at costs which are below those of the illegal market. Nonetheless unsanctioned cultivation, production, transport, distribution, sale, possession, or use of illicit drugs above quantities consistent with personal use would continue to be regarded as offences.

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[39] Weatherburn, D & Lind, B. 1999. 'Heroin harm minimisation: do we really have to choose between law enforcement and treatment?' *Crime and Justice Bulletin*, NSW Bureau of Crime Statistics and Research. No 46, November.