

NSW RESPONDS TO ILLICIT DRUGS

GUEST EDITORIAL

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New South Wales is the centre of Australian illicit drug use. Trends in Sydney are followed more or less in other States and regional areas. Heroin use is now visible in Aboriginal communities, as well as in urban and rural settings. Heroin is both cheap and available. Heroin markets develop in places of disadvantage, for instance: in central Sydney, in south-west Sydney, and in rural Aboriginal communities.

To be a 'dealer' has status: a role with a short-term future, where no long-term future exists. For a while there is money in the pocket and Nikes or Reeboks on the feet; and to be someone of account is important to the dispossessed. Ethnographic studies in the south-west Sydney area describe the stories of these young people:

'Vietnamese people, they got skill for dealing. They don't like to do this—to do stealing and go in people's houses. They like to deal heroin. A lot of young people, most of them you know, white people, they break in and armed robbery, you know, to get money to buy heroin. Most Asian they deal heroin than armed robbery... That's why all the Vietnamese they always deal, they didn't do break and enter a lot and armed robbery.'

(Tran, a 22-year old Indo-Chinese male)¹

'People mightn't buy for themselves, they might go out and resell it again so they'll sell it cheap again but they'll double the price on what they paid for it and that's still cheap. So say a thing is worth \$100 and I'll sell it to the bloke for \$30, he'll go out and sell it for \$60. He's doubled his money and the thing's worth \$100 so that's still \$40 cheaper. He'd sell it easy.'

(Harry, a 34-year old Koori male)²

These accounts mirror those of 30 years ago from New York's dispossessed street people: African-Americans, Puerto Ricans, and others on the fringe.

'It's an exciting life, a dangerous life—at the farthest remove from the safety and savings-banks of the middle-classes. Addiction is a poor boy's university. One addict calls it "the Wild West," and "the New Frontier" ... Small wonder that, when asked why they started on heroin, almost every one of them included in his answer the phrase, to kill time.'³

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Time they certainly killed. The obvious measure of heroin-related harm is the number of deaths caused by overdose. These have doubled between 1987 and 1997. The deaths occur mainly among males in their late 20s who are generally not receiving treatment for their addiction.⁴ This, however, is not the public picture of overdose fatalities, which is of the very young.

There is a profound problem among our young people. Thirty percent of deaths in the age group 15–24 years are due to suicide (one in five) and overdose fatalities (one in 11).⁵ Young people are being exposed to suicide and overdose fatalities at earlier ages. The illicit drug reporting system tells us that injecting drug users (IDUs) are becoming younger, injecting more frequently, using larger doses, and that heroin is more often the first drug of use. The system data indicates increasing criminalisation and death. There is evidence of increasing illicit drug use and problems of related harm in regional areas of NSW. The emergency departments, wards, and mental health units of our hospitals contain—or care for—young patients severely damaged by drug use. The burden on health care is high. The potential of these young people is lost.

Compare this with the epidemiology of drug use in the general population. The 1998 National Drug Strategy Household Survey (NDSHS) reports heroin use in the general population as less than one per cent: it is not rising, and in some age groups it is declining.⁶ Heroin poses two tasks for public health: first, innovation to prevent initial uptake; and second, measures to prevent mortality and harm in users. One is fundamental, the other is pragmatic, and both are ethical.

Ingrid van Beek, Medical Director for the Uniting Church's trial of a medically-supervised injecting centre in Sydney, describes the perceived need of IDUs to be:

- safe from overdose
- at reduced risk of blood-borne viral infection
- protected from harassment
- accepting of such a facility.

The idea of a medically supervised injecting centre was acceptable to a majority of local residents in Kings Cross who were surveyed by telephone in 1997–1998.

These are difficult times to implement a public health approach to injecting drug use: an environment of illegality, hazardous and contaminated injections, multiple needle use, and hostility towards new initiatives by vociferous groups. In spite of this, there is humane engagement with the health risk of IDUs and their needs. Initiatives such as needle and syringe programs have shown real benefits for the community.

Public health has never been simply a matter of epidemiology measuring problems. In the 19th century John Snow described cholera deaths in a London borough, took personal action, and advocated that local authorities initiate a response to protect the public. Edwin Chadwick, a lawyer and Poor Law Commissioner who knew nothing about bacteria, blended economic and engineering ideas in his report to Parliament. Since then town sewerage has been separated from the water supply.⁷ In our own century, while there is evidence that the HIV epidemic is being contained, especially among IDUs, there are still risks from unsafe sex in homosexual men; and Aboriginal and Torres Strait Islander women are exposed to heterosexual transmission of HIV. The epidemic of hepatitis C has yet to respond significantly to current public health initiatives.

True to the spirit of public health—as a coordinated effort of informed public policy, planned implementation, education and community involvement—the May 1999 NSW Drug Summit was a remarkable democratic and public event. Citizens and their politicians worked together across the spectrum of related issues, from law enforcement to health; the fundamental needs of young people, their opportunities for development and education; and on responses to their problematic use of drugs.

The State of New South Wales now understands that the 'drug problem' is a 'whole of government' problem. Ministers needed the evidence on which to base good policy; they wanted to know what would work; gut feelings were set aside. In health, this will mean a wider engagement with outside sectors and agencies. It will mean innovation in the health system. Area Health Services must see the 'drug problem' as core business. There is no doubt that the community expects that of them.

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HEROIN USE AND RELATED HARM IN NSW: RESULTS FROM THE NATIONAL DRUG STRATEGY HOUSEHOLD SURVEY

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INTRODUCTION

This article describes heroin use and related harm in NSW, using data from the National Drug Strategy Household Survey (NDSHS). It is the second in a series of articles that provide information and commentary on drug and alcohol use.¹

The National Drug Strategy Household Survey

The NDSHS explores community general knowledge and attitudes about drug and alcohol issues, as well as consumption and related behaviours. The most recent NDSHS was carried out between June and September 1998 with 10,030 Australians—including 1,486 residents of NSW. Details of the NDSHS methodology have been published elsewhere.²

Heroin-related harm

Recently there has been much attention and community discussion about illicit drug use in NSW, and in particular heroin use. At the NSW Drug Summit, held in May 1999, heroin was identified as a drug of particular concern, and one where the Government's central response has been to increase the provision of integrated and comprehensive treatment services in NSW.³

In NSW the number of overdose fatalities has been steadily increasing over the past decade, with 128 deaths reported in 1987, rising to 264 deaths reported in 1997.⁴ While the majority of these deaths are linked with the concurrent use of other depressants of the central nervous system—such as alcohol and benzodiazepines—the use of heroin is a major concern for government and community alike.

RESULTS FROM THE NDSHS

Prevalence of heroin use

Among the NSW population aged 14 years and older, two per cent reported using heroin at least once in their lifetime, compared to 2.3 per cent of the Australian population (Table 1). This is an increase from the 1995 survey, where one per cent and 1.6 per cent reported heroin use in NSW and Australia, respectively.

In NSW during 1998, age-specific rates of lifetime use of heroin were lower than the rest of Australia, except for males in the 20–29 age group who were 20 per cent more likely to have tried heroin than their national counterparts. Males in NSW were at least twice as likely to have tried heroin than females (2.7 per cent compared to 1.3 per cent). This gender differential was consistent across most age groups, with the exception of females in the 14–19 age group, where the reported rate of lifetime heroin use was 2.7 times higher than for males of the same age.

There has been no increase from 1995 to 1998 in the proportion of the NSW population who reported using heroin in the previous 12 months (0.6 per cent) despite marginal increases at the national level. Males aged 20–29 years were most likely to report recent use of heroin (3.2 per cent); however, this rate represents a 46 per cent decrease in use among this age group since 1995. Unlike the prevalence of lifetime use of heroin, there was no difference in the rates for males and females among 14–19 year olds (1.0 per cent compared to 0.9 per cent). The changing pattern between lifetime and recent heroin use among this age group can be partly attributed to a notable decline since 1995 in the proportion of young girls recently using heroin: that is, a 64 per cent decrease from 2.5 per cent to 0.9 per cent.

Type of heroin used and source of heroin supply

Of those respondents reporting recent heroin use in NSW, the most frequently used type of heroin was in powder form (43.4 per cent) followed by rock (32.9 per cent). In comparison, heroin rock was the preferred type in Victoria

TABLE 1
**HEROIN USE AMONG MALES AND FEMALES AGED 14 YEARS OR OVER:
NSW AND AUSTRALIAN NDSHS DATA, 1995 AND 1998**

Age	Lifetime use				Recent use ^(a)			
	1995		1998		1995		1998	
	Aus	NSW	Aus	NSW	Aus	NSW	Aus	NSW
(%)								
Males								
14-19	0.7	–	1.1	1.0	0.7	–	0.3	1.0
20-29	2.6	5.9	5.9	7.1	0.7	5.9	2.7	3.2
30-39	4.8	2.2	4.2	4.1	0.6	–	1.2	–
40+	1.2	0.6	2.0	0.8	–	–	0.4	0.5
All ages	2.2	1.6	3.1	2.7	0.3	0.9	1.0	1.0
Females								
14-19	–	2.5	2.1	2.7	–	2.5	1.6	0.9
20-29	2.2	1.6	3.4	2.9	0.7	–	1.2	1.4
30-39	0.9	–	2.1	2.1	0.3	–	0.5	–
40+	0.8	–	0.4	0.2	–	–	0.2	–
All ages	1.0	0.5	1.5	1.3	0.2	0.3	0.6	0.3
Persons								
14-19	0.4	1.1	1.6	1.8	0.4	1.1	0.9	1.0
20-29	2.4	3.6	4.6	5.1	0.7	2.8	2.0	2.3
30-39	2.8	1.0	3.2	3.1	0.5	–	0.9	–
40+	1.0	0.3	1.2	0.5	–	–	0.3	0.2
All ages	1.6	1.0	2.3	2.0	0.3	0.6	0.8	0.6

(a) Used in the last 12 months.

(54.9 per cent), Queensland (71.3 per cent) and Tasmania (82.3 per cent).

Most males (95.4 per cent) first obtained heroin from a friend or acquaintance, whereas current sources of supply are commonly obtained from street dealers (39.1 per cent). In comparison, 28.4 per cent of females first obtained heroin from their spouse or partner, and recent users all reported obtaining heroin from a friend or acquaintance, with no reports of street dealing.

Mode and place of administration

Of all respondents who reported recent illicit drug use in 1998, heroin was the drug most commonly administered parenterally (59.8 per cent). Amphetamines were also frequently injected (26.3 per cent). In NSW, recent users of heroin administered the drug through injection (29.3 per cent), smoking (24.3 per cent) or snorting (23.7 per cent). Non-injecting administration of heroin differed from other States where recent users primarily injected heroin: Queensland (82.7 per cent) and Victoria (71.0 per cent).

New South Wales data showed that recent users of heroin were likely to administer the drug in their own home (38.2 per cent), in a car or other vehicle (35.2 per cent), or in

public places such as a park (18.5 per cent).

Non-fatal heroin-related overdoses

New South Wales figures showed 44.7 per cent of recent heroin users reported ever having had one or more overdoses when using heroin, a rate higher than all other States in Australia. In Sydney, the rate of overdose was lower than the rest of NSW with 14.7 per cent experiencing an overdose. Of those people in NSW who had overdosed, the majority were reporting recent events, with 41.3 per cent occurring 6–12 months prior to the survey. For incidents where a respondent was present when someone else overdosed, an ambulance was called in 44.3 per cent of cases. In Sydney, the likelihood of an ambulance being called when someone else overdosed was much higher (69.2 per cent) than the overall State rate.

Public perceptions of heroin

Heroin was the drug most commonly associated with being a 'drug problem' (40.5 per cent), an increase of 42 per cent since 1995. This corresponds with a similar decrease in the proportion of people who associated marijuana with a 'drug problem' (down from 31.3 per cent in 1995 to 19.0 per cent in 1998). Despite growing concerns over heroin as a 'drug problem' the proportion of the NSW population

who support the personal use of heroin being made legal (8.1 per cent) has not changed since 1995.

DISCUSSION

The use of heroin is not widespread in NSW, with less than one per cent of the population reporting recent use. There is also no indication from the NDSHS that recent heroin use is increasing. Indeed, the previously reported high rates of recent heroin use among males aged 20–29 and females aged 14–19 have declined notably.

There are, however, a number of limitations with the NDSHS that must be taken into consideration when interpreting the results presented here. First, the overall survey response rate was 56 per cent, which may have resulted in some selection bias. If illicit drug users were less likely to participate then drug use would be underestimated. Other potential limitations include: a small NSW sample size for low-prevalence behaviours; the exclusion of non-private dwellings, institutional settings (including prisons) and homeless people from the sample; and potential reporting and recall bias when recounting illicit drug use. These limitations have been discussed in more detail elsewhere.^{1,2}

The increased public and government concern about heroin as a 'drug problem' reflects increased coverage and discussion around both patterns in heroin use and trends in heroin-related overdoses. Accordingly, the 1999 NSW Drug Summit primarily concentrated on illicit drugs, especially heroin, in developing new responses to problematic drug use. In response, the NSW Government is providing a significant expansion of—and enhancement to—drug treatment services, supported by innovative approaches to drug education and prevention. The NSW Department of Health is presently developing a five-year Drug Treatment Services Plan that will outline statewide goals and priorities for service delivery and expansion.

Note: With regard to type and source of heroin used, and mode and place of administration, there are differences in the calculation of the percentages in this report. All data relating only to NSW excludes non-responders from the denominator, while data presenting interstate or capital city comparisons includes non-responders. These data were derived from that provided by the AIHW.

ACKNOWLEDGMENTS

This series of articles is a joint enterprise of the Australian Institute of Health and Welfare and the NSW Department of Health. The assistance of the following groups is particularly appreciated: the Department of Health and Aged Care Policy Reference Group, and the Survey Technical Advisory Committee.

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Further information on national statistics, response rates, estimation procedures, reliability of estimates, and comparability to the 1995 survey, are available in the AIHW Drug Statistics Series (1), which can be accessed from the AIHW Web site at www.aihw.gov.au.

THE ILLICIT DRUGS REPORTING SYSTEM

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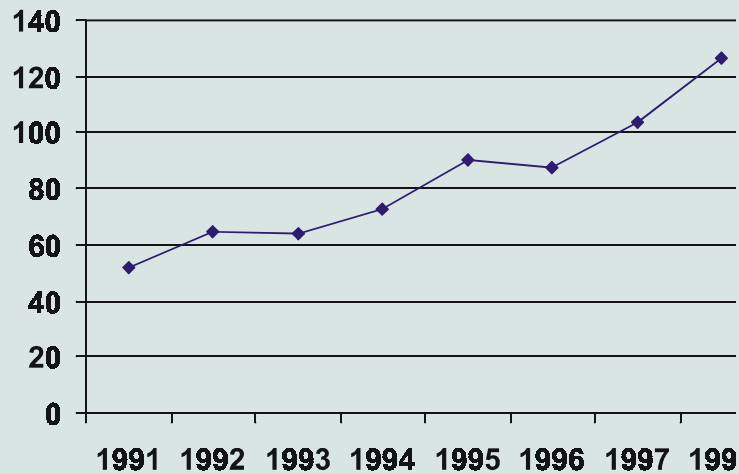
This article outlines the purpose and methodology of the Illicit Drug Reporting System (IDRS), an initiative funded by the Commonwealth Department of Health and Aged Care; and presents major trends identified by the IDRS in 1999.

PURPOSE AND METHODOLOGY OF THE ILLICIT DRUG REPORTING SYSTEM

The IDRS aims to monitor data on the use of opiates, cocaine, amphetamine and cannabis. It is intended to act as a strategic warning system by identifying problematic drug trends that require further investigation. As such, the IDRS aims to be sensitive to emerging drug trends of national significance. Findings from the IDRS are disseminated to the Commonwealth Department of Health and Aged Care, the Inter-Governmental Committee on

FIGURE 1

**OVERDOSE FATALITIES AMONG THOSE AGED 15–44 YEARS IN NSW,
RATE PER MILLION OF POPULATION, 1991–1998**



Drugs, the Australian National Council on Drugs, and the Ministerial Council on Drug Strategy.

The IDRS has been operational in NSW since 1996, where it has proved able to detect new and problematic drug trends. Drug trends are detected by examining information from three sources:

- survey of injecting drug users (IDUs)
- survey of key informants
- other indicators,

which are described below. These three data sources both complement and supplement each other, describing both qualitative and quantitative aspects of drug trends, and providing evidence of convergent validity.

Survey of Injecting Drug Users

The IDU survey consists of annual face-to-face interviews with at least 150 IDUs recruited from sentinel drug-using regions in Sydney. A standardised and structured interview schedule is administered to participants, and includes sections on:

- demographics
- use of drugs
- price of drugs
- purity and availability of drugs
- drug-related crime

- risk-taking behaviour
- health and general drug trends.

Previous IDRS research has found that IDUs are a good group for detecting trends in illicit drug use, due to their high exposure to many types of illicit drugs and their first-hand knowledge of drug price and availability.

Survey of key informants

At least 30 key informants, who work in the field of illicit drugs, are interviewed each year. These key informants have at least weekly contact with users of illicit drugs, or contact with at least 10 different users of illicit drugs, in the past six months. Key informants include:

- health professionals
- Needle and Syringe Program (NSP) workers and outreach workers
- law enforcement officers
- researchers.

Key informants are interviewed, usually over the phone, using a semi-structured interview schedule which parallels the interview schedule of the IDU survey described above. Interviews of key informants have been found to provide good qualitative data on the context of drug use and health-related issues, such as presentations for treatment.

Other indicators

To complement and validate data collected from both the

IDU and key informant surveys, a range of secondary data sources are examined. These include:

- health data
- survey data
- law enforcement data.

Most indicator data includes at least 50 cases annually, and covers several drug classes. Examples of data sources include:

- telephone advisory data
- purity of drug seizures made by the Australian Federal Police
- population surveys
- NSP client data
- toxicology data on drug-related deaths and urine of methadone patients
- drug arrest data.

The above IDRS methodology was initially trialled in 1996 in NSW, in accordance with recommendations made by Wardlaw Consulting in 1994.¹ Data collection was then expanded to South Australia and Victoria in 1997–98. In 1999 the IDRS became a national project, with an abbreviated form of the methodology being conducted in the remaining States and Territories. This methodology consisted of a survey of key informants and collection of other indicator data.

DRUG TRENDS IN NSW, 1999

Several major trends were detected in NSW by the IDRS during 1999. These included changes in the demographics of injecting drug users, and trends in heroin use. These are summarised below.

Trends in the demographics of IDU

The frequency of injecting among the NSW IDU sample had increased substantially since 1997. In 1997, 26 per cent of subjects reported injecting more than once a day, compared to 70 per cent in 1999. Importantly, younger IDUs (<=25 years) reported more frequent injections than older IDUs, with 82 per cent of younger IDUs injecting more than once a day in the preceding month, compared to 62 per cent of older IDUs. Also, the average age of the initiating injecting drug user was two years younger in 1999 than it was in 1997 (17.1 years in 1999 versus 19.0 years in 1997). These younger IDUs were also significantly more likely to report having injected heroin as their first drug in 1999 (76 per cent in 1999 versus 49 per cent in 1997), whereas initial use of amphetamine was more likely among older subjects in 1997 (47 per cent in 1999 versus 21 per cent in 1997). Overall, there appears to have been a major shift in initial drug use patterns among younger IDUs,

who initiated injection at a younger age and, overwhelmingly, commenced their IDU careers with heroin.

Trends in heroin use

Although heroin use remains relatively low among the general population,² its use among IDUs appears to have increased dramatically over the last four to five years. According to the Australian Needle and Syringe Program Survey, heroin is the most popular injected drug among IDUs in NSW. The prevalence of heroin, as the last drug injected, has increased from 31 per cent to 48 per cent since 1995. Consistent with the survey findings, many participants in the IDRS IDU survey and key informant survey noted an increase in the number of heroin users, especially an increase in the number of young heroin users and more 'mainstream' people using heroin. There was also a perception among key informants and IDUs that heroin users were using more heroin in a day than previously observed. This observation is consistent with findings mentioned above, that there has been a dramatic increase in the frequency of injection among the IDUs surveyed by the IDRS.

Local indicator data collected by the IDRS was consistent with an increase in the prevalence of heroin use. Trends in specific indicators of heroin use are summarised below.

- The number of criminal incidents relating to narcotic use and/or possession in NSW increased from 1,541 in 1996 to 3,020 in 1998.
- The number of methadone clients in NSW, on the 30th of June each year, has increased steadily throughout the 1990s: from 5,009 in 1990 to 12,549 in 1999.
- The number of heroin-related telephone inquiries to the Alcohol and Drug Information Service in NSW increased from 3,670 in the 1996–97 financial year to 6,763 in 1998–99. There are now more inquiries relating to heroin than to any other illicit drug.
- The number of confirmed overdose fatalities has risen from around 100–200 per year between 1990 and 1993 to 358 in 1998, and account for nearly half the overdose fatalities in Australia. Overdose rates for 1991 to 1998 are shown in Figure 1. Local indicator data on suspected drug-related deaths also suggests a substantial increase in the number of overdoses occurring in regional NSW.

All of the IDRS indicators point toward an increase in heroin use over the last few years, characterised by younger users of heroin, more 'mainstream' users of heroin, and an increase in the frequency of heroin use among regular users. There was a corresponding increase in heroin-related problems, most notably overdose fatalities. New South Wales has the highest rate of overdose fatalities in

Australia, accounting for nearly half the overdose fatalities in the country.

CONCLUSION

The frequency of heroin use among IDUs has risen substantially over the last few years, and all indicators of heroin use suggest that there has been an increase in the number of heroin users in NSW. Harm to public health associated with injecting heroin use continues to be prominent, particularly overdose fatalities.

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The following IDRS reports are available through the National Drug and Alcohol Research Centre by telephone on (02) 9398 9333; by fax on (02) 9399 7143:

- Drug Trends Bulletin: a free quarterly report from the IDRS that contains an update on recent drug trend information;
- State reports: annual reports that contain the findings of the IDRS from each state and territory (\$10 each);
- National report: an overview of Australian drug trends (\$10).

For a summary of the latest drug trends visit the IDRS Web site at: www.med.unsw.edu.au/ndarc/idrs.

NSW DRUG SUMMIT UPDATE

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In May 1999, the NSW Drug Summit was held at the NSW Parliament. For one week members of State Parliament, drug experts, parents, former drug users, and community leaders, met to decide how best to deal with the drug problem in NSW. The summit endorsed a number of resolutions, the majority of which were accepted by the NSW Government. A Government Plan of Action (GPA) was developed, and this article describes initiatives developed to implement this plan.

The GPA describes a comprehensive, 'whole of government' and 'whole of community' approach to the prevention and management of illicit drug misuse. Over \$176 million has been provided by the State Government to implement a range of new initiatives over the next four

years. This has been the most significant enhancement in funding to drug and alcohol services since the National Drug Strategy in 1985. To coordinate this significant investment the State Government has established the Office of Drug Policy within the NSW Cabinet Office. An expert advisory committee, reporting to the Premier, has also been established and is chaired by Professor Ian Webster.

IMPLEMENTATION

NSW Health has received significant enhancements. The new monies have been allocated to significantly enhance service provision; and to ensure that a system built on quality, equity and fairer access is in place. The Drug Programs Bureau (formerly the Drug and Alcohol Directorate) within the Public Health Division, and the Area Health Services (AHS), have primary responsibility for more than 100 projects resulting from the GPA.

A strategic approach to delivering drug treatment services

The Summit recognised the importance of clear strategies, as well as the need for quality services. A NSW Drug Treatment Services Plan (DTSP) has been developed, which describes the priorities for treatment over the next five years, and how the Government will achieve an appropriate level and mix of treatment options. The DTSP ensures that NSW has in place an effective and responsive system of services for people affected by drug use.

Area Health Service Project Plans

As a first step to allocating funding and implementing the DTSP, each AHS was required to submit a project plan to the NSW Department of Health. This approach allows for a coordinated response across the state, but tailored to individual Area needs and priorities. Comprehensive AHS plans now exist for a range of projects, including: home detoxification, data collection, methadone maintenance treatment, and additional specialist staffing positions such as nurses and counsellors.

New and Expanded Drug Treatment Services

New or enhanced services will be established in a number of areas identified as having a high need. These areas include detoxification facilities in Northern Rivers, Wentworth and Central Coast Area Health Services; multi-purpose drug and alcohol units in New England, Mid-North Coast and South Western Sydney Area Health Services; and increased residential beds for non-government organisations providing rehabilitation services.

Ambulatory and home detoxification services will be expanded, which will enhance accessibility to detoxification services, ease pressure on hospital beds, and extend the range of treatment services available to the community. Ambulatory and home detoxification is being trialled in the Central Sydney, South Western Sydney, Southern, Greater Murray and the Far West Area Health Services. Greater general practitioner (GP) participation in the program is being encouraged.

Expansion of pharmacotherapies and comprehensive case management

Access to pharmacotherapy treatment programs will be increased across all AHSs. Health and social outcomes will be improved by:

- increasing the number of places available in the public methadone maintenance treatment program;
- expanding counselling and case management services

in the public methadone program as well as those managed by GPs and pharmacists.

Treatment agreements are to be put in place across the pharmacotherapy treatment programs. These agreements will provide a mechanism for improving communication between the patient and the service provider, and will improve the quality of treatment in NSW by outlining the responsibilities of both the client and the provider.

Improved data and information

The collection, collation and availability of accurate and consistent data is essential for effective service planning. For the first time, all AHSs will develop a standardised data collection and reporting mechanism that will function across all drug treatment services funded by NSW Health. Data will be kept describing client profiles and service activity and funds have already been allocated to all Areas for this project.

Improved ability of primary care providers to provide drug and alcohol services

Area Health Services will be working closely with their local Divisions of General Practice to increase the capacity of GPs to provide drug and alcohol services. Eleven AHSs have initially been provided with funding for 1999–2000 and 2000–2001. Funding will be extended to all Areas from 2001–2002 onwards. Project officers will undertake activities to improve links between GPs and drug and alcohol services, and to develop GP training initiatives.

A strategy is also being developed to increase the capacity of nurses in general health care settings to handle patients with drug and alcohol issues. Clinical practice guidelines will complement the strategy and both will soon be released.

It can be seen that, almost one year after the Drug Summit, much has been achieved. The breadth of projects covered should lead to:

- better availability of information
- a greater number and range of services
- better service planning
- a highly skilled workforce
- quality drug and alcohol services accessible to those in need.

It is a large task but NSW Health is committed to implementing the GPA to reduce the problems resulting from drug use, and to provide services to those who require assistance. ☞

APPROACHES TO INJECTING DRUG USE IN KINGS CROSS: A REVIEW OF THE LAST 10 YEARS

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Uniting Church of Australia*

This article describes public health and public order issues around injecting drug use in Kings Cross over the past decade.

Since the early 1990s an increasing number of commercial sex establishments in the central business district of Kings Cross began to provide injecting drug users (IDUs) with injecting equipment and/or rooms to inject in. In several instances these establishments also supplied illicit drugs. Following the Royal Commission into the NSW Police Service, which resulted in the incarceration of the most significant operators of these establishments, the majority ceased to operate, leading to a significant shortfall in the supply of injecting equipment in Kings Cross, and an increase in the 'public nuisance' associated with public injecting. Meanwhile, cocaine injecting—a behaviour associated with very high frequency injecting and sexual risk behaviours—became endemic during the same period, particularly among female sex workers who worked in this part of Kings Cross.

ESTABLISHMENT OF K2: 1997

After the closure of the commercial establishments, which had provided injecting equipment and rooms, it was of particular public health importance to replace the supply of injecting equipment through a fixed-site needle and syringe service located in the main street of Kings Cross. There was also a need to reach out to the local venues frequented by sex workers who were also IDUs. In 1997, to cater for these needs, K2—a satellite service of the Kirketon Road Centre (KRC)—was established close to the heart of the street-based drug scene in Kings Cross.

K2 provides:

- a needle and syringe service
- health and social welfare advice
- assessment and referral for drug treatment
- other relevant support services.

The service currently operates from 2.00 p.m. to 10.00 p.m. seven days a week and has contact with around 200 IDUs each day.

ESTABLISHMENT OF A JOINT SELECT PARLIAMENTARY COMMITTEE: 1997

In 1997, the NSW Government established a Joint Select Parliamentary Committee into Safe Injecting Rooms, in response to the recommendation of the Royal Commission into the NSW Police Service, which stated that: 'consideration be given to the establishment of safe, sanitary injecting rooms under the licence or supervision of the Department of Health, and the amendment of the Drug Misuse and Trafficking Act 1985 accordingly'.¹

This Safe Injecting Rooms (SIR) Committee visited several Sydney suburbs, and a number of rural areas, to speak to members of the community, health workers and drug users. A subcommittee of the SIR Committee also visited five safe injecting rooms in Europe and held discussions with key stakeholders there. The Committee received 103 submissions and took formal evidence from 89 witnesses. Just over half of the written submissions supported the establishment of safe injecting rooms, and a large majority of the expert witnesses testified in favour of the proposal. However, six of the 10 members of the SIR Committee did not recommend the establishment of such premises in NSW.

Meanwhile, a telephone survey of more than 300 local residents of Kings Cross—undertaken in 1997 and 1998 to measure K2's effect on the community—demonstrated a rise in support for the establishment of safe injecting rooms in the area (69 per cent to 76 per cent).

SAFE INJECTING ROOM PROPOSAL, NSW DRUG SUMMIT: 1999

A safe injecting room proposal was raised again during the NSW Drug Summit, an initiative of the NSW Government held in May 1999. One of the 172 resolutions passed by the Summit was that a medically-supervised injecting centre (MSIC) be trialled. It was subsequently proposed that this trial be undertaken in Kings Cross, and legislation was passed to enable establishment of the trial for a period of 18 months. In December 1999, the NSW Government accepted a proposal from the Uniting Church of Australia to apply for a licence to manage the facility, and plans for the MSIC are now well underway.

A recent survey among IDUs who use the needle and syringe service at K2 indicates there is a high level of

preference for having access to such a facility for drug injection: 71 per cent of those IDUs who inject alone, and 82 per cent who inject in a public place, would prefer to use a MSIC. A high number of those who inject with others (70 per cent) and/or in a private place (66 per cent) would also prefer to use a MSIC. These findings suggest that this trial may have the potential to significantly shift current patterns of injecting drug use in Kings Cross. The effect on the community will need to be monitored and managed over time.

CONCLUSION

The MSIC trial and evaluation hopes to answer the question of whether this is an effective strategy to reduce:

- overdose fatalities
- transmission of blood-borne viruses
- the public nuisance associated with public injecting,

while increasing IDUs' access to drug treatment. It will also inform future decisions to trial this strategy in other parts of NSW and Australia.

REFERENCE

1. Royal Commission into the NSW Police Service. Final Report, Volume 2, *Reform*. Sydney: NSW Government, 1997; 226. ☒

DEATHS AND HOSPITAL SEPARATIONS DUE TO ILLICIT DRUGS, NSW, 1989–1998

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The harmful use of illicit drugs contributes to many causes of death and illness, including overdose, hepatitis B, hepatitis C, HIV and AIDS, psychoses, suicide, and low birth-weight.¹

The data presented in Figure 2 were derived by applying aetiological fractions (the probability that a particular case of illness or death was caused by use of specific illicit drugs) to death and hospital morbidity data for NSW.

Illicit drugs caused an estimated 6,990 hospital separations (4,106 males and 2,884 females) in 1997–1998. Opiate dependence and drug psychoses were contributors to hospital morbidity for the majority of these cases. Over the 10-year period between 1989 and 1998 there has been a sharp rise in hospital separations attributed to illicit drugs, with more than a threefold increase among men, and more than a twofold increase among women.

In 1998, illicit drugs caused an estimated 343 male and 71 female deaths in NSW. Of these, almost all—324 and 63 respectively—were from opiate overdose. The majority of all overdose fatalities can be attributed to heroin.²

In the period 1988–1998, there was a large increase in overdose fatalities, with the age-adjusted death rate among males more than doubling, while the death rate among females has increased by 40 per cent. Since 1992, over 80 per cent of overdose fatalities have been among males. This sex difference in death rates is larger than would be expected from clinical treatment populations where males make up approximately 65 per cent of NSW methadone program clients.³

More information on illicit drug use in NSW will be presented in the forthcoming Report of the Chief Health Officer on the Health of the People of NSW, 2000.

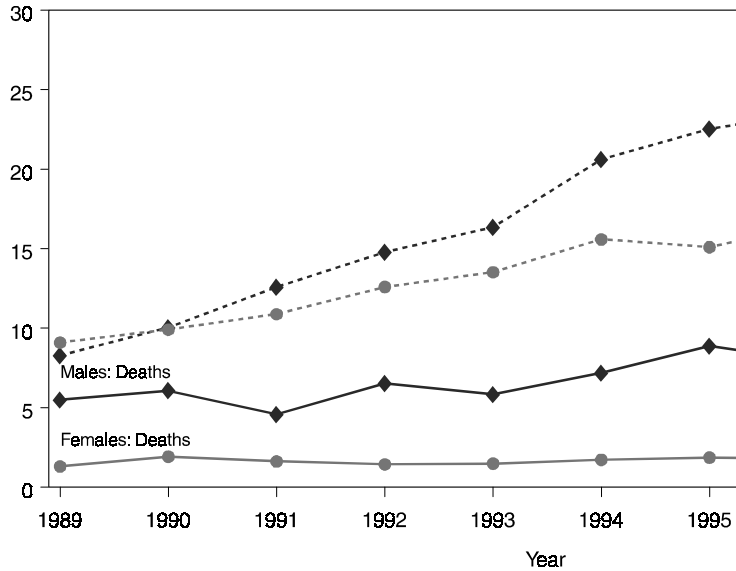
REFERENCES

1. English DR, Holman CDJ, Milne MG, et al. *The quantification of drug caused morbidity and mortality in Australia*. Canberra: Commonwealth Department of Human Services and Health, 1995.
2. Zador DA, Sunjic S, Darke S. *Toxicological findings and circumstances of heroin related deaths in NSW, 1992*. Sydney: National Drug and Alcohol Research Centre (monograph no. 22), University of New South Wales, 1995.
3. NSW Department of Health. *NSW methadone program 1995–1996: annual statistical report*. Sydney: NSW Department of Health, 1997. ☒

FIGURE 2

DEATHS AND HOSPITAL SEPARATIONS DUE TO ILLICIT DRUGS, NSW, 1989–1998

Deaths: Rate
per 100,000 population



			1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Number	Deaths	Males	160	177	135	194	174	213	268	238	287	343
		Females	37	55	47	42	44	50	55	53	64	71
		Persons	197	232	181	235	217	263	323	291	351	414
	Separations	Males	1203	1468	1855	2186	2418	3047	3344	3520	4106	.
		Females	1308	1432	1593	1842	1979	2271	2219	2461	2884	.
		Persons	2511	2901	3448	4029	4396	5318	5563	5981	6990	.
Rate per 100,000	Deaths	Males	5.5	6.1	4.6	6.5	5.8	7.2	8.9	7.9	9.5	11.3
		Females	1.3	1.9	1.6	1.4	1.5	1.7	1.9	1.8	2.2	2.3
		Persons	3.4	4.0	3.1	4.0	3.7	4.5	5.4	4.8	5.8	6.9
	Separations	Males	41.4	50.2	62.9	73.9	81.7	103.1	112.7	118.0	137.4	.
		Females	45.5	49.5	54.4	63.0	67.6	77.9	75.5	83.0	97.2	.
		Persons	43.4	49.8	58.7	68.5	74.6	90.5	94.1	100.6	117.4	.

Note: Deaths and hospital separations were calculated using age- and sex-specific aetiological fractions from English et al. 1995.¹ Deaths are for calendar years. Separations are for financial years, starting in the indicated year. Rates were age-adjusted using the Australian population as at 30 June 1991.

Source: Australian Institute of Health and Welfare (aetiological fractions). NSW Department of Health Inpatient Statistics Collection (ISC) and ABS mortality data and population estimates (HOIST). Epidemiology and Surveillance Branch, NSW Department of Health.

INAPPROPRIATE PRESCRIBING OF BENZODIAZEPINES BY DOCTORS IN NSW

Pia Salmelainen

Policy Analyst

Pharmaceutical Services Branch

Benzodiazepines are widely used, most commonly to treat short-term conditions such as anxiety and insomnia. Although they are generally effective in treating these conditions, and are relatively safe to use, physical dependence and symptoms of withdrawal can occur, even when taken in recommended therapeutic doses. Benzodiazepines are also liable to be abused by some people, such as alcohol- and heroin-dependent persons.

For these reasons benzodiazepines should be prescribed with some caution. To assist doctors, the Pharmaceutical Services Branch has developed guidelines called *Recognising and Handling Patients Liable to Abuse Benzodiazepines*. The guidelines include information about how to recognise and deal with patients who seek benzodiazepines and who are likely to abuse benzodiazepines obtained on prescription. It also outlines a doctor's obligations under the Poisons and Therapeutic Goods Regulation. These include prescribing within therapeutic standards, and maintaining appropriate records. It should be noted that patients are legally obliged to inform a doctor of the quantity of any benzodiazepines prescribed to them within the previous two months.

Each year a number of doctors come to the attention of the Pharmaceutical Services Branch of the NSW Department of Health because they prescribe benzodiazepines inappropriately. This includes: prescribing at rates in excess of the recommended therapeutic dose, prescribing for inappropriate purposes, prescribing to persons liable to abuse benzodiazepines, and prescribing benzodiazepines long-term. This paper presents findings from an examination of the benzodiazepine-prescribing practices of doctors who were investigated by the Pharmaceutical Services Branch. It highlights the problems in this area of prescribing, and describes guidelines that have been developed to assist doctors.

METHOD

Data were extracted from investigation files held by the Branch. The sample, selected for convenience, comprised 21 doctors who had come to the attention of the Branch during the period 1995 to 1997, because of inappropriate benzodiazepine prescribing. It is estimated that the sample represented between five and 10 per cent of all doctors investigated some time during 1995–97 for their prescribing of benzodiazepines.

The majority of the sample (18) practised in the Sydney metropolitan area. Most of the doctors (20) were general

practitioners. The doctors in the study were investigated about their prescribing to a variable number of patients, ranging from 1 to 113 (median=2).

FINDINGS

All of the doctors in the sample engaged in more than one inappropriate prescribing practice.

Prescribing at rates in excess of the recommended therapeutic dose

At least 10 doctors prescribed benzodiazepines at rates indicating daily doses in excess of the recommended therapeutic dose. Generally in these cases, the amount prescribed was three or more times the recommended therapeutic dose. In one case a patient had been prescribed what appeared to be 50 times the recommended therapeutic dose.

Prescribing for inappropriate purposes

At a follow-up interview 13 doctors indicated they had prescribed benzodiazepines to a patient because the patient had requested the particular drug. Often in these instances the patient requested the drug to deal with a condition they claimed to have, such as a sleeping problem or pain. Sometimes the patient claimed that only one particular benzodiazepine was effective.

Six doctors said they prescribed benzodiazepines because they were trying to control the patient's benzodiazepine dependency problem. However, the doctors were not able to control their patients' access to benzodiazepines, as some patients sought further prescriptions from several different doctors (that is, were 'doctor shopping').

Prescribing to persons liable to abuse benzodiazepines

At least 16 doctors prescribed benzodiazepines to persons who were on the methadone maintenance program, or to persons whom the doctor knew were—or suspected of—abusing drugs. Most of the doctors treating patients who were on the methadone maintenance program did not take appropriate action, such as asking the patient about their methadone treatment, or contacting the patient's methadone prescriber, or seeking assistance from the Pharmaceutical Services Branch.

In those instances where the doctor knew a patient had a history of drug abuse, it was uncommon for the doctor to refer the patient to a drug and alcohol specialist.

Some doctors suspected their patients were seeing other doctors for benzodiazepines, while others appeared to be unaware that their patients were 'doctor shopping'. Several doctors in this latter group expressed surprise or shock at

hearing from the investigator that their patient was a 'doctor shopper'. Only occasionally did a doctor indicate to the investigator that they asked their patients whether they were seeing other doctors.

Prescribing benzodiazepines long-term

All doctors in the study had prescribed benzodiazepines on a long-term basis. Over half of the doctors had prescribed benzodiazepines to one or more patients for a period of at least 12 months. One patient had been prescribed benzodiazepines for a 10-year period.

DISCUSSION

While benzodiazepines are generally effective and safe drugs to use, there is a significant risk of a patient becoming dependent or experiencing withdrawal after a relatively short period of use. Furthermore, there is a small

but significant group of patients in the community who abuse benzodiazepines.

The Royal Australian College of General Practitioners has produced a publication, called *Anxiety and Insomnia: Think Twice Before Prescribing*, which outlines principles of good management for the prescribing of benzodiazepines.¹ It includes information on the management of anxiety and insomnia, withdrawal from benzodiazepines, and the prevention of dependence. There is also a section on drug misuse that discusses prescribing in relation to habitual drug users.

REFERENCE

1. Mant A, de Burgh S, Letton T, Shaw J. *Anxiety and insomnia: think twice before prescribing*. Melbourne: The Royal Australian College of General Practitioners, 1997. ☒

To obtain a copy of *Recognising and Handling Patients Liable to Abuse Benzodiazepines* (publication number TG199) write to the Duty Pharmacist, Pharmaceutical Services Branch, NSW Department of Health, PO Box 103, Gladesville, NSW 1675; or telephone (02) 9879 3214. The Duty Pharmacist is also able to supply doctors with written information to assist them with patients seeking other drugs of dependence.

HIV INFECTION, AIDS, HEPATITIS C, AND SEXUALLY TRANSMISSIBLE INFECTIONS IN AUSTRALIA: NATIONAL SURVEILLANCE RESULTS TO DECEMBER 1998

Ann McDonald

National Centre in HIV Epidemiology and Clinical Research, Darlinghurst

The third annual surveillance report *HIV-AIDS, Hepatitis C and Sexually Transmissible Infections in Australia Annual Surveillance Report 1999* was released in October 1999.¹ The report, framed in the context of the third *National HIV-AIDS Strategy 1996-97 to 1998-99*, provides a comprehensive summary of current knowledge on the pattern of HIV infection, AIDS, hepatitis C, and sexually transmissible infections in Australia. It includes information on:

- time trends in diagnoses of those infections;
- incidence and prevalence in populations at higher or lower risk of HIV infection, such as gay and other homosexually-active men, indigenous people, people who have injected drugs, and people at risk through heterosexual contact only;
- patterns of treatment for HIV infection;
- patterns of risk behaviour for HIV and related infections.

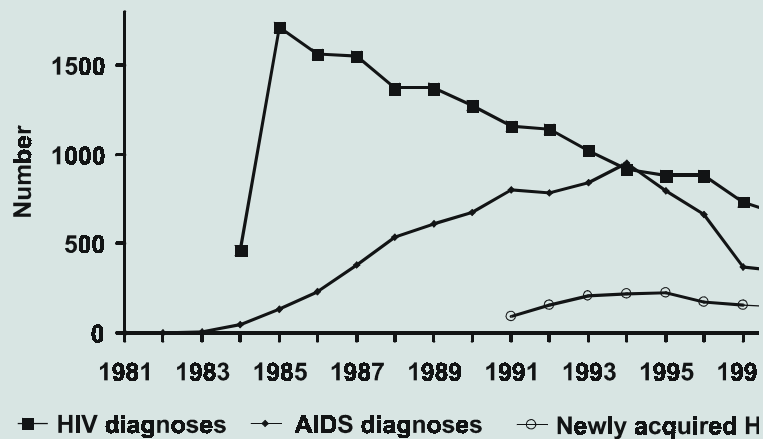
The main findings are presented as text, supported by figures. The data are presented as tables and follow the main report. This article outlines key results from the report.

TRENDS IN DIAGNOSES OF HIV INFECTION AND AIDS

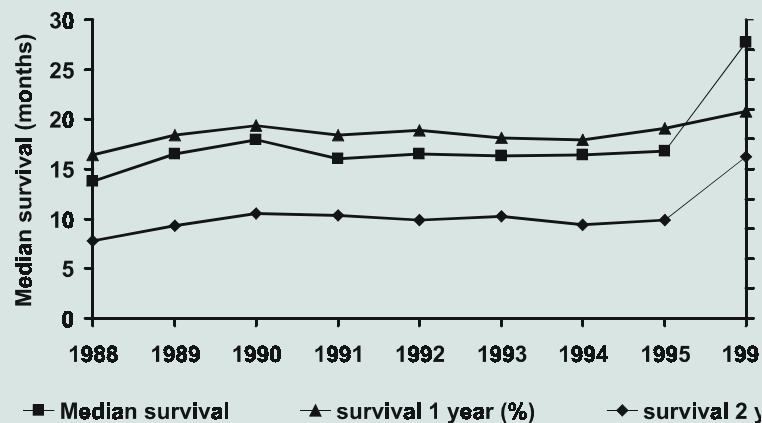
The annual number of diagnoses of AIDS in Australia has dropped from a peak of 950 cases in 1994 to an estimated 348 in 1998 (Figure 3). The annual number of diagnoses of HIV infection has also continued to decline, to around 660 in 1998. However, the number of documented cases of newly acquired HIV infection in 1993-1998 has remained stable at 150-200 infections per year, providing a lower limit to the number of cases of HIV transmission that have actually occurred in Australia each year. Allowing for undocumented cases, it is estimated that 450 cases of newly acquired HIV infection occur in Australia annually.

The number of people living with HIV infection in Australia was estimated to be 11,800 by the end of 1998 including 2,430 people living with AIDS. The number of people living with HIV infection in Australia is estimated to gradually increase to around 13,000 by the year 2003.

Transmission of HIV in Australia continues to occur primarily through sexual contact between men. No evidence was available of recent change in rates of HIV transmission through male homosexual contact, nor any increase in the very low rates of transmission through

FIGURE 3**HIV-AIDS DIAGNOSES IN AUSTRALIA, ADJUSTED FOR MULTIPLE REPORTING AND DELAYS**

Source: State and Territory health authorities

FIGURE 4**SURVIVAL FOLLOWING AIDS DIAGNOSIS**

Source: State and Territory health authorities

injecting drug use or heterosexual contact.

In almost 50 per cent of 526 cases of HIV infection attributed to heterosexual contact in 1994–1998, infection was acquired through heterosexual contact in an overseas country with a high prevalence of HIV infection, or through heterosexual contact with a person from a high prevalence country, such as countries in sub-Saharan Africa, or countries in South East Asia such as Cambodia, Thailand and Myanmar.

Rates of HIV and AIDS diagnoses *per capita* differed little between indigenous and non-indigenous people. Among indigenous people, however, a higher percentage of diagnoses occurred in women and a higher percentage of infections were acquired heterosexually.

EFFECT OF ANTIRETROVIRAL TREATMENT ON AIDS DIAGNOSES

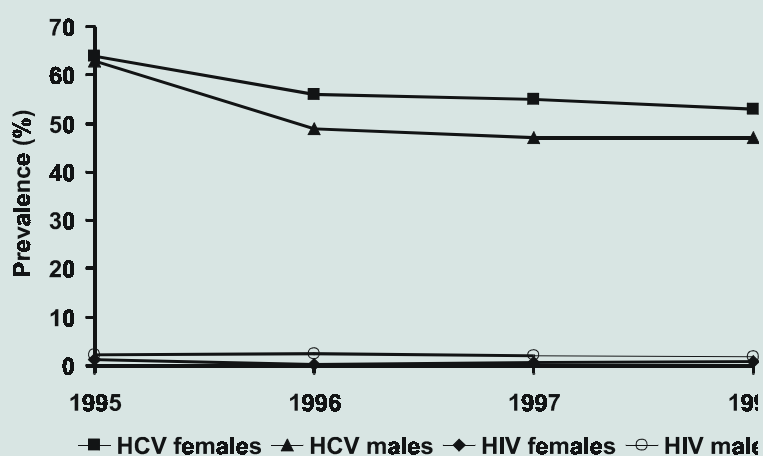
It is now clear that the fall in AIDS incidence observed from 1994 has been substantially accelerated by improvements in therapy. Over 1,000 fewer cases of AIDS have occurred than would have been expected had there been no improvement in therapy for HIV infection.

Median survival following AIDS has increased significantly from 19.7 months among people diagnosed in 1995 to 27.7 months among those diagnosed in 1996 (Figure 4).

Over 40 per cent of AIDS cases in 1998, up from 20 per cent in 1994, occurred in people who were newly diagnosed with HIV infection within the preceding three

FIGURE 5

HIV AND HCV PREVALENCE IN NEEDLE AND SYRINGE PROGRAMS



Source: collaboration of Australian needle and syringe programs

months. These people were therefore unable to benefit from antiretroviral therapy or prophylaxis for opportunistic infection. As a consequence 1998 saw an increase, for the first time since the 1980s, in the proportion of AIDS diagnoses presenting as *Pneumocystis carinii* pneumonia.

Trends in HIV risk behaviour

Surveys carried out among gay and other homosexually active men in Sydney indicate an increase in the percentage of men who report unprotected anal intercourse with casual partners, from 14 per cent in 1996 to 18 per cent in 1998. Surveys carried out among gay and other homosexually active men in Adelaide, Brisbane, Melbourne and Perth show similar levels of unsafe sexual behaviour with casual partners.

The number of rectal isolates of gonorrhoea increased among men in New South Wales, from 72 in 1997 to 158 in 1998, suggesting a recent increase in sexual risk among gay and other homosexually-active men.

Surveys of 17–19 year old first-year university students show increasing levels of condom use with casual partners.

TRENDS IN DIAGNOSES OF HEPATITIS C INFECTION

Hepatitis C was the most frequently reported notifiable infection in Australia in 1998. A substantial increase was observed in the number of diagnoses reported among people aged less than 20 years.

The number of cases of newly acquired hepatitis C infection increased sharply in 1998, attributable to increased efforts to identify and report these cases.

Transmission of hepatitis C continued at high levels

among people who report injecting drug use. There has been no further decline in prevalence following that observed among people attending needle and syringe programs in 1996 (Figure 5).

TRENDS IN DIAGNOSES OF SEXUALLY TRANSMISSIBLE INFECTIONS

Reported cases of gonorrhoea increased in 1998, as did reported cases of syphilis. These trends may be partially attributable to changing diagnostic methods and case definitions, and partly to real shifts in prevalence or incidence of these infections.

Indigenous people continue to be diagnosed with these infections at much higher rates than non-indigenous people.

REFERENCE

1. National Centre in HIV Epidemiology and Clinical Research. *HIV/AIDS, Hepatitis C and Sexually Transmissible Infections in Australia Annual Surveillance Report 1999*. Sydney: National Centre in HIV Epidemiology and Clinical Research, University of New South Wales, 1999. ☐

The 1999 Annual Surveillance Report is accessible through the Web site www.med.unsw.edu.au/nchechr. Copies of the report can be obtained by writing to the Epidemiology Section at the National Centre in HIV Epidemiology and Clinical Research, Level 2, 376 Victoria Street, Darlinghurst, NSW 2010; by telephone: (02) 9332 4648; by facsimile: (02) 9332 1837; or by email at: recept@nchechr.unsw.edu.au.

NSW HEALTH CLINICAL INFORMATION ACCESS PROGRAM

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HOW THE PROGRAM EVOLVED

In 1996 the NSW Health Clinical Systems Steering Committee, which governs a number of clinical committees, endorsed the development of a Web site to provide information to clinicians in the NSW public health system. As a result, the Clinical Information Access Project (CIAP) Web site was established on 4th July, 1997. The CIAP provides access to a comprehensive range of peer-reviewed information 24 hours a day, seven days a week, via the Internet and Intranet. Utilisation of the Web site has steadily increased, peaking at 840,000 'hits' in the month of March 2000, which is an all-time monthly record. The site has averaged 340,000 'hits' per month since July 1999, and has recorded over eight million 'hits' since its inception in 1997.

THE OBJECTIVES OF CIAP

The primary objectives of making this information available on the Web were to:

- provide support for decision making within the public health system
- promote evidence-based practice
- improve communications at the point of care (that is, wherever a patient is located).

Clinicians were therefore consulted to ascertain the information resources needed to meet these objectives. A CIAP Committee was convened to oversee the project, including the acquisition and approval of information resources. The pre-implementation survey, completed in September 1997, confirmed the top 12 priorities of NSW clinicians for information resources on the Web (Figure 6).

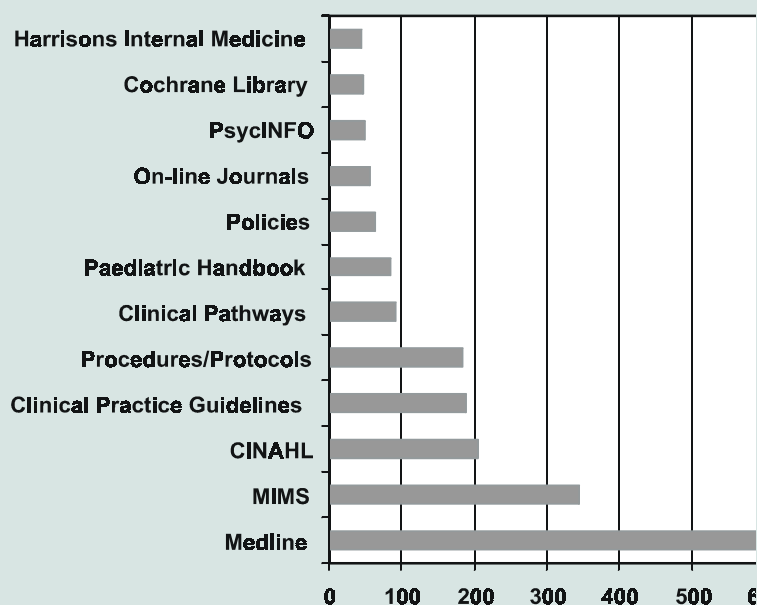
THE CONTENT OF CIAP

Content has grown over the past two years in response to requests by clinicians and the following on-line information is now available via the CIAP Web site:

- Medline and CINAHL with over 12 million citations and links to 30 full text medical and nursing journals
- the full Cochrane Library with over 700 evidence-based reviews
- PsycINFO: psychiatry and psychology databases linked to 10 full text mental health journals
- MIMS for prescription decision-support
- Consumer Medicines Information (CMIs) pamphlets linked to MIMS
- HealthStar for health services, technology, research and quality management literature
- Antibiotic Guidelines (10th edition)
- Micromedex: Poisindex, Toxpoints, Emergindex, DrugREAX and Martindale databases

FIGURE 6

THE TOP 12 PRIORITIES OF NSW CLINICIANS FOR INFORMATION RESOURCES ON THE WEB



- Harrison's Textbook of Internal Medicine (14th edition)
- Primary Care Online: nine textbooks for medicine, nursing, drugs and diagnostic tests
- Interactive ECG: a tutorial of ECG case studies and tests
- Internet and email tutorials
- policies, procedures, protocols, clinical practice guidelines and clinical pathways from contributing Area Health Services in NSW
- NSW Health policies and guidelines
- list servers to improve communications between clinicians
- Therapeutic Guidelines: Analgesic, Gastrointestinal, Neurology, Endocrinology and Psychotropic Guidelines (on trial Feb—May 2000)
- links to International and National clinical Web sites
- Public Health Web sites including those of the Public Health Division, NSW Department of Health; the *NSW Public Health Bulletin*; the Public Health Association of Australia (PHA); and the Public Health Division, Health and Community Services, Victoria.

Other relevant Web sites can be added to this list by advising CIAP via the Feedback link on the CIAP Web site.

ACCESS

While the CIAP knowledge databases (MIMS, Cochrane, etc.) are protected by password, they are accessible to any

health professional employed in the NSW public health system. Passwords are available by contacting the local Area Health Service CIAP representative at www.clininfo.health.nsw.gov.au/contacts/index.html

CIAP ON-LINE SURVEY

Feedback from clinicians has been positive and there is a continuous high demand for education on how to effectively search the databases. In 1998, the CIAP received:

- the *Data Management Association (DAMA) Australia Achievement Award for Excellence in Information Management*;
- the *Australian Library and Information Association (ALIA) NSW Branch Merit Award for Services to Rural and Remote Users and the Community*;

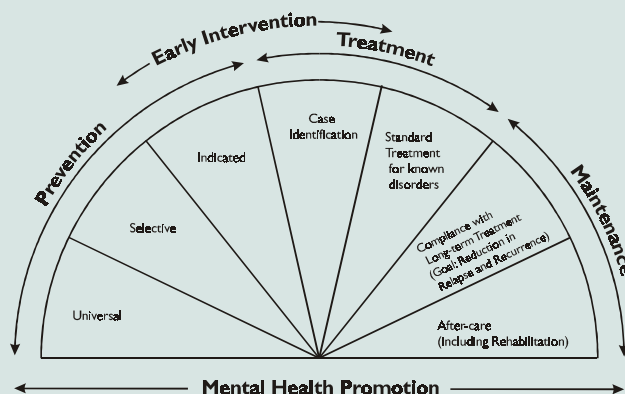
and was nominated in the top 10 medical Web sites in Australia by *PC Authority*.

In 2000, CIAP will continue to provide on-line access to information that supports evidence based health care in NSW. ☒

For further information please contact Michelle Wensley, Senior Project Officer, Clinical Systems, NSW Department of Health; telephone (02) 9391 9742; or email mwens@doh.health.nsw.gov.au. The CIAP Web site can be found at: www.clininfo.health.nsw.gov.au.

ERRATUM

In the March 2000 issue of the *NSW Public Health Bulletin* (Volume 11, Number 3, page 31), Figure 2 in the article by Scanlon and Raphael, 'Building capacity for promotion, prevention and early intervention in mental health', contained a small error. The left arrow of the heading *Early Intervention* should have stopped at the section of the pie chart labelled *Indicated* (under *Prevention*). A corrected figure is printed below.



HEPATITIS C

WHAT IS HEPATITIS?

- ‘Hepatitis’ means inflammation or swelling of the liver. It can be caused by chemicals or drugs, drinking too much alcohol, or by different kinds of viral infections.
- There are a number of different hepatitis viruses: A, B, C, D, E. They are all completely different; they cause different illnesses and may require different treatments.

WHAT IS HEPATITIS C?

- Hepatitis C is a liver inflammation caused by the hepatitis C virus (HCV). Before the virus was identified in 1989, hepatitis C was known as non-A/non-B hepatitis. Currently, there is no vaccine to prevent HCV infection.

HOW DO YOU CATCH HEPATITIS C?

- HCV is nearly always caught through blood-to-blood contact with someone who is infected. This involves sharing of drug injecting equipment, unsafe tattooing or skin piercing, receiving blood transfusions prior to February 1990, needle-stick injuries, or unsterile medical procedures. Since February 1990, Australian blood banks have screened donated blood for HCV.

HOW DOES HEPATITIS C AFFECT PEOPLE?

- Of every 100 people exposed to HCV, approximately 25 will clear the virus within four to six weeks of infection. The other 75 will develop a chronic or ongoing infection.
- When people are first infected with HCV, there is usually no sign of illness. Over a long period of time HCV infection goes on to affect different people to varying degrees.

IS THERE A TEST FOR HEPATITIS C?

- A blood test showing presence of antibodies to the virus is evidence of present or past infection. If a person tests positive for the antibodies to hepatitis C, and has a definite risk factor for exposure to blood and/or abnormal liver function tests, it is likely they have hepatitis C and are infectious.
- PCR (Polymerase Chain Reaction) tests can determine the presence of HCV in blood (the PCR viral detection test). PCR tests can also determine the amount of virus circulating in the blood (the PCR viral load test), and the HCV sub-type with which the person is infected (the PCR genotype test).

- Other blood tests, called liver function tests, may suggest if someone has any liver damage.
- A liver biopsy—studying a tiny sample of liver tissue—is the only accurate way of telling whether the liver is damaged.

IS THERE ANY TREATMENT FOR HEPATITIS C?

- Current government-funded treatment involves the drug Interferon. People who do not respond to Interferon treatment may then be offered government-funded ‘combination therapy’ with Interferon and Ribavirin. A person with hepatitis C has to meet certain conditions to receive government-funded treatments.
- *Interferon* helps the body fight the virus and helps prevent the virus from multiplying. It leads to a good long-term response for around 10–25 per cent of people who try it.
- *Combination treatment* involves Interferon injections and Ribavirin tablets. To date, HCV genotypes 2 and 3 have been shown to have a higher long-term response rate to combination therapy (up to 70 per cent) than genotypes 1 and 4 (up to 40 per cent). Overall, a person’s chance of responding well to combination therapy is related to their hepatitis C genotype and the amount of virus in their blood. If people have responded to Interferon but then relapsed, there is still a good chance of response to combination therapy. Those who did not respond at all to previous Interferon have only a low chance of responding to combination therapy.
- Both Interferon and combination therapy can have serious side effects and need to be carefully monitored. For more detailed information on these treatments, phone the NSW Hep C Helpline or speak to your doctor.
- *Herbal and other complementary therapy treatments:* some of these therapies may reduce liver damage and improve overall health. If people seek treatment from a complementary therapist they should:
 1. make sure the therapist has experience in working with hepatitis C;
 2. ensure they are properly qualified and belong to a recognised professional organisation;
 3. ask how much the treatment will cost;
 4. ask how they have measured the health outcomes of their therapy;
 5. find doctors and complementary health practitioners who will work together.

SELF-MANAGEMENT

- People with hepatitis C can consider the following actions to improve their health:
 1. stop drinking alcohol, or cut down alcohol intake
 2. consider having hepatitis A and hepatitis B vaccinations
 3. eat a balanced diet
 4. learn how to manage stress
 5. seek counselling if needed
 6. rest when feeling unwell
 7. when taking prescription or over-the-counter drugs, check with a doctor and follow the directions carefully
 8. talk to someone close about feelings or problems
 9. if injecting drugs, use safer injecting methods.

CAN PARTNERS OR KIDS CATCH IT?

- Hepatitis C cannot be caught by hugging, or sharing plates, cutlery, toilets or washing machines. Although HCV is rarely passed on sexually, all sexually active people need to consider safe sex due to the range of sexually transmissible diseases with which they can become infected.
- There is a small chance the virus will be passed on to a baby during pregnancy or at birth. The risk is increased if the mother has only just become infected (or re-infected) or if she has serious liver damage. HCV does not seem to be passed on via breast milk.

HOW CAN WE STOP THE HEPATITIS C VIRUS FROM SPREADING?

- People with HCV should not donate blood, sperm or organs.
- People who inject shouldn't share *any* injecting equipment, including needles and syringes, spoons, filters, water, swabs and tourniquets. Hands should be washed thoroughly before and after injecting.
- Ideally, people should use a new fit for every hit. Tables or benches should be wiped down before people prepare a hit. Used fits should be disposed of in a fitpack or sealed plastic container (for example, a juice bottle).
- Blood spills should be wiped up with absorbent paper towel and the spill site cleaned with detergent and water.
- Cuts and wounds should be covered with waterproof dressings (for example, band-aids).

- Body piercing and tattooing should be done at shops that use proper methods of sterilisation.
- Razors, toothbrushes or nail scissors shouldn't be shared.
- People should use condoms for sex that might involve blood to blood contact.

HEPATITIS C AND INJECTING DRUG USE

- Injecting drugs (past or present) is the most common risk factor for contracting HCV. The majority of people who have injected drugs have hepatitis C. Those people who inject and don't have hepatitis C are at great risk of infection.
- Anyone who has ever shared injecting equipment may have possibly caught hepatitis C. It doesn't matter what was injected—heroin, methadone, pills, speed or steroids—it is how the drugs are injected that is a risk for transmitting infection.
- People who inject drugs will benefit from good medical follow-up after a hepatitis C diagnosis is made. Knowing about hepatitis C status is an important part of deciding to make the recommended lifestyle changes to improve health (see Self-Management section above).
- For those people who already have hepatitis C, it's important to inject as safely as possible to avoid passing the virus on to others or becoming reinfected with a different HCV genotype or sub-type. It is believed that reinfection may cause a more serious form of illness or place a greater strain on the liver.

FOR MORE INFORMATION:

- People should speak to their doctor. If necessary your doctor can also refer you to a liver specialist.
- Information on general community support services can be found in the front of local telephone books.
- Ring the NSW Hep C Helpline on 9332 1599 or 1800 803 990
- ADIS (Alcohol & Drug Information Service) 9361 2111 1800 422 599
- NUAA (NSW Users & AIDS Association) 9369 3455 1800 644 413

The information in this fact sheet was produced by the Hepatitis C Council of NSW with funding from the NSW Department of Health. For more information please contact your local public health unit, community health centre, pharmacist or doctor. ☒

NSW PUBLIC HEALTH BULLETIN

The *NSW Public Health Bulletin* is a publication of the NSW Department of Health. The acting editor is Ms Allison Salmon, Acting Manager, Public Health Training and Development Unit, NSW Department of Health. Dr Michael Giffin is production manager.

The *Bulletin* aims to provide its readers with population health data and information to motivate effective public health action.

Submission of articles

Articles, news and comments should be 1000 words or less in length and include a summary of the key points to be made in the first paragraph. References should be set out in the Vancouver style, described in the *New England Journal of Medicine*, 1997; 336: 309–315. Send submitted articles on paper and in electronic form, either on disc (Word for Windows is preferred), or by email. The article must be accompanied by a letter signed by all authors. Full instructions for authors are available on request from the editor.

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Please address all correspondence and potential contributions to The Editor, *NSW Public Health Bulletin*, Locked Mail Bag 961, North Sydney NSW 2059 or to Lmadd@doh.health.nsw.gov.au. Tel (02) 9391 9956, Fax (02) 9391 9232.

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INFECTIOUS DISEASES, NSW: APRIL 2000

This month, regular readers will notice a new presentation of notifications which includes, for each disease presented in Figure 7, a snapshot of demographic characteristics of cases during the three months to February 2000. Cases are broken down by age, sex and whether they live in the Sydney metropolitan area (including the Health Areas of South Eastern, Central, Northern, Western Sydney, South Western Sydney, and Wentworth), or the rural Areas (the rest of the State). This information may provide additional insights into the recent epidemiology of—including risk factors for—these conditions. For example, readers who compare the characteristics of recent cases with those of the general NSW population may note that:

- **arbovirus** infections occurred mostly among rural residents, but reports have been fewer than in previous summers;
- **cryptosporidiosis** occurred mainly among rural residents and a large proportion were small children;
- **gonorrhoea** continued to be reported, mainly among Sydney men;
- **hepatitis A**, while fewer in number, was also mainly reported among men from the metropolitan area;
- only a small proportion of the notifications of **pertussis** (traditionally thought to be a disease mainly of small children) cases were reported among children under five years old. The majority are from outside Sydney. ☒

FIGURE 7

REPORTS OF SELECTED INFECTIOUS DISEASES, NSW, JANUARY 1995 TO FEBRUARY 2000, BY MONTH OF ONSET

These are preliminary data: case counts in recent months may increase because of reporting delays

NSW population
 Male 50%
 <5 yo 7%
 Rural 42%

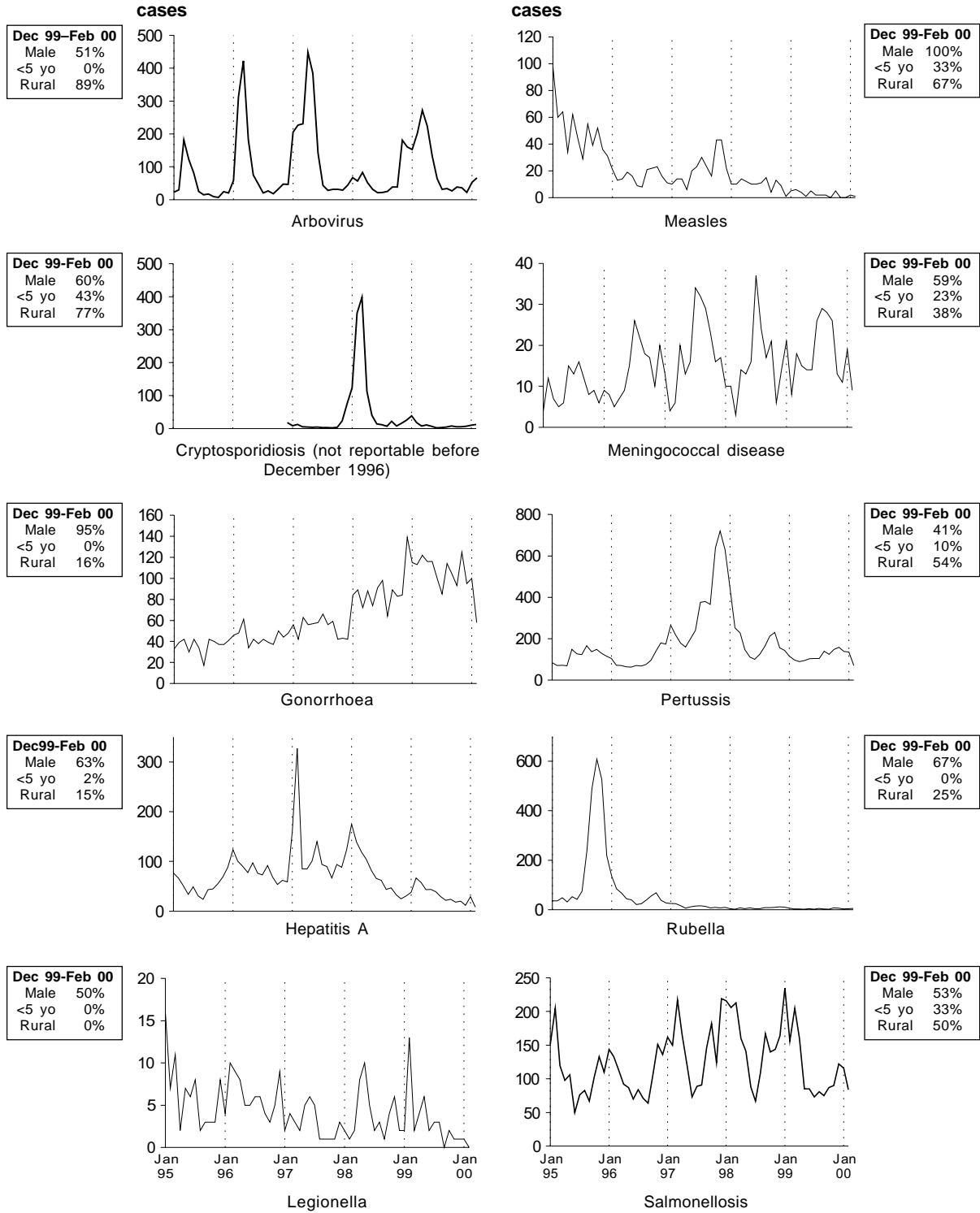


TABLE 2 REPORTS OF NOTIFIABLE CONDITIONS RECEIVED IN FEBRUARY 2000 BY AREA HEALTH SERVICES

Condition	Area Health Service (2000)																	Total	
	CSA	NSA	WSA	WEN	SWS	CCA	HUN	ILL	SES	NRA	MNC	NEA	MAC	MWA	FWA	GMA	SA	for Feb*†	To date†
Blood-borne and sexually transmitted																			
AIDS	3	4	-	-	3	-	2	-	4	-	-	-	-	-	-	-	1	17	36
HIV infection*	-	1	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	26	73
Hepatitis B - acute viral*	-	1	-	-	1	-	1	-	-	-	1	-	1	-	-	-	-	5	10
Hepatitis B - other*	48	32	74	7	6	-	14	47	3	1	3	1	1	11	-	-	3	258	521
Hepatitis C - acute viral*	-	1	-	1	-	-	1	-	-	-	-	-	-	-	-	-	-	3	11
Hepatitis C - other*	81	43	147	44	1	41	73	28	81	40	43	17	5	25	8	18	19	715	1,340
Hepatitis D - unspecified*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Hepatitis, acute viral (not otherwise specified)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Chancroid*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Chlamydia (genital)*	19	12	16	1	10	5	21	12	53	17	10	16	3	1	4	13	6	221	479
Gonorrhoea*	11	7	8	4	-	2	3	2	36	2	1	2	-	-	1	-	1	81	215
Syphilis	6	2	5	1	1	-	-	-	12	3	1	1	2	-	2	-	-	37	85
Vector-borne																			
Arboviral infection (BFV)*	-	-	-	-	-	1	1	1	-	-	6	1	1	1	-	1	1	14	32
Arboviral infection (RRV)*	-	2	2	1	-	2	4	-	-	2	5	7	2	2	2	10	-	41	76
Arboviral infection (Other)*	-	1	-	-	1	-	-	-	-	-	-	-	-	-	1	-	-	3	4
Malaria*	1	4	-	1	-	-	-	-	-	1	-	-	-	-	-	-	-	7	24
Zoonoses																			
Brucellosis*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Leptospirosis*	-	-	-	-	-	-	1	-	-	2	-	-	-	-	-	-	-	3	3
Q fever*	-	-	-	1	-	-	-	-	-	1	2	1	-	-	4	1	1	11	27
Respiratory and other																			
Blood lead level*	1	3	-	2	10	-	6	3	7	-	-	-	2	-	10	-	-	44	73
Legionnaires' Longbeachae*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Legionnaires' Pneumophila*	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1
Legionnaires' (Other)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Leprosy	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Meningococcal infection (invasive)	-	2	1	1	1	1	-	-	1	1	-	-	-	-	-	1	-	9	30
Mycobacterial tuberculosis	5	5	8	1	6	3	6	-	6	-	1	-	1	-	-	-	-	43	72
Mycobacteria other than TB	3	7	-	1	2	-	-	4	-	-	-	-	-	-	-	4	-	21	49
Vaccine-preventable																			
Adverse event after immunisation	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
H.influenzae b infection (invasive)*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	1	2
Measles	-	-	-	-	-	-	-	-	-	1	1	-	-	-	-	-	-	2	3
Mumps*	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	5
Pertussis	11	12	25	5	9	9	37	12	12	5	2	5	-	3	-	10	3	160	315
Rubella*	1	1	-	-	-	-	-	1	-	1	-	-	-	-	-	-	-	4	9
Tetanus	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Faecal-oral																			
Botulism	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cholera*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cryptosporidiosis*	1	-	-	-	-	-	-	-	1	2	-	1	-	-	-	1	1	7	17
Giardiasis*	5	14	12	3	1	3	7	8	12	7	1	3	6	1	1	1	4	89	160
Food borne illness (not otherwise specified)	-	3	3	-	2	2	-	-	3	-	3	-	27	-	-	-	-	29	56
Gastroenteritis (in an institution)	-	-	-	-	-	-	4	-	-	-	-	-	-	-	-	-	-	4	35
Haemolytic uraemic syndrome	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	1	2
Hepatitis A*	-	5	3	4	2	-	-	-	2	-	-	-	1	-	-	-	-	18	44
Hepatitis E*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Listeriosis*	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1	3
Salmonellosis (not otherwise specified)*	13	9	-	3	11	9	7	6	13	13	11	4	-	2	-	8	2	111	239
Typhoid and paratyphoid*	-	1	1	-	2	-	-	-	1	-	-	-	-	-	-	-	-	5	7
Verotoxin producing Ecoli*	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

* lab-confirmed cases only

† includes cases with unknown postcode

CSA = Central Sydney Area
NSA = Northern Sydney AreaWSA = Western Sydney Area
WEN = Wentworth Area
SWS = South Western Sydney AreaCCA = Central Coast Area
HUN = Hunter Area
ILL = Illawarra AreaSES = South Eastern Sydney Area
NRA = Northern Rivers Area
MNC = North Coast AreaNEA = New England Area
MAC = Macquarie Area
MWA = Mid Western AreaFWA = Far West Area
GMA = Greater Murray Area
SA = Southern Area

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