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THE NSW DRUG SUMMIT

NSW Health Drug Programs Bureau

BACKGROUND

Illicit drug use has re-emerged as a major issue of political and community concern in recent years both locally and overseas. The underlying factors contributing to an expansion of illicit drug use include: the wider availability of a range of substances; persisting youth unemployment; the integration of drug use and recreational activities; and family and social dislocation.

In NSW an increasing number of fatal opiate-related overdoses, the decreasing age of initiation to injecting drug use, and a rise in the number of young people experimenting with cannabis use, have focused greater attention on:

- the quality of existing drug education and prevention programs
- the role of the criminal justice system
- the efficacy and capacity of drug treatment programs
- the need for a more coordinated and strategic response to illicit drug use across government and throughout the community.

THE PROCESS

In February 1999 the Premier of NSW announced that, if re-elected, he would convene a Parliamentary Drug Summit to stimulate fresh thought, and renewed effort, in preventing and managing illicit drug use. The Drug Summit was held over five days, 17–21 May 1999, and was attended by elected members of all parties in both Houses of Parliament.

The NSW Drug Summit consisted of debate, plenary presentations, and issues-based working parties, held within Parliament. The Summit also included visits to treatment agencies and services, and pre-Summit consultations in regional cities. National and international experts were among 100 delegates invited to provide a range of experience and expertise.

Active debate was encouraged in a bipartisan spirit, and this resulted in significant shifts in perspective on the part of some politicians.

continued on page 2

CONTENTS

Consensus decision-making was the goal and the Summit passed some 160 resolutions from a much larger number that were developed by the working parties. An implementation plan is to be developed within six weeks to progress Drug Summit resolutions (for release in late July).

POLICY FRAMEWORK

The NSW Drug Summit acknowledged the importance of existing National and State drug strategies, which provide a framework for evolving government responses to a difficult social problem.

In particular, the Summit recognised the key role of the *National Drug Strategic Framework 1998–1999 to 2002–2003—Building Partnerships* (NDSF), to which all Australian jurisdictions are signatories. NDSF has been developed by the Ministerial Council on Drug Strategy, which brings together the Commonwealth, State and Territory Ministers responsible for health and law enforcement. This group holds the major responsibility for collectively determining national policies and programs designed to reduce the harm caused by drugs.

OUTCOMES

The Summit was preceded by weeks of media discussion of the relative merits of a heroin trial, a proposal that most health experts (both supporters and opposers) acknowledged would have a limited impact on the drug-related problems being encountered in the health and criminal justice systems.

At the opening of the Summit, Premier Carr identified the potential for the Summit to become: 'some sort of factionalised debate between the advocates of removing the legal prohibition on heroin on the one hand, and those who argue for a continuation of prohibition on the other hand—that is, a war on the drugs versus legalisation; zero tolerance versus harm reduction.'

While this debate was present throughout the proceedings, the Summit developed a solid framework of recommendations for future action in this State by concentrating on particular issues such as: training, education, treatment, and diversion of minor drug offenders from the criminal justice system into treatment programs.

Recommendations included:

- recognition of the benefit of diverting drug users away from the criminal justice system into treatment;
- models of 'support coordination' to be piloted that link clients accessing NSPs and treatment programs to social services including: housing, employment, child care, education and training;
- an understanding of the complexity of illicit drug use and a realisation that no one treatment is able to provide a 'cure' to drug misuse;
- improved community involvement in preventing and managing illicit drug use, with the development of localised responses;
- a call for more treatment places with appropriate levels of funding;
- a system of accreditation for treatment clinics and programs to improve the quality of overall delivery;
- the possibility of non-government organisations establishing medically-supervised injecting facilities;
- expansion of general practioner and pharmacist involvement in delivering drug treatment;
- significant expansion of current drug and alcohol training programs, both at a specialist and generalist level;
- proposed introduction of Drug Action Teams across the State to better manage and coordinate policy and programs;
- local communities to develop effective local responses.

A later issue of the *NSW Public Health Bulletin* will include a summary of the Government response with a particular emphasis of the implications for the NSW public health system.

ANNOUNCING A SERIES ON DRUG AND ALCOHOL ISSUES FOR NSW

Over the coming months the *NSW Public Health Bulletin* will publish a series of articles focusing on drug and alcohol use in the population of NSW. Limited information is currently available estimating the extent of drug use in NSW, and this series will provide a relevant and timely overview. The series will discuss policy directions, and present a range of information, including NSW data obtained from the 1998 National Drug Strategy Household Survey (NDSHS) on illicit drug, alcohol, and tobacco use.

INJECTING ROOMS IN SWITZERLAND

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This report describes injecting rooms in Switzerland, and discusses the history of injecting rooms, the context in which they began, and how they operate. These are observations made during a visit to Switzerland in February 1996, and from discussions with health workers and researchers in Switzerland.

The main aim of injecting rooms in Switzerland is to reduce the public health risks, and the public nuisance, associated with drug injecting. These health risks include death from overdose, and infection with blood-borne viruses (HIV, HBV and HCV) from using shared injecting equipment. Medically-trained staff are available at all times to resuscitate clients who experience drug overdoses on the premises.

CONTEXT FOR INJECTING ROOMS

Switzerland has implemented a number of innovative HIV prevention programs that have rarely been adopted elsewhere. Examples include 'needle parks'—open drug scenes where drug users buy, sell and use drugs; a heroin trial that included current prisoners; and syringe exchange schemes for prisoners. Switzerland has a high number of injecting drug users (IDUs), and they are very visible in the streets because of housing shortages. HIV prevalence among Swiss IDUs was already high, up to 50 per cent in some cities, when HIV–AIDS was first recognised.

The first injecting room in Switzerland was established in Bern in 1986 after health workers noticed that IDUs were marginalised from mainstream society, and were being shunned from cafes and restaurants. These health workers proposed establishing a special cafe for IDUs within a government-run health centre that could be a convenient point of contact with IDUs who did not utilise health services. Another factor was the desire to reduce public nuisance resulting from IDUs injecting in parks and public toilets. IDUs then began injecting in these cafes. The workers soon realised that this provided an opportunity to monitor and modify IDUs' risk behaviour to reduce harms associated with injecting. Community opposition in Basel decreased after concerned residents attended an open day at the centre.

THE CENTRES AND INJECTING ROOMS

The injecting rooms are housed within centres, which also contain a cafe, a counselling room and a clinic for primary medical care. The injecting rooms are discrete rooms within the centres, and the terms 'centre' and 'injecting room' will be used in this report to distinguish between the two levels of intervention.

The actual injecting rooms are small and have a sterile ambience. The three rooms visited contain three tables where up to six clients could sit to prepare and inject their drugs. Injecting paraphernalia such as needles and syringes, a candle, sterile water and spoons, were placed at each position at the tables. Paper towels, cotton pads, bandaids, and rubbish bins were also provided. The tabletops were made of stainless steel for ease of cleaning.

Access to the injecting rooms

Staff must verify that clients are at least 16 years old and have a history of injecting before they are allowed to use the injecting rooms. Each room has a maximum capacity that varies depending on its size.

In addition to rules that are common in most drug agencies—such as no violence or drug dealing—there are specific rules for the injecting rooms. Clients must wash their hands on entering the injecting room, and clean their own place at the table after injecting. Clients are not allowed to smoke in the injecting rooms. Most centres have a maximum time limit (30 or 60 minutes) that a client can spend in the injecting room. Clients are allowed to prepare only their own drugs in the injecting room. Staff are not permitted to help clients inject in any centre. Clients who break the rules are barred from the centre for a few days.

Staff and operation

At all centres at least one staff member is present in the injecting rooms at all times. This staff member changes every hour or so, because extended periods in the injecting room are considered to be too taxing. All staff are trained to resuscitate clients if they overdose, although one staff member has the prime responsibility for this duty.

Most centres open for approximately seven hours a day, and some centres are closed for one or two days a week. Centres usually operate at full capacity. In cities with a number of centres, operating times are staggered to maximise the number of hours per day that IDUs can inject safely. Doctors are employed on a sessional basis to visit a centre for a few hours a week. Some centres have direct phone lines to the police and ambulance service.

In the event of an overdose

When a client collapses, the worker in the injecting room calls another worker to assist. Oxygen from a small bottle is administered to the client via a facemask and simple resuscitation bag until the client regains consciousness.

If the client doesn't resume breathing within 10 minutes, an ambulance is called. Naloxone, an antagonist commonly used to reverse the effects of narcotics, is not used to revive clients.

Other services

Counselling, referral to drug treatment, free soup, tea and coffee, and cheap fruit and vegetables are provided in the centres. In Zurich clients volunteer to work in the cafe, and to collect discarded syringes in the vicinity of the centre.

RESEARCH INTO INJECTING ROOMS

Approximately 100 clients a day visit the centres in Zurich and Basel. Within a one-year period in three centres in Zurich, there were an estimated 68,000 injections, 3,000 abscesses treated, 22 clients resuscitated and 10 calls for an ambulance to attend. A comparison of clients surveyed in Bern in 1990 and in 1995, undertaken by the University of Basel, showed a significant increase in the proportion of clients reporting that their first injection with a sterile needle and syringe occurred during the study period. Reuse of injecting equipment decreased significantly during the study.

The main reasons given for attending injecting rooms in 1995 were: to inject in peace (86 per cent); to obtain free injecting equipment (33 per cent); and to have medical attention available. There have been no deaths in any injecting rooms in Switzerland to date. Workers in Basel believe that the number of deaths due to overdose in the community has decreased as a result of injecting rooms.

In Bern, workers believe they have made the injecting ritual less dangerous by moving clients from 2 ml to 1 ml syringes, which carry less risk of blood-borne infection.

Injecting rooms provide drug users with hygienic and controlled conditions; prevent infection by providing sterile syringes, needles and condoms; give access to medical care; and provide opportunities for intervention in the case of such emergencies as overdoses. All key stakeholders have overwhelmingly welcomed the demonstration project and, in Basel, the evaluation team has called for the continuance of the strategy to provide a stable environment for Basel IDUs.[1]

CONCLUSIONS

Injecting rooms are only needed in areas of cities with high injecting drug use and frequent public injection. The main benefits of injecting rooms have been the reduction of public nuisance and the improvement of health in a very vulnerable and unhealthy group. Injecting rooms enable the adoption of less hazardous injecting practices, reduce the number of overdose deaths, minimise the nuisance to the community of injecting in public places, and probably reduce HIV transmission. The centres are well tolerated in Swiss communities. Some IDUs have entered treatment as a result of attending injecting rooms.

REFERENCE

1. Ronco C, Spuler G, Coda P, Schopfer R. *Evaluation der Gassenzimmer I, II and III in Basel.* Basel: Institut fur Sozial und Praventivmedizin der Universitat Basel, 1994. Unpublished.

AN INJECTING ROOM FOR KINGS CROSS

As part of the NSW Government response to the Drug Summit, it was announced that the Sisters of Charity Health Service, and St Vincent's Hospital Darlinghurst, had reached agreement with the NSW Government to run an 18-month clinical trial of a medically-supervised injecting room.

The initial proposal is for a facility to be located in Kings Cross and operate for seven hours per day, every day. The facility will be staffed by a medical director, registered nurses, counsellors and security staff. Necessary amendments to the *Drug Misuse and Trafficking Act* are expected to be made in the spring session of Parliament. Final approval rests with the Director-General of Health and the Police Commissioner. An independent evaulation team has been identified.

IMPROVING PRESCRIBING FOR PAIN: GUIDELINES FOR GENERAL PRACTITIONERS PRESCRIBING FOR MIGRAINE AND LOW BACK PAIN

Karen Kaye and Wendy Rotem
NSW Therapeutic Assessment Group

This report describes two new guidelines for general practitioners (GPs), aimed at improving prescribing for pain associated with migraine and low back pain, which have been distributed recently in NSW. Both guidelines were prepared by the NSW Therapeutic Assessment Group (NSW TAG), with a grant from the NSW Department of Health, in response to a need for better information on the prescribing of opioids. NSW TAG is a committee of clinical pharmacologists, pharmacists and clinicians who are committed to promoting the quality use of medicines in hospitals and in the wider community. The guidelines integrate clinically appraised evidence from the medical literature with knowledge gained from relevant clinical experience. The unique feature of these guidelines is that they were prepared in consultation with GPs, with their needs specifically in mind. A complementary education strategy has also been implemented.

BACKGROUND

Pain has been identified as one of the three most costly areas of health care in Australia. Both undertreatment and overtreatment of pain are associated with disability, suffering and escalating cost. Therefore appropriate treatment of pain, especially non-malignant pain (both acute and chronic), is a subject of concern to prescribers, funders and consumers.

Among the many painful conditions that lead people to consult their GPs, migraine and back pain are two of the most prevalent. Migraine, for example, occurs in 10 to 20 per cent of the population and has been reported to account for approximately one in every 140 occasions of service in general practice. Similarly low back pain is reported to be one of the most prevalent health problems in the general population.

Despite the advent of new therapies, these common conditions can be complex and difficult to treat. In some cases doctors and patients resort to opioid analgesics such as pethidine in an effort to achieve pain relief. Unfortunately patients can become dependent on these drugs, requiring escalating doses (with an accompanying increase in dysfunction) while the underlying problem is not resolved.

There is evidence of an increase in opioid prescribing for non-malignant pain associated with these conditions. In this context the Pharmaceutical Services Branch of the NSW Department of Health commissioned this project because of concern about the number of prescriptions for pethidine, and the potential for the associated problems of addiction and drug-seeking behaviour.

PREPARATION OF THE GUIDELINES

The aims of this project were to:

- improve the selection of analgesics by GPs managing migraine and low back pain;
- reduce the prescription of pethidine for these conditions;
- raise community awareness about appropriate treatment of migraine and low back pain.

An 11-member committee was established to guide the project. It consisted of representatives from the Royal Australian College of General Practitioners (RACGP), NSW Divisions of General Practice, NSW Health Pharmaceutical Services Branch, drug and alcohol specialists, neurologists, rheumatologists, and consumers. A review of current evidence and existing guidelines provided the basis for initial drafts of each guideline, which were distributed to 10 Divisions of General Practice for written comment on the content, format, applicability in general practice, and educational support requirements. A subsequent draft was sent for comment to all NSW Divisions of General Practice, NSW Department of Health, RACGP and other relevant colleges and organisations, consumer organisations and other interested parties.

The resulting guidelines for migraine recommend that the most effective treatment is aspirin or paracetamol commenced as soon as possible after the onset of the attack—usually at the onset of the migraine aura—plus an anti-emetic if vomiting accompanies the attack. For low back pain, paracetamol or a non-steroidal anti-inflammatory drug, and a graded exercise program, is the recommended treatment. Pethidine's short duration of action generally provides little benefit in controlling the prolonged and recurring pain associated with these conditions. If stronger analgesics are required then long-acting oral forms are preferable to short-acting injectable forms like pethidine.

The final guidelines were printed in a format that had been identified during the consultation process as user-friendly for GPs. The guidelines were launched in January 1999 by the NSW Minister for Health, and 10,000 copies were distributed to all GPs in NSW and to relevant organisations and individuals. The guidelines are also available in electronic version via the Internet at **www.medeserv.com.au/tag**.

EDUCATION STRATEGIES

Feedback from GPs and others indicated that patient education was an important aspect of the successful management of migraine and low back pain. Consequently patient brochures were developed, with input from patient support groups, to complement the guidelines. Eighty

thousand brochures were distributed to GPs and patient support groups.

A workshop was provided for staff from the Pharmaceutical Services Branch of the NSW Department of Health, which focused on the management of pain and the use of the guidelines. The goal of the workshop was to facilitate the implementation of the guidelines by staff who are involved with advising doctors with regard to the prescription of opioids. Liaison with Divisions of General Practice was undertaken to encourage inclusion of the guidelines in their continuing education programs.

CONCLUSION

NSW TAG's guidelines for general practitioners prescribing for migraine and low back pain have been very positively received by both general practitioners and consumers. They provide recommendations based on the principles of evidence-based medicine and incorporate clinical experience and accepted practice.

An additional grant from the NSW Department of Health is currently facilitating the formal evaluation of outcomes from use of the guidelines in several Divisions of General Practice.

Both guidelines, and their companion patient information brochures, can be accessed via the Internet at **www.medeserv.com.au/tag**. Copies of the guidelines (but not the patient brochures) are available from the Better Health Centre. Phone (02) 9816 0353 and quote publication numbers PSB 990134 for migraine and PSB 990135 for lower back pain. Further information can be obtained from NSW TAG by phone (02) 9361 2852, or by email at **nswtag@stvincents.com.au**.

NSW AREA HEALTH SERVICE HEALTH STATUS PROFILES

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This article reports on the *NSW Area Health Service Health Status Profiles*, which have been produced as companion documents to each of the Performance Agreements (PAs) for the 17 Area Health Services (AHSs) in NSW.

BACKGROUND AND PURPOSE

The *NSW Area Health Service Health Status Profiles* are on-going surveillance reports on a set of key population health status indicators for each of the AHSs. The Profiles are produced by the Epidemiology and Surveillance Branch in consultation with relevant groups within the NSW Department of Health and the AHSs. The initial purpose of the Profiles as companion documents to the 1999–2001 AHS PAs was to provide:

- summaries of each AHS's standing in relation to key statewide health issues as a context for the negotiation of PAs at the area level;
- background population health data for annual AHS performance reviews;
- summaries of the health status of the populations of particular AHSs in relation to the state and averages for urban and rural areas.

The Profiles will be updated annually and published electronically.

CONTENT

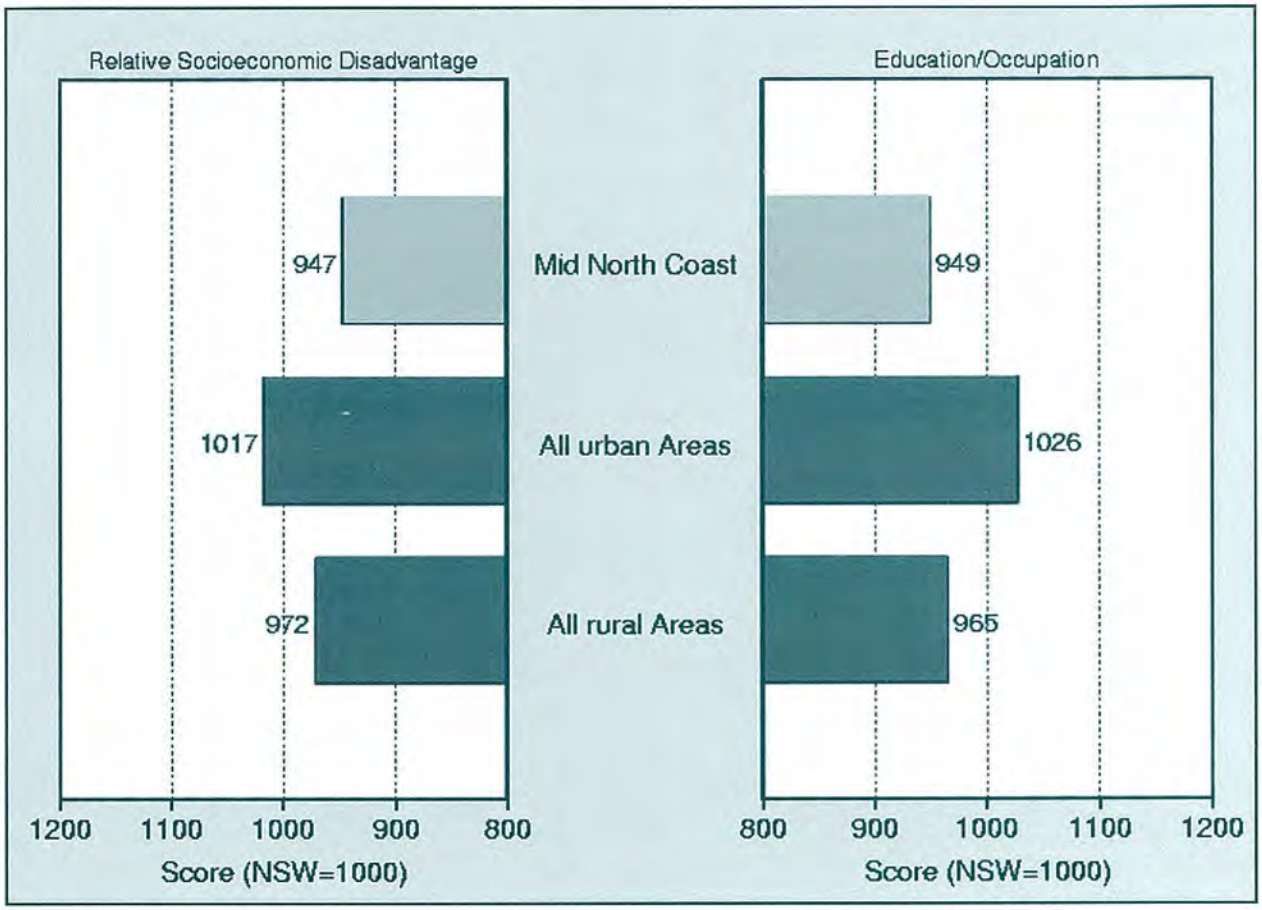
The content of the Profiles was agreed upon by the NSW AHS Performance Agreement Steering Committee. The first edition, *1999–2000 NSW Area Health Service Health Status Profiles*, is based on the indicators included in *The Health of the People of NSW: Report of the Chief Health Officer (1997)*, the 1997 NSW Health Survey Electronic Report, and the AHS profiles used for the most recent round of performance reviews between the Director-General and AHS Boards. While the initial set of indicators was kept to a minimum, they still provide a reasonably comprehensive picture of the demographics and health status of the population of an AHS. For later editions the indicators will be reviewed and refined through further consultation with various content experts and AHS representatives.

The profile for each AHS includes sections on:

- demographics
- overall health status

FIGURE 1

SEIFA* INDICES: MID NORTH COAST AREA HEALTH SERVICE, 1996



Source: *SEIFA, Socio-Economic Indices for Areas, 1996 Census Basic Community Profile, ABS, Canberra, 1997 (HOIST), Epidemiology and Surveillance Branch, NSW Health Department.

- health of Aboriginal and Torres Strait Islander people
- mental health
- national and state key health priorities (cardiovascular diseases, diabetes, asthma, cancer and injury)
- health risk factors (tobacco smoking, alcohol use, illicit drugs use, nutrition, oral health, sun exposure, physical activity)
- immunisation and communicable diseases.

CRITERIA FOR INCLUSION OF INDICATORS

The indicators selected had to meet the following criteria. Ideally indicators had to:

- focus on NSW health priorities and related statewide key initiatives, and be consistent with national indicators;
- be simple and understood by a wide audience, including both health and non-health professionals;
- give a meaningful picture of the health of an Area's population, while allowing comparisons with the state as a whole, and with rural and metropolitan AHSs as two separate groups;
- be valid and of high quality, with a special provision for some content areas in which data quality improvement is a priority (for example, recording of Aboriginality);
- be easily calculable from readily available data, preferably via the Health Outcomes Information and Statistical Toolkit (HOIST).

Although the indicators selected for the first edition of the Profiles might not have satisfied all criteria, particularly those of validity and quality, it is intended that each indicator be reviewed, validated and evaluated for future editions, using a standard protocol.

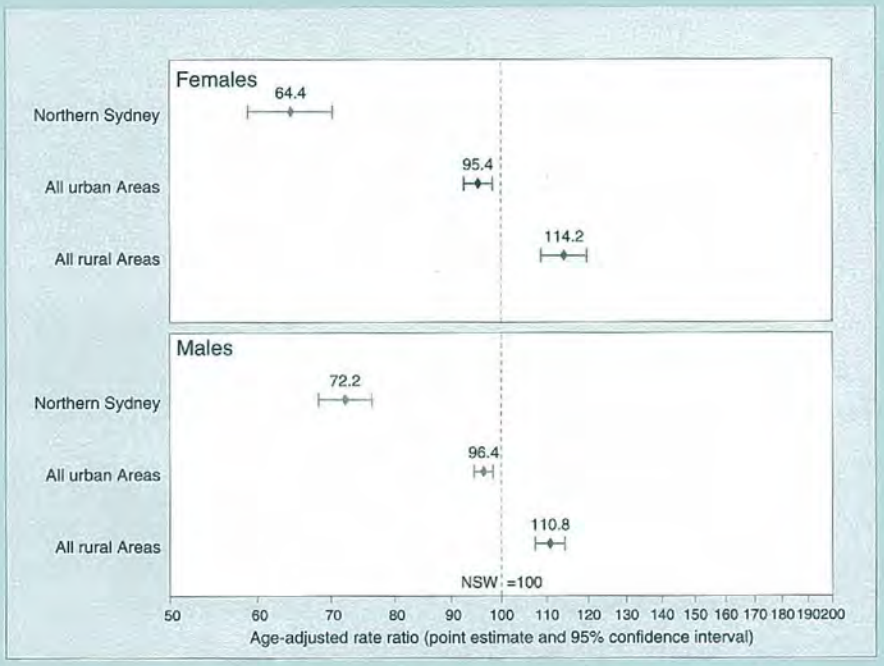
PRESENTATION AND PUBLICATION

Indicators are presented using either bar charts (Figure 1) or 'Hi-lo-close' charts (Figure 2).

Hi-lo-close charts are graphs that plot age-adjusted rate

FIGURE 2

CORONARY HEART DISEASE: MORTALITY FOR PERSONS AGED 25 TO 74 YEARS, NORTHERN SYDNEY AREA HEALTH SERVICE, 1992–1996



Source: ABS mortality data and population estimates (HOIST), Epidemiology and Surveillance Branch, NSW Health Department. Coronary heart disease was classified according to the ICD-9 codes 410–414.

ratios or age-adjusted prevalence ratios for the AHS in question and for the rural and urban AHSs as two separate groups. NSW always has a value of 100. AHS estimates are shown as horizontal lines, representing the 95 per cent confidence interval with central diamonds indicating the point estimate. Statistical tests were performed to determine whether the underlying age-adjusted rate or prevalence for a particular AHS or group of AHSs was significantly different from the age-adjusted NSW rate at a significance level of $p < 0.01$. If the underlying age-adjusted rate or prevalence for a particular AHS was significantly different from the age-adjusted NSW rate, the relevant point estimate and confidence interval line are shown in red if significantly higher or 'worse' than NSW or blue if significantly lower or 'better' than NSW. For a given indicator, such graphs allow comparisons at-a-glance a particular AHS and the state or the rural and urban averages. However this format precludes comparisons between subgroups: hence, the age-adjusted rate ratios for males and females cannot be compared directly.

The graphs are complemented with comments about relevant statewide initiatives and variations among AHSs for the indicator in question.

Other important epidemiological issues, such as trends over time and absolute numbers of a disease or a risk factor, have not been reported in the first edition, but will be considered for future versions.

CONCLUSION

Despite the limitations described above, The *NSW Area Health Service Health Status Profiles* provide summaries at-a-glance of key health status and health risk indicators for a particular AHS in relation to the state and averages for urban and rural areas. It is anticipated that its availability in electronic form and regular updating will ensure that the profiles become a useful tool for many health professionals.

Each AHS Health Status Profile can be downloaded from the NSW Health Web site at: **www.health.nsw.gov.au/public-health/ahsprof/ahsprof.html**.

COMMUNITY CONSULTATION AND PARTICIPATION RESOURCE KIT

Meryl Edwards
Manager, Health Improvement Strategy

The *Community Consultation and Participation Resource Kit for Area Health Service Managers and Project Leaders* has been produced by the Health Improvement Branch, in collaboration with the Health Public Affairs Branch. The resource kit is a compilation of publications describing community consultation and participation written by other state government organisations, including the area health services, and the former Social Policy Directorate of the NSW Health Department (see example Table 1).

A draft of the resource kit was evaluated favourably by 80 staff from metropolitan area health services, four months after a workshop held in December 1998. The contents:

- provide principles to guide the consultation process and the identification of potential and barriers;
- describe a variety of available consultation methodologies—including focus groups and workshops, public meetings and forums, polling and surveys—and how the methodology chosen should reflect the objective of the consultation;
- suggest communication strategies (for example, consensus decision-making) depending on the purpose of the consultation (that is, information giving, information seeking, information sharing, and/or participatory decision-making);
- provide a checklist to guide the consultation process that includes identifying the issues or problems, clarifying the objectives of consultation and identifying the consultation participants;
- discuss ways of addressing the needs of key stakeholders, particularly people with disabilities, non-English-speaking communities and Aboriginal people;
- list ways of evaluating a consultation to assess whether objectives were achieved and appropriate methodologies were used.

Case studies of consultations by two NSW government agencies—the Home Care Service of NSW and the Office of Youth Affairs—are used to illustrate strategies and methodologies, and to examine the lessons that emerged from each of the consultations.

The kit has been published in a ring binder to allow users to add or remove material easily, and has been produced using original publications that can be used as masters for photocopying. It provides an extensive reference list of published resources, as well as useful contact information for area health services and colleagues with experience and expertise in the process of consultation and participation.

A collection of materials on consultation and participation has been established in the Department of Health Library, including this resource kit and a useful training video from South Australia. The library is on the fourth floor of 173 Miller Street, North Sydney, and the librarian can be contacted by phone on (02) 9319 9078, or by email at **gwood@doh.health.nsw.gov.au**.

To obtain copies of the *Community Consultation and Participation Resource Kit for Area Health Services Managers and Project Leaders*, please contact Meryl Edwards, Manager Health Improvement Strategy, by telephone on (02) 9391 9319, or by email at **medwa@doh.health.nsw.gov.au**.

TABLE 1

CONSULTATION BRINGS SOME WIDELY RECOGNISED BENEFITS TO POLICY-MAKING

Identifies stakeholders	A consultation process draws out those with an interest in a policy area and helps define their expectations.
Defines the agenda	A consultation process sets boundaries for a policy question by encouraging debate around a structured set of opinions.
Improves information	An exchange of views among interested parties through consultation ensures that a wide range of information is included in policy discussions.
Exchange of views	Because much consultation involves a two-way exchange, it makes participants aware of the views of others. Dialogue assists in reaching choices that are acceptable to a wide range of interests.
Quality of decision	Because consultation brings a diverse range of views into the policy process, decision-makers are more likely to understand the consequences of their choice and to avoid mistakes that are based on ignorance.
Improves legitimacy	People are more inclined to accept a decision made with consultation than one imposed without discussion.
Compliance through ownership	People prefer to implement a policy they helped to frame.
Avoids challenges	By ensuring a transparent process with appropriate opportunities for public input, policy-makers avoid later political or administrative law challenges. A decision reached through a robust consultative process is more difficult to overturn.

Source: Byrne J, Davis G. Participation and the NSW policy process: A discussion paper for The Cabinet Office NSW. Sydney: NSW Parliament, 1998, p.41.

INFECTIOUS DISEASES, NSW: JUNE 1999

TRENDS

Reports of infectious diseases were largely unremarkable for this time of year (Figure 3 and Table 2).

NOTIFICATION OF TYPHOID

On 8 June, the Victorian Department of Health reported a case of typhoid in a man who had been ill since 30 May. Later that evening the Western Sydney Public Health Unit (WSPHU) reported that a man from Western Sydney had been diagnosed with typhoid, and the Victorian Department of Health Department reported another case in a woman.

Typhoid is caused by infection with the bacteria *Salmonella typhi* which, after an incubation period of generally one to three weeks, results in an illness characterised by headache, fever, malaise, abdominal pain, nausea, diarrhoea or constipation, vomiting and cough. The bacteria are spread via the faecal–oral route, mainly by consuming contaminated food or water, or through contact with infected persons.

All three cases reported cruising on a ship operated by Company P that had left Cairns on 12 May, visited Port Moresby, then some Pacific Islands, and finished in Sydney on 25 May. There were some 950 passengers from across Australia and New Zealand, and about 450 crew on board.

While in Port Moresby, 159 passengers and crew took an 8-hour land tour to the Kokoda Trail, stopping at an inn for a lunch that included chicken, beef, pork, coleslaw, fruit, cake, iced water, and coffee. Over the few days following the tour, 105 passengers and 15 crew reported sick with diarrhoea to the ship's doctors. All 120 people who became ill had been on the Kokoda Trail tour, while none of the other passengers reported sick. The cause of this outbreak remains unclear.

Company P provided a list of all passengers, as well as a list of ill people seen by the ship's doctors. The NSW Department of Health (and other state and territory health departments) mailed a letter to all passengers outlining these events, advising them to see a doctor if they became sick and, if they had been on the Kokoda Trail tour, to call their local public health unit. Public health unit staff telephoned passengers who went on the Kokoda Trail tour to:

- advise them of the situation
- administer a questionnaire about their health and exposures while on the trip
- seek stool and urine samples from them for testing.

The public was alerted through media releases.

South Eastern Sydney Public Health Unit (SESPHU) is coordinating the NSW response to this outbreak. SESPHU staff inspected the ship, but no likely source of the outbreak was identified on board. It is probable that the initial outbreak of illness and the typhoid outbreak were caused by different organisms acquired from the same source in Papua New Guinea.

A national team including staff from the Commonwealth Department of Health and Aged Care, the State Departments of Health, and the Master of Applied Epidemiology Program of the National Centre for Epidemiology and Population Health (ANU) is coordinating an epidemiological investigation aimed at confirming the extent of the outbreak and its likely source. In NSW, public health unit staff have interviewed 65 Kokoda Trail tour participants and arranged for at least one stool sample to be tested from 62 of these.

To date, 12 cases of typhoid (including six from NSW) have been identified among persons who were on the cruise and visited the Kokoda Trail. Investigations continue.

NSW INFUENZA SURVEILLANCE UPDATE

Rob Menzies

Summary

Influenza activity continued at moderate levels for most of June; however, both laboratory reporting and clinical activity increased markedly in the last week of the month.

Clinical activity

Rates of influenza-like illness showed an increase in the last week of June, reaching a level similar to that for the same time in 1998 (Figure 4). Reports were received weekly from 31 general practitioners (GPs) through four Public Health Units, including more than 3,200 consultations.

Virological activity

There was an overall increase in laboratory reports for all respiratory viruses in the last week of June, with the exception of influenza B (Figure 5).The laboratory reporting rate for influenza A increased markedly in the last week of June to a level higher than for the same period last year. There were 50 cases of influenza A reported (36 virological, 14 serological), one case of influenza B (virological), and 129 of respiratory syncytial virus (RSV). In the same week last year, there were nine cases of influenza A, none of influenza B and 168 of RSV.

Directed virological surveillance

In the last week, 43 nasopharyngeal swabs were received from 15 GPs. Eight tested positive for influenza A. No

FIGURE 3

REPORTS OF SELECTED INFECTIOUS DISEASES, NSW, JANUARY 1994 TO MAY 1999, BY MONTH OF ONSET

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

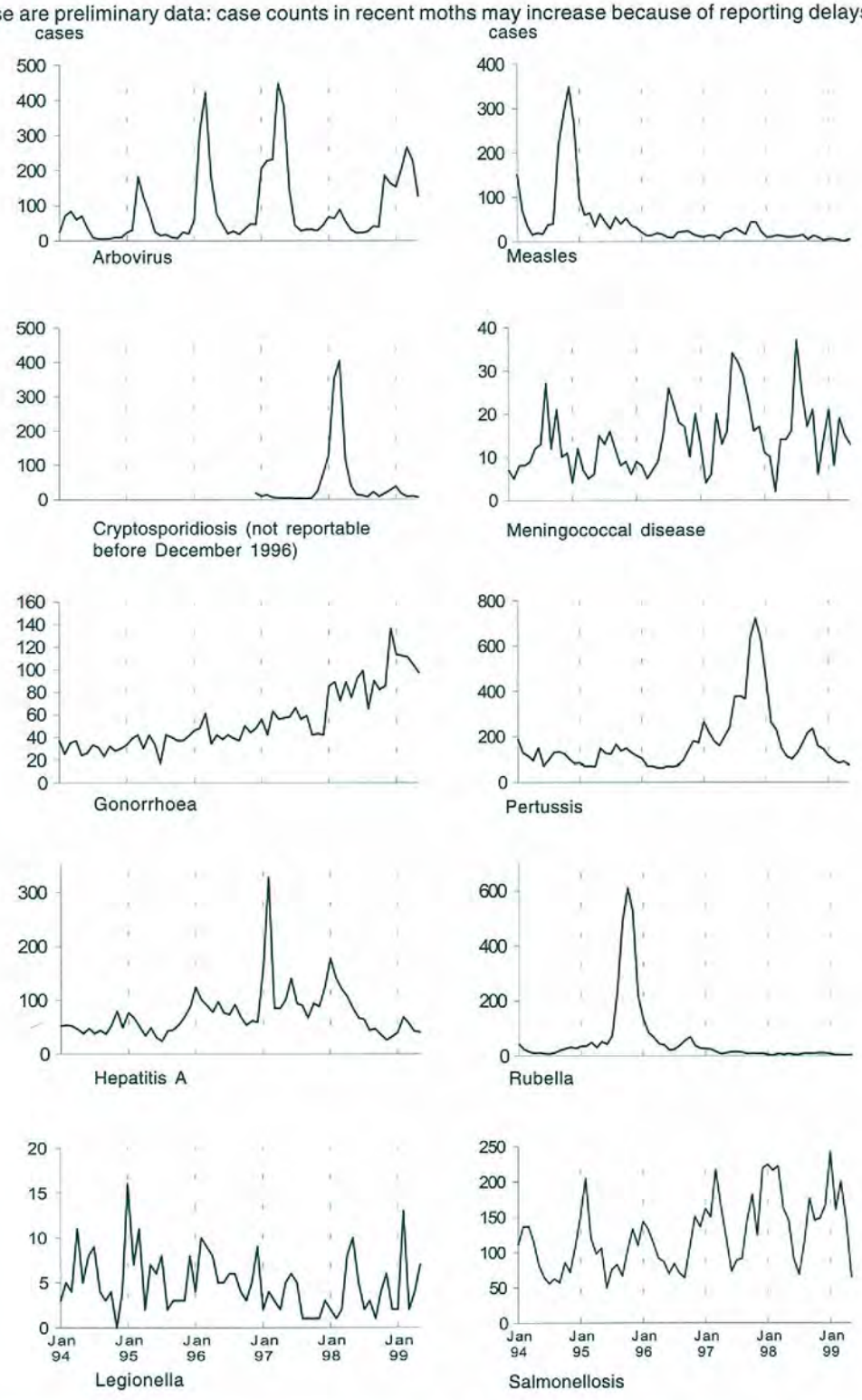


TABLE 2 REPORTS OF NOTIFIABLE CONDITIONS RECEIVED IN MAY 1999 BY AREA HEALTH SERVICES

Condition	Area Health Service (1999) CSA	NSA	WSA	WEN	SWS	CCA	HUN	ILL	SES	NRA	MNC	NEA	MAC	MWA	FWA	GMA	SA	Total for May†	Total To date†
Blood-borne and sexually transmitted																			
AIDS	4	–	1	–	–	–	–	–	2	–	–	–	–	–	–	–	–	9	83
HIV infection*	3	1	–	–	–	–	–	–	3	–	–	–	–	–	–	–	–	23	148
Hepatitis B: acute viral*	–	–	–	–	–	–	–	–	–	1	–	–	1	–	–	1	–	3	24
Hepatitis B: other*	55	26	74	8	4	6	10	6	42	5	5	3	–	4	9	4	1	262	1424
Hepatitis C: acute viral*	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	–	1	30
Hepatitis C: other*	117	37	1	46	–	45	69	28	92	41	37	15	8	36	4	20	40	636	3469
Hepatitis D: unspecified*	–	–	1	–	–	–	–	–	1	–	–	–	–	–	–	–	–	2	4
Hepatitis, acute viral (not otherwise specified)	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Chancroid*	–	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	1	1
Chlamydia (genital)*	22	12	8	7	–	6	26	5	29	15	11	8	5	8	10	14	4	197	963
Gonorrhoea*	27	7	2	4	1	1	–	–	36	5	1	3	1	–	3	–	1	94	563
Syphilis	7	2	5	–	1	–	–	–	14	2	2	3	–	1	3	–	–	40	266
Vector-borne																			
Arboviral infection*	4	3	4	5	4	8	14	12	4	62	29	7	4	2	2	69	13	246	1,080
Malaria*	–	4	–	1	–	–	1	–	–	1	–	1	–	–	–	–	–	8	86
Zoonoses																			
Brucellosis*	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1	3
Leptospirosis*	1	–	–	–	–	–	1	–	–	–	2	–	–	–	–	–	–	4	20
Q fever*	–	–	–	–	1	–	2	1	–	3	6	3	–	–	–	1	–	17	64
Respiratory and other																			
Blood lead level*	6	1	–	2	1	1	4	4	–	1	–	1	–	–	13	1	–	35	282
Legionnaires' disease*	–	–	–	–	1	1	–	1	–	–	–	–	–	–	–	–	–	3	25
Leprosy	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Meningococcal infection (invasive)	3	–	2	1	5	–	–	3	1	–	1	1	–	–	–	–	1	18	77
Mycobacterial tuberculosis	7	4	6	–	–	1	2	1	8	1	2	–	–	1	–	2	–	35	169
Mycobacteria other than TB	5	7	–	2	–	–	1	–	6	–	3	2	–	–	–	1	–	27	170
Vaccine-preventable																			
Adverse event after immunisation	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	24
H. influenzae B infection (invasive)*	–	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	1	4
Measles	1	–	–	–	–	–	–	–	1	–	–	–	1	–	–	–	–	3	18
Mumps*	–	1	–	–	–	–	–	–	1	–	–	–	–	–	–	–	–	2	9
Pertussis	8	16	6	3	8	2	25	12	15	1	4	–	3	–	–	3	3	109	538
Rubella*	–	–	–	–	–	1	–	–	1	–	2	–	–	–	–	–	–	4	19
Tetanus	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Faecal-oral																			
Botulism	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Cholera*	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2
Cryptosporidiosis*	3	–	–	–	–	–	1	–	1	2	1	–	–	–	–	1	–	9	93
Giardiasis*	4	17	–	4	2	6	16	5	20	9	2	5	4	3	2	1	–	100	542
Food-borne illness (not otherwise specified)	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	8
Gastroenteritis (in an institution)	–	–	–	–	–	–	19	–	–	–	–	–	–	–	2	–	–	21	85
Haemolytic uraemic syndrome	–	–	–	–	–	–	1	–	–	–	–	–	–	–	–	–	–	1	7
Hepatitis A*	3	3	5	–	6	4	–	1	14	–	–	1	–	1	–	1	5	44	246
Hepatitis E*	–	–	–	–	–	–	1	–	–	–	–	–	–	–	–	–	–	1	2
Listeriosis*	–	–	–	–	–	1	–	–	2	–	–	–	–	–	–	–	–	3	10
Salmonellosis (not otherwise specified)*	4	12	3	4	–	2	5	6	9	13	3	5	3	4	–	5	4	83	885
Typhoid and paratyphoid*	–	–	1	–	1	–	–	–	–	–	–	–	–	–	–	–	–	2	10
Verotoxin-producing *E. coli**	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

* lab-confirmed cases only

† includes cases with unknown postcode

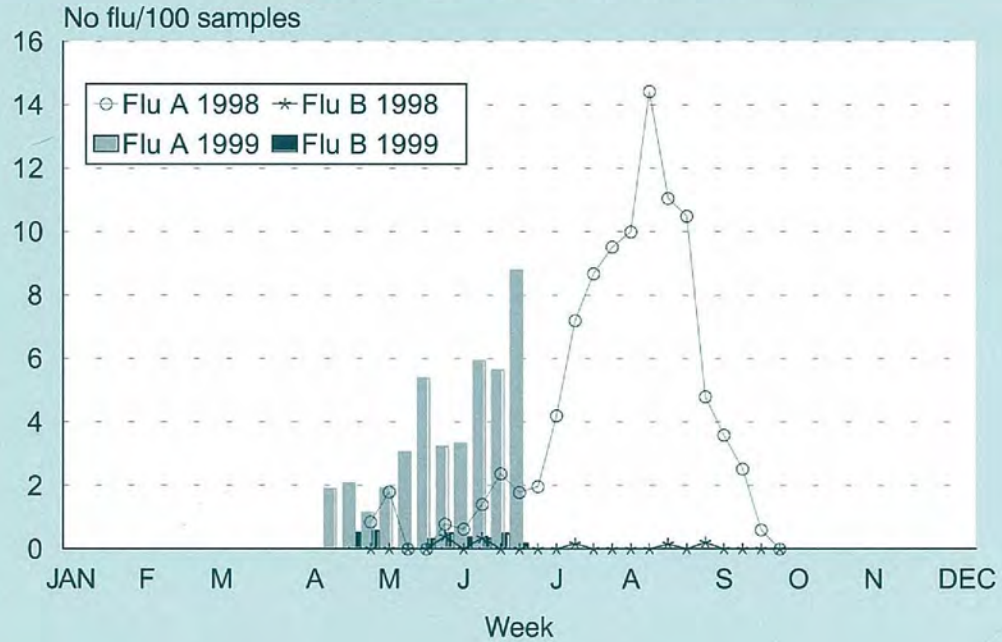
CSA = Central Sydney Area
NSA = Northern Sydney Area
WSA = Western Sydney Area
WEN = Wentworth Area
SWS = South Western Sydney Area
CCA = Central Coast Area
HUN = Hunter Area
ILL = Illawarra Area
SES = South Eastern Sydney Area
NRA = Northern Rivers Area
MNC = North Coast Area
NEA = New England Area
MAC = Macquarie Area
MWA = Mid Western Area
FWA = Far West Area
GMA = Greater Murray Area
SA = Southern Area

FIGURE 4

NSW GP SENTINEL SURVEILLANCE, INFLUENZA-LIKE ILLNESS (ILI), BY WEEK OF CONSULTATION, WITH HISTORICAL COMPARISONS

FIGURE 5

INFLUENZA VIRUS ISOLATION RATES, NSW, 1998–99



other respiratory viruses were reported. This represents an increase in the rate of isolation of viruses to 20 per cent from approximately 10 per cent over the past five weeks. Influenza A continues to be the predominant strain of influenza circulating in the community. Approximately 30 GPs from Central Sydney, South Eastern Sydney, Western Sydney, Wentworth, Central Coast, Hunter, Illawarra, Greater Murray and Southern Areas are participating in the surveillance scheme this year.

International surveillance

Brazil, South Africa, Argentina, New Zealand and New Calendonia reported influenza activity to the World Health Organization during June. Brazil reported a widespread outbreak of influenza A during early June which continues, while New Caledonia (Noumea) also reported influenza A. South Africa continues to report both influenza A(H3N2) and B. Argentina reported a local outbreak of influenza. New Zealand also reported sporadic cases of influenza B and A(H3N2).

Next issue

The July issue of the NSW Public Health Bulletin will be the first in a series of two issues on injury surveillance and prevention. Articles include:

- Firearm injury and death in NSW
- Injury in rural and remote communities
- Childhood injury surveillance: The value of emergency department data
- Head injuries in infants: A closer look at baby-walkers, stairs and nursery furniture
- NSW Injury Prevention Network contact and mailing list
- Families First: A support network for families raising children.

LETTER TO THE EDITOR

DEAR EDITOR

I refer to the article by Margaret Ashwell in Vol. 8, No. 10, page 84, entitled 'Normal immunoglobulin (human): Indications and safety'.

The author correctly points out that intramuscular gammaglobulin may be used as prophylaxis for susceptible contacts if given early in certain infections. It should be pointed out that this strategy may also be used for pre-exposure prophylaxis (though active immunisation is to be preferred). The author recommends the use of intramuscular immunoglobulin for the prophylaxis of varicella zoster. However, as is pointed out in the next paragraph, a zoster immune globulin preparation is available and this is the agent the use of which should be advised for the purpose of preventing varicella zoster infection.

The author correctly points out that there has been no HIV transmission since the introduction of donor screening in 1985. It should be pointed out that there were no HIV transmissions associated with immunoglobulin products in this country prior to that date despite the fact there certainly would have been donors during that period who carried HIV.

The author correctly points out that there have been no known reports of transmission of hepatitis C associated with the use of the normal immunoglobulin product for IV use manufactured by CSL in Australia. However, I am aware of a case still undergoing investigation in which the only possible source of hepatitis C was intramuscular immunoglobulin or the early IV preparation supplied by this company.

Yours sincerely,

Associate Professor John B. Ziegler, FRACP
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Sydney Children's Hospital, Randwick
J.Ziegler@unsw.edu.au

15 April, 1998

Since this letter was written, in July 1999 Victorian authorities reported a case of HIV transmission in contaminated blood. The NSW Department of Health investigates any claims of association between infectious diseases and immunoglobulin or other blood products. Suspected cases should be reported to the local public health unit.

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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.

Editorial correspondence

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