



GLOBAL INDICATORS FOR MONITORING THE ILLICIT DRUG ENVIRONMENT IN NSW

VOLUME II - CATALOGUE OF DATA SETS AND
DATA SOURCES

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INTRODUCTION

As a result of considerable community concern surrounding the use, availability and harms of illicit drug use in New South Wales (NSW), in May 1999 the NSW Government convened a Drug Summit to discuss these issues, and produced a series of recommendations for action to ameliorate them. In response to these recommendations, the NSW Government developed a Plan of Action (POA), which comprised eleven sections replicating the working groups who took part in the Summit. The Plan outlined the response of the NSW Government to the Summit's recommendations and the ways in which it would address them.

Over the ensuing three years, the NSW Government provided \$176 million in additional funding to carry out these initiatives. This brought the Government's expenditure on drug related programs to close to \$500 million over four years. The NSW Office of Drug Policy (ODP) was established within the NSW Cabinet Office. Part of the ODP's role was to oversee the implementation of the POA, and of the effectiveness of the initiatives put in place.

A key component of this initiative was the requirement of Drug Summit-funded agencies to define **project level performance indicators**. All agencies which received funding were required to define performance indicators and to evaluate Drug Summit funded projects against these indicators.

As part of the Drug Summit evaluation, the National Drug and Alcohol Research Centre (NDARC) was funded to identify and catalogue all known indicators that could be utilised for monitoring the illicit drug environment in NSW¹. These indicators were mapped against the eleven sections of the Drug Summit POA in order to advise the ODP of a valid, comprehensive, and effective method of evaluating whether NSW Drug Summit initiatives have contributed to a global improvement in the illicit drug problem in NSW.

The current report is the result of over ten months of extensive liaison and collaboration with agencies and organisations across NSW, and comprises two volumes. The first follows the structure of the Drug Summit Plan of Action, and has mapped all potential indicators that were identified against each of the content areas of the POA. The second is a catalogue of the major indicator data sources that were identified. The outline of these two sections is briefly summarised below. Before doing these, we will discuss the concept of an "indicator", the types of indicators available and some of the key issues that need to be considered in any monitoring of illicit drug use or related harms.

INDICATORS OF THE ILLICIT DRUG ENVIRONMENT

By the term "indicator" we mean "that which serves to indicate or give a suggestion *of* something". In other words, an indicator is an indirect measure of a variable of interest. With respect to illicit drugs, variables of interest are often difficult to quantify, and even if they can be easily quantified, they may be difficult to measure in a reliable and exact fashion. Indicator data are therefore approximate and often imperfect measures of a particular event or outcome.

The World Health Organisation (WHO) further classifies indicators according to their function - structural, process or outcome.

¹ In addition to this individual project level evaluation, the ODP planned a second regional evaluation which comprised a longitudinal analysis of illicit drug indicator data (time pre and post Drug Summit) in two regions.

Structural indicators provide qualitative information (i.e. yes or no) on the basic structures that are considered necessary for implementing a policy. That is, they merely check whether the basic structures exist but do not evaluate the functioning of these structures.

Process (output) indicators provide quantitative information by assessing the performance of structural indicators. They allow for the assessment of the effectiveness and efficiency of mechanisms and activity that have been put into place. Phase 1 and 2 of the evaluation component of the 1999 NSW Drug Summit would have been primarily concerned with this level of investigation. However it is important to note that monitoring process indicators (such as the number of frontline workers trained) by their nature will not be able to inform whether there has been any change in **outcomes** (such as number of illicit drug users accessing treatment/receiving better treatment etc).

Thus, **outcome indicators** provide quantitative information on the achievement of the major objectives of a policy (such as reducing the demand for and supply of illicit drugs, as well as minimising the harms to the user and the community). They measure the results achieved (e.g. number of illicit drug-related overdoses, hospital admissions, treatment episodes and seizures) and the changes that can be linked to the implementation of a policy. Ideally, they allow for the comparison between the situation at the time the indicator is used and the situation a few years before and therefore comment on the progress achieved.

From the above discussion, it is clear that the major focus of this report is to identify outcome indicators in NSW, and nationally, that can globally reflect the illicit drug situation over the course of time pre and post drug summit. However, since outcome indicators are not available for some of the eleven sections (such as prevention, training and education), it is important to note that output indicators are alternatively mentioned and assessed for recommendation. In addition, due to the nature of the Drug Summit, some indicators will only be able to reflect data from post-Drug Summit, since the Drug Summit assisted in identifying gaps in data collected.

The quality (and usefulness) of any indicator can be affected by a broad range of factors. These include:

- The accuracy with which the indicator reflects the variable of interest;
- The accuracy with which the indicator is collected;
- The reliability with which the indicator is collected;
- The time period over which the indicator has been collected (in this case, whether the indicators cover both the pre and post Drug Summit time period);
- Whether the indicator can differentiate between licit and illicit drugs;
- The extent to which the indicator can differentiate between illicit drugs (such as the more “traditional” or well-known drug classes [heroin, cocaine, methamphetamine, cannabis], more recently identified “party drugs” [ecstasy, MDA, ketamine, GHB] and other emerging drugs [e.g. 1,4-BDO, PMA]);
- The ability of the indicator to monitor state-wide and national trends.

In the first part of this report indicators are recommended based on the abovementioned key issues. This is judged on the information made available to NDARC through liaison with the relevant agencies. More comprehensive information pertaining to the datasets, from which the indicator is extracted, is available by referring to the catalogue of datasets found in volume 2 of this report. Examples of additional information that is collected by the majority of datasets, and which is relevant for monitoring includes: type of illicit drug; the age and sex of those who use illicit drugs; method of use; employment status; ATSI status; ethnicity; accommodation type; source of income; and educational attainment. These data items allow for the potential generation of a large number of different indicators as well as more complex manipulations of data than have been outlined in this volume.

Further data issues to consider that are relevant include:

- The representativeness of the data, be it of the general population, the broader community of illicit drug users, or injecting drug users;
- The ability of data to provide information about non-injecting drug users;
- The ability of the data to provide information about minority groups;
- The ability of the data to provide information about regional variations;
- The ability to detect change; and
- Whether causal attribution can be ascertained.

Representativeness of the data

To consider the first point, indicator data are generally obtained from routine data collection systems (such as survey and administrative datasets) that have been designed to a greater or (often) lesser degree as collection systems for the monitoring of the phenomena they are involved with. For example, the primary aim of administrative datasets is to support and facilitate the provision of a service. Although data may be routinely collected, it is often from a non-random population and is only one by-product of the service (Trewin, 2001). This means that the data items may: be limited; change over time; not be tailored to research use; be recorded manually and/or electronically; lack stringent quality checks for missing or incorrectly entered data; and not be completely comparable with definitions used by other agencies.

Second, while survey datasets have the advantage of being targeted to the population of interest, they may or may not use random selection, have a sufficient population size, sufficient geographic coverage, include participants from all potential resident types, have a high response rate or a closed questionnaire design. These factors all impact on the ability to draw accurate conclusions about some issues. For example, although a survey or program may target injecting drug users, it cannot be automatically assumed that this information is representative of all people who inject drugs. The ability of the data to generalise to the broader population of injecting and non-injecting drug users and the general community therefore depends not only on data quality issues but the purpose of the dataset from which the indicator data is drawn.

Information provided regarding non-injecting drug use

Due to the significant harms associated with injecting drug use (IDU), there is an emphasis of policy and programs (hence datasets) to record the outcomes associated with IDU. As a result there is less information available on the more widespread non-injecting use of illicit drugs (Trewin, 2001). However, endeavours have been made to assist in filling this information gap, an example being the Party Drugs Initiative (PDI) of the Illicit Drug Reporting System (IDRS).

Information provided about minority groups

Many datasets collect some manner of information on minority groups (defined by a variety of criteria including ethnicity, country of birth, language spoken at home or ATSI status). Although the ability of datasets to reliably comment on these groups is not a focus of this report, is important to note that the small number of respondents usually contained within each category may limit the use of the information (Trewin, 2001). In addition, although minority groups such as the homeless and mentally ill are amongst the more disadvantaged groups in society, generally datasets do not have the potential to record these items despite the acknowledged associations between these factors and illicit drug use.

Information provided about geographic location

The majority of datasets also collect geographic information, usually postcode data, and while some agencies release post-code data many agencies prefer to release and publish data at the statistical local area (SLA) level. Although the ability of datasets to provide reliable sub-state information is also not a focus of this report, it is important to note that some survey datasets do not record sub-state data (such as the IDRS) or if they do (such as the National Drug Strategy Household Survey - NDSHS) the numbers are generally considered too small to provide reliable sub-state data on illicit drug use and related harms (Trewin, 2001).

The ability to detect a “real” change

The ability to detect change is influenced by the size of the sample. Given that some indicators reflecting illicit drug use and related harms involves small numbers (e.g. the number of overdoses in a month), this leads to potential problems in ascertaining statistically significant differences over time. In addition, if there are perceivable changes in an indicator over time, it is important to note that they may be due to changes in the way the data has been recorded and/or measured (i.e. artificial artefacts of the data recoding process) (Spooner, Hall & Lynskey, 1999).

Attributing causal inferences

Finally, if change can be reliably detected, the next question is whether causal attribution can be ascertained. That is, did the policy initiative contribute to the observed changes alone or did other factors alone or in combination (such as national strategies, international strategies or local phenomena e.g. heroin shortage) or was it due to the cyclical nature of drug use? Unless randomised controlled trials are conducted it is impossible to establish causality (Spooner, Hall & Lynskey, 1999). Thus, caution should be exercised when commenting on why there are observed changes in the data.

CONCLUSIONS

All of the data issues mentioned above serve to illustrate that the monitoring of data over time, and in the “real world” (i.e. outside of studies and experiments), is a complicated task. There is a myriad of factors influencing the quality of available data. However, if all the caveats are considered, and multiple indicators point to the same finding, researchers and policy makers are able to more confidently draw conclusions about the data. This is the premise of the IDRS and the model recommended for interpreting findings from illicit drug-related data.

This publication has attempted to highlight key *global* indicators worth monitoring, from both state and national datasets. For the purposes of identifying global indicators that are easily understood, in this report all indicators are referred to in terms of numbers or proportions. Many indicators described in this report have not been recommended for the purposes of *globally monitoring* the illicit drug problem in NSW. These indicators may, however, have utility for evaluating programs or for agencies reporting requirements. If an indicator is not recommended in this document, this should not be taken to mean that either the indicator or the program it is taken from cannot be used for other monitoring purposes.

A final consideration that should be highlighted is that although efforts were made to present the most accurate information about each dataset, all the strengths and limitations of a dataset may not become apparent until the dataset is actually used. When data from the recommended indicators are analysed, it is suggested that this potential caveat is kept in mind, since these indicators may not be as easily manipulated as originally thought.

VOLUME 1: INDICATORS FOR MONITORING THE EFFECTIVENESS OF THE PLAN OF ACTION

The structure of Volume 1 is as follows:

1. Preventing Drug Abuse
2. Young People and Drug Abuse
3. Health Maintenance and Treatment Services
4. Case Management, Co-ordinated Care, Service Standards
5. Training Requirements: Building Skills
6. Breaking the Drugs and Crime Cycle
7. Drugs in Correctional Centres
8. Drugs and Community Action
9. Drugs and Law Enforcement
10. Drug Education in Schools and the Community
11. Drugs in Rural and Regional NSW

For further details on the Government's Plan of Action, please go to the Cabinet Office of Drug Policy website (<http://www.druginfo.nsw.gov.au>). To download the report, go to the following address: <http://www.druginfo.nsw.gov.au/pdf/plan.pdf>.

Volume 1 aims to map the indicators identified against the above eleven sections to aid in the evaluation of the Government's performance in responding to issues in these areas.

VOLUME 2: CATALOGUE OF IDENTIFIED INDICATOR DATA SOURCES

The second volume of the report comprises a catalogue of all of the available NSW and national datasets that were identified during the course of the project, which contain illicit drug-related information.

The dataset descriptions are based on publicly available information (hardcopy and electronic) that NDARC reviewed and agency feedback. It is important to note that the degree of detail in the data descriptions differed amongst agencies.

The catalogue describes the following:

- Title of dataset
- Data custodian
- Purpose of data collection
- Population/Sample included
- Data items
- Data format
- Geographic level
- Years referenced
- Sample size
- Data collection
- Reporting
- Access
- Data uses

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Adult Drug Court Program (ADCP)

Data Custodian	Drug Court of NSW and NSW Attorney General's Department.
Purpose	Drug Courts are specialist courts that deal with offenders who are dependent on drugs. They aim to assist drug-dependent offenders to overcome both their drug dependence and their criminal offending by diverting offenders into supervised treatment programs. Drug court statistics are a valuable court management and program evaluation tool.
Sample	Adult offenders residing in the LGA's of the following courts: Campbelltown, Penrith, Liverpool, Bankstown, Blacktown, Burwood, Fairfield, Parramatta, Richmond, Ryde, Windsor.

Data items held	<p><i>Client Information:</i> ID no.; name; age; sex; suburb; postcode; ATSI status; bail/custody status; arrest date & time (1 matter only); COB; interpreter required; no. school years completed; educational level; no dependants; drug using partner; treatment history (episodes only).</p> <p><i>Criminal/Court Information:</i> prior imprisonment; no. prior conviction episodes; date last conviction; legal representation; code & location of referring court; date & time of return to other court; offences; penalty at commencement and completion (date imposed, penalty type, duration, start/end date, concurrent with another penalty, time already served & taken into account).</p> <p><i>Program Information:</i> assessment date & outcome; detox start/end date & outcome; start date of each phase & completion date; treatment provider, name and type; conditions; court appearances (date, attendance, program status, action, breaches yes/no); urine drug screens test date & results (opiates, amphetamines, benzodiazepines, cocaine, cannabis, methadone).</p>
Data format	Unit of measurement = client; unit of time = date; offences coded using ASOC.
Geographic level	LGA.
Years referenced	Since February 1999 (calendar year). (New ADCP database will be implemented late 2002 or early 2003).
Sample size	In 2001, N of referrals = 204 & N of accepted cases = 146. Since the beginning of the program total referrals = 1271 & number of accepted cases = 726.

Data collection	Continuous. Information obtained from hard copy court papers, area health services, Probation and parole, Corrections Health and treatment providers. Urine drug screens are collected at the Drug Court Registry (instant reports). Data is entered by clerical staff as it becomes available. During the Drug Court evaluation period, BOCSAR received quarterly downloads of data and undertook cleaning of the data (check for inconsistencies and missing information against paper files).
Reporting	All reporting is compiled manually. Monthly statistics are manually reported (e.g. number of clients on program) to the AGD. BOCSAR published quarterly reports during the evaluation period only (last report Dec 2000).
Access	External requests for data should be made to the Director General of the AGD. Internal requests for data should be directed to the Registrar, Drug Court of NSW.

Data uses	Number of adult offenders referred to the drug court. Number of offenders accepted into the drug court program. Number of offenders who successfully complete the drug court program.
Strengths	Direct measure of the number of adult offenders diverted to treatment. Reliable information regarding the number and outcome of persons referred to and participating in the ADCP can be obtained from the manual collation of this data.
Limitations	Due to the problems extracting data from the original Drug Court database (identified by BOCSAR during the Drug Court Evaluation), a new database will be implemented late 2002. However, only current matters will be transferred from the existing database to the new database, making it difficult to monitor trends over time. The drug court sample is not representative of the total drug using or offending populations. That is, program entry is restricted to persons: dependent on drugs; reside within the catchment areas (of Western and South Western Sydney); be willing to participate; and be willing to plead guilty to the offence. Current issues with urine samples include: inability to ascertain how much use is associated with each positive urine drug screen (eg amount or frequency); half life of a drug affects the rate of clearance from urine; & frequency of urine drug screens (& therefore detection of drug use) dependent upon program phase. Prior to January 2001, data may not be as reliable as current data.
Future developments	New user friendly database will be implemented late 2002. Data from January 2001, will be transferred to the new database.
Reference (s):	Personal communication with Bruce Flaherty (AGD) and John Castellan (NSW Drug Court).

Alcohol and Drug Information Service (ADIS)

Data Custodian	St Vincent's Hospital, Alcohol and Drug Service.
Purpose	To provide 24-hour telephone assistance and referral for NSW residents and professionals who have concerns regarding their own or someone else's alcohol and other drug use.
Population	Persons from across NSW who ring the ADIS line seeking information or assistance with their drug and alcohol issue.
Data items held	Time of call, length of call, date, communication assistance required, type of call, status of caller, ([sex, age, postcode, country of birth] of caller and person called about), pregnancy status, primary occupation, drugs involved, pattern of use, method of use, duration of use, safe injecting practices, ([recent intervention, referral to other agencies] of caller and person called about), source of referral. ADIS referral field options relating to treatment include referral to: drug and alcohol counsellor, rehabilitation, detoxification, pharmaceutical, methadone, needle and syringe programs, counselling, health and mental health.
Data format	Unit of measurement = case; unit of time = time of day; coding system = internal.
Geographic level	AHS of residence, postcode of residence.
Years referenced	Since 1995/1996 (financial year).
Sample size	No. of calls 2001/2002: 50,069 answered on all lines, 38,087 ADIS calls answered.
Data collection	Continuous. Collected through an ADIS database. Enquiries are answered by trained staff (counsellors); counsellors enter information from their own calls as they are completed. Personal &/or sensitive information is not always collected, such as age, postcode, pregnancy status, occupation, method of administration, and recent intervention.
Reporting	Statistics collated annually (financial year) but are not released; quarterly data is provided to Drug Programs Bureau relating to Drug Summit and Cannabis Cautioning Scheme; data feeds into the Illicit Drug Reporting System (IDRS).
Access	Requests for data can be made through the Manager of ADIS and are typically processed within 2 working days; there is no cost for data requests.
Strengths	Drug use information is presumed highly reliable.
Limitations	Personal/sensitive information unreliable because of missing data (eg age distribution negatively skewed). This is because age is not a mandatory field. The degree to which the data captures all relevant events is affected by the following: (i) use of the service is dependent upon knowledge/utilisation of the service (influenced by media campaigns); and (ii) the unit of measurement is a 'case' rather than 'person' or 'client' and therefore a single person could generate a number of 'cases'.

Future developments The database software is soon to be converted to windows software. No major data collection changes are anticipated; however codes may change to National Minimum Data Set standards.

Reference (s): Personal communication with Fran Lowe (ADIS).

Ambulance Service of NSW (ASNSW)

Data Custodian	Ambulance Service of NSW and NSW Health Drug Programs Bureau (DPB).
Purpose	To monitor the activity of ambulance officers that are called out to emergency situations. In particular, data is collected related to ambulance attendances at drug overdose events.
Population	Clients who receive assistance from the Ambulance Service relating to a drug overdose event.
Data items held	<p><i>Patient Details:</i> AHS of residence, age, suburb of residence, identifier, sex, SLA of residence.</p> <p><i>Episode Details:</i> AHS of attendance, aggressive patient – hospital, aggressive patient –scene, date of attendance, drug, suburb of attendance, hospital destination, postcode of attendance, SLA of attendance, time of call, time of clearance from job, time of arrival at destination, time of departure from location, time of arrival at location, time of departure from depot, time of return to station.</p> <p><i>Clinical details:</i> airway – endotracheal, airway – manual, airway – nasal, airway – oral, airway – suction, airway assessment – hospital, airway assessment – scene, buccal mucosa colour – hospital, buccal mucosa colour – scene, breathing assessment – hospital, breathing assessment – scene, circulation – hospital, circulation – scene, diastolic BP – 1st - 6th, drug, intervention – 1st – 10th, oxygen – 100% demand valve, oxygen – high concentration mask, oxygen – nebuliser, oxygen – non-rebreather mask, Glasgow Coma Score – 1st – 6th, Observation time – 1st – 6th, protocol, Pulse – 1st – 6th, Respiratory rate – 1st – 6th, Systolic blood pressure – 1st – 6th.</p>
Data format	Unit of measurement = ambulance attendance; unit of time = time of day; coding system used = internal.
Geographic level	AHS (attendance and residence), postcode (attendance and residence).
Years referenced	Since 1995.
Sample size	Number of attendances for non-fatal drug overdoses in 2001/2002: 1570.
Data collection	Continuous. Collected through the Ambulance Officer case reports and entered into the callout database maintained by Ambulance Service of NSW. Client information is not always collected, such as age and sex.
Reporting	Ambulance attendance at overdose data is reported to NSW Health DPB on a monthly basis. The raw data is stored in a private library on the HOIST data warehouse accessible only to selected staff from DPB and Epidemiology and Research Branch. Statistics are collated for the Opiate Overdose Bulletin which is reported 6-monthly. Historical data (pre-February 2001) has been reported to Turning Point Alcohol and Drug Service for its collation of national statistics for ambulance attendance at overdose events. Also used for ad-hoc requests from Minister's Office, Office of Drug Policy and NSW Police Service.
Access	Applications for data from external agencies should be directed to NSW Health Department Chief Health Officer. Internal enquiries should be directed to NSW Health, DPB. There is no cost associated with requests for data.

Data uses	Number of ambulance attendances at illicit drug-related non-fatal overdoses
Strengths	Information is collected state-wide by ambulance officers and is believed to reliably capture non-fatal drug overdose.
Limitations	Attendance at overdose figures include the number of patients attended for 'overdose' who were administered Naloxone. They are based on ambulance officers' assessment of the patient at time of treatment and may include patients who have not overdosed on heroin. Not all ambulance officers are authorised to administer Naloxone, and so not all heroin overdose cases may have Naloxone administered
Future developments	The NSW Ambulance Service is currently reviewing its case sheets with regard to collecting overdose data to ensure it aligns with national standards and to collect better quality information.
Reference(s):	Personal Communication with Devon Indig (NSW Health DPB).

Australian Illicit Drug Report (AIDR)

Data Custodian	Australian Bureau of Criminal Intelligence (ABCI).
Purpose	To provide a strategic review and a statistical analysis of the illicit drug situation in Australia for the financial year from a law enforcement perspective. To inform decision making in developing supply reduction strategy.
Population	State/Territory and Commonwealth law-enforcement agencies.
Data items held	<p>Arrests by consumer/provider, sex, type of drug, seizures by number and quantity, purity and prices by state and territory, customs detections, trends in trafficking methods, and developments in countries where illicit drugs are cultivated and produced.</p> <p>For arrest data illicit drugs are categorised into one of the following groups: cannabis, heroin and other opioids, amphetamine-type stimulants, cocaine, hallucinogens, other and unknown drugs. Note that ABCI classifies amphetamine-type stimulants as: amphetamine; methylamphetamine; crystalline methylamphetamine; and phenethylamines (such as MDMA - ecstasy, MDEA, MDA, DMA and PMA).</p> <p>Breakdowns available for seizure purity include: state, year, quarter in year, drug type (heroin, amphetamine, methylamphetamine, phenethylamines and cocaine), police type (state or AFP), quantity (< or > 2 grams), number of seizures and percent of purity (median, minimum & maximum).</p>
Data format	unit of time: annual (financial year).
Geographic level	State/Territory.
Years referenced	Since 1991/92 (financial year).
Sample size	Varies.
Data collection	Annual (financial year). Retrospective collection (over approximately 6 month period following end of the financial year). Qualitative report (based on ABCI guidelines) obtained from all State and Territory Police Services, the Australian Federal Police, the Australian Customs Service, The National Crime Authority & the Queensland Crime & Misconduct Commission. (Note: historically, data collection has been questionnaire-based.) Statistical data on drug arrests, seizures, purity and prices obtained from various State, Territory and Commonwealth law enforcement agencies. Interviews of key informants (including drug and alcohol research institutions).
Reporting	Annual report published approximately 9 months following the end of the financial year.
Access	Copies of the report can be obtained by contacting the Coordinator Intelligence Reporting, ABCI.
Data Uses	There are state/territory breakdowns for arrest, seizure number, seizure purity and price data for major drug classes.
Strengths	Provides the best collection of arrest and seizure statistics available in Australia. Collates data from a wide variety of sources - state/territory and national law

enforcement agencies and government laboratories – to provide a national picture of trends in supply and demand for illicit drugs. Trends in the supply of and demand for illicit drugs can be determined by examining data on patterns of use, prices and purity.

Limitations

A number of factors limit the ABCI's ability to produce a comprehensive, reliable assessment based on the data supplied: lack of uniformity in both recording and storing data on illicit drug arrests and seizures across all states/territories; problems with quality control; differences in counting methodologies applied in the jurisdictions; differences in definitions of drug consumer and provider offences across jurisdictions; differences in the way drugs and offences may be coded by the jurisdictions.; and inadequate drug identification.

Limitations specific to seizures include: seizure data undercounts the number of seizures and amount of drug seized for all drug types since it only includes seizures where a drug weight was recorded; there is no way to adjust for double counting of seizures that result from joint operations between the Australian Federal Police and state/territory police services; comparison of data from 2000/01 onwards with previous years is problematic since prior to this seizure data was a combined total of state police and AFP data.

Limitations specific to seizure purity: purity figures relate to an unrepresentative sample of illicit drugs seized in Australia. That, is not all illicit drugs seized by Australia's law enforcement agencies are subjected to forensic analysis. Seized drugs are usually only analysed in a contested court matter (i.e. large indictable quantity) or when the nature of the drug is in dispute.

Future developments

For 2002, the ABCI is utilising a new processing system that will increase the quality of the law enforcement seizure, offender and purity data. The ABCI is also aiming to assess the viability of quarterly reports within the next year, depending on jurisdictional capabilities.

Reference (s):

Australian Bureau of Criminal Intelligence (2002). *Australian Illicit Drug Report 2000-01*. ABCI, Canberra.
Personal correspondence with Siobhan Hennessey (ABCI)

Australian Needle and Syringe Program (NSP) Survey

Data Custodian	National Centre in HIV Epidemiology and Clinical Research (NCHECR).
Purpose	To systematically monitor HIV and HCV infection and related risk behaviours among people who inject drugs. To assess the impact of prevention activities on HIV and HCV infection, a monitoring system was established at selected Needle and Syringe Programs (NSPs) throughout Australia.
Population	Census of clients at selected NSPs over a one-week period in every state/territory.
Data items held	<p><i>Demographic items:</i> gender, sexuality, age, language spoken at home by parents, country of birth, Aboriginal and Torres Strait Islander identification.</p> <p><i>Injecting practices:</i> age when first injected drugs, drug last injected, frequency of injecting in the past month and where this took place, needle sharing behaviour in the past month, recent imprisonment, sexual activity and behaviours in the past month, hepatitis B, hepatitis C and HIV status, treatment history, tattoo and body piercing activities, and needle and syringe purchasing behaviour.</p>
Data format	Unit of measurement: person, unit of time: annual, nil coding system used.
Geographic level	State/territory, AHS, NSP site reports.
Years referenced	Since 1995.
Sample size	N = 433 in 1995 and N = 691 in 2001 in NSW.
Data collection	Self-administered questionnaire and finger-prick blood are collected by needle and syringe program staff and sent to NCHECR. Survey and blood borne virus results are entered into database by trained staff at NCHECR.
Reporting	Reports on findings are released annually, internally and externally, approximately 6 months following the end of the calendar year. The latest report entitled "Australian NSP Survey National Data Report 1995-2001" summarised the results of the survey for the past 7 years.
Access	Requests for copies of the report can be made directly to NCHECR. The level of data released is aggregate data on a state/territory basis. There is no cost associated with this type of request.
Data Uses	National and state/territory comparisons of prevalence of HIV and HCV and related risk behaviours among IDU who attend NSPs.
Strengths	NSP clients represent a heterogeneous population of injecting drug users. Provides a consistent snapshot of the association between injecting drug use and blood borne viruses. Able to monitor trends over time due to length of time the study has been conducted for. Minimal missing data.
Limitations	It can not be assumed that the results of the Australian NSP survey are generalisable to all people who inject drugs in Australia.
Future developments	Expanding to increase geographic coverage although the aim is sentinel surveillance not complete coverage.
Reference (s):	Personal communication with Margaret MacDonald (NCHECR).

Australian Secondary Students Alcohol and Drug Survey (ASSADS)

Data Custodian	NSW Health, Health Promotion Branch and NSW Cancer Council.
Purpose	Quantify drug use patterns and prevalence of use amongst adolescents so as to inform policies and programs.
Population	Target population is secondary school students (government & independent) aged 12-17 years in NSW during the collection period. Stratified target sample based on AHS size, school system & sex; drawn at random from 143 schools. Target schools randomly selected by the ACCV; students randomly selected by State/Territory data collection agencies. Sample is representative of NSW except very remote areas.
Data items held	<p><i>Core Questionnaire:</i> demographics (age, sex, school year/level, spending money, language spoken at home, ATSI status), tobacco, alcohol, other drugs (such as cannabis, amphetamines, cocaine, heroin & other opiates, inhalants, ecstasy & hallucinogens), frequency of use (no. times used in last week, last 4 weeks, last 12 months & ever) & sun protection.</p> <p><i>NSW Supplementary Questionnaires:</i> 1. demographics, future smoking intentions, access to tobacco, access to alcohol, falsification of proof of age and violent and criminal behaviours. 2. demographics, eating patterns, physical activity, injury and mental health. Note, supplemental survey items are not necessarily the same with each administration.</p>
Data format	Unit of measurement = student; unit of time = triennial; nil coding system used.
Geographic level	State/Territory
Years referenced	Current format 1996 & 1999. Previously 1983, 1986, 1989 & 1992.
Sample size	Varies; 1996 sample consisted of 31,529 students.
Data collection	Triennial. Consists of a core questionnaire (national) and two supplementary questionnaires (NSW), each of which is answered by approximately half of the sample population in NSW. In NSW, a market research company undertakes the data collection (according to the guidelines set down by the ACCV) and a separate organisation is contracted to undertake the data analysis. Data is collected across 1-2 school terms.
Reporting	Survey results for Tobacco, Alcohol & Sun Protection are published 3 years following the end of the data collection period. Illicit drug information may or may not be released (1996 data not released; 1999 not yet released). Copies of reports are available from NSW Health or NSW Cancer Council and will be available on the internet later this year.
Access	Applications for data from external agencies should be directed to NSW Health Department Chief Health Officer and NSW Cancer Council. Internal enquiries should be directed to NSW Health. Unreleased data is not available for access by other organisations. Released data is available at a state aggregate level only. There is no cost associated with requests for data.
Data Uses	Trends re: illicit drug use by secondary school students across and within age groups; age trends within a single cohort.

Strengths	All questionnaires were coded and entered by the Centre for Behavioural Research in Cancer at the Anti-Cancer Council in Victoria. After data entry, data were cleaned and students with a large amount of missing data or whose responses were widely exaggerated were removed from the dataset before analyses commenced. The use of an anonymous self-completion questionnaire is a method that decreases under-reporting. Conducting the study at a national level allows for interstate comparisons as well as trends analysis in the future.
Limitations	May not be representative of all adolescents as includes only those currently in school. Bias may be introduced when some schools that were selected in the original sample refused or were unable to participate in the survey. The largest group lost to the sample were older students absent from school on the survey day. Regional analyses were unreliable due to small sample size. Illicit drug questions in the 1996 ASSAD survey were modified from the previous secondary school surveys conducted in NSW. Altering such questions affects the robustness of comparisons with previous surveys.
Future developments	n/a.
Reference (s):	Personal communication with Margaret Thomas (NSW Health).

Bettering the Evaluation and Care of Health (BEACH)

Data Custodian	University of Sydney (USYD), General Practice Statistics and Classification Unit (GPSCU) and Australian Institute of Health and Welfare (AIHW).
Purpose	To monitor general practice activity with regard to patients seen, reasons people seek medical care, problems managed and treatments provided.
Population	Patients attending the rolling sample (20 GPs recording per week) of approximately 1000 GPs randomly selected annually across Australia from Health Insurance Commission (HIC) Medicare records. Each GP reports on 100 consultations.
Data items held	<p><i>GP Characteristics:</i> age, gender, years in general practice, country of graduation, post-grad GP qualifications, size of practice.</p> <p><i>Patient Characteristics:</i> DOB, sex, patient postcode, NESB/ATSI status, health care card & veteran affairs status, patient status (new/seen before).</p> <p><i>Encounter Information:</i> date of encounter; payment details (including workers compensation), start/finish times, patient reasons for encounter (up to 3), problems managed (up to 4) & problem status (new, old, work related), medication prescribed, procedures/treatment/counselling provided, referrals to specialists & allied health professionals, admissions, tests & investigations (imaging, pathology).</p> <p><i>SAND:</i> supplementary questions of interest to funding partners (eg alcohol intake) rotated each 5 week recording block.</p>
Data format	Unit of measurement: encounter; unit of time: date; coding system used: International Classification of Primary Care – 2nd edition PLUS (ICPC-2 PLUS) and Coding Atlas for Pharmaceutical Substances. The ICPC is used in over 45 countries as the standard for data classification in primary care and was developed by the World Organisation of Family Doctors.
Geographic level	State/territory RRMA
Years referenced	Since April 1998.
Sample size	400,000 encounters to date.
Data collection	Continuous (April to March) and divided into 10 recording blocks of 5 weeks each. GPs complete a paper based structured recording form for all consultations that result in management action (including indirect consultations eg telephone). Data entry and cleaning is undertaken by the GPSCU secondary coding staff.
Reporting	Annual report published approximately 9 months following the end of the collection period. Quarterly reports & analyses released to funding partners.
Access	Annual report and abstracts for the supplementary question analyses & interactive data cubes are available on the internet at http://www.fmrc.org.au . Standard reports are available to non-participating organisations at a cost of \$1,200 / \$12,000 (academic/corporate). A check to determine viability of statistical question (eg adequate sample size) is undertaken prior to analysis. If the Cabinet Office were to become a funding partner they would be given a share of SANDS to nominate variables of interest.

Data Uses	Monitor illicit drug abuse group (i.e. rubric) as a whole and also group heroin related drug diagnoses together and monitor both groups over time. Data reflects management rates of drug abuse diagnoses in general practice as opposed to prevalence rates.
Strengths	At present this is the most reliable method of gaining detailed data about morbidity and its management in general practice. There are rubrics (i.e. which consist of many specific codes) for alcohol abuse, nicotine abuse, medication abuse and drug abuse. Quality assurance via computer-aided error checks plus a physical check of samples of data entered versus those on the original recording form. Patients are representative of HIC patients.
Limitations	The level of specificity of coding depends on the detail provided by the GP. Although it is intended that the drug abuse rubric refers to illicit drugs there are many non-specific codes [such as dependence, drug(s); addiction, drug (s); abuse, drug (s)] that could represent licit drug use, illicit drug use or poly-drug use. Another caveat is that dependence, addiction and abuse are used as synonyms with no definition to allow differentiation. This prevents monitoring in trends between dependence and misuse. An initial analysis of the drug abuse rubric by the BEACH team showed that the drugs terms most frequently described by GPs are non-specific, making it difficult to discriminate, and therefore monitor, between illicit drug classes and levels of misuse.
Future developments	The GPSCU has recently received funding to conduct a longitudinal matched controlled trial of active computerised data collected compared with the paper-based data collection, in the Western Sydney area.
Reference (s):	Personal communication with Stephanie Knox (GPSCU- USYD)

Brief Treatment Outcome Measure (BTOM)

Data Custodian	NSW Health Drug Programs Bureau (DPB).
Purpose	To collect treatment outcome data on clients of drug and alcohol treatment services including methadone, counselling, rehabilitation and detoxification.
Population	Clients of publicly funded methadone services. Currently being trialled in other drug and alcohol treatment services, such as detoxification, counselling and withdrawal settings.
Data items held	<p>NSW <i>Minimum Dataset</i> – see documentation for NSW Minimum Dataset for complete listing of items</p> <p><i>General Episode Details:</i> date of interview, SDS score questions, Blood-borne virus exposed risk score, Occasions of Drugs Used score – alcohol, Other Drugs Used score – opiates, Other Drugs Used score – cannabis, Other Drugs Used score – amphetamines, Other Drugs Used score – cocaine, Other Drugs Used Score – tranquillisers, Other Drugs Used score – tobacco, Polydrug use scale, General health status, days in hospital, days mental problems, PWB scale, social functioning score, times arrested, number of offences, involvement with Child Protection.</p> <p><i>Treatment specific section details (Methadone):</i> currently in treatment, dosing commenced, prescriber, dosing point, case manager, last dose received, last dose OK, dose stable, case management activities, satisfaction with treatment.</p>
Data format	unit of measurement = treatment episode; unit of time = collected at assessment and at 3-monthly intervals; coding system used = NMDS AODTS and internal.
Geographic level	SLA of treatment agency, AHS of treatment agency
Years referenced	Full implementation in all publicly funded methadone clinics since July 2002. Began collection in trial AHS in November 2000.
Sample size	As at July 2002, 741 baseline interviews, 160 at 3 months, 72 at 6 month, 33 at 9 months, 16 at 12 months.
Data collection	Continuous. Data is currently being collated by the National Drug and Alcohol Research Centre on behalf of NSW Health Department, Drug Programs Bureau.
Reporting	No external reporting mechanism exists for this data. It has been provided to the Minister for Health to document the effectiveness of methadone as a treatment modality. Ongoing monitoring is continuing for quality assurance purposes.
Access	Applications for data from external agencies should be directed to NSW Health Department Chief Health Officer. Internal enquiries should be directed to NSW Health , DPB. There is no cost associated with requests for data.
Data uses	Number of people with significant changes in treatment functioning (across subscales: severity of dependence; blood borne virus exposure risk; polydrug; health; psychological distress; social distress; occasions of drug use and other data items such as arrests) as assessed by the BTOM.
Strengths	The BTOM represents the first time in any jurisdiction in Australia that it has been attempted to implement a routine treatment outcome monitoring system that is standardised and uniform across the state which allows for comparisons across

treatment agencies, treatments, drug types and client demographics. Enables collection of regular health outcome data for the primary drug and alcohol treatments. This data is very useful as a quality assurance and service delivery improvement tool, both at a state-wide and agency level. It enables clinicians to better monitor the progress of their patients. It also incorporates the NSW and National Minimum Data Set for Alcohol and Other Drug Treatment Services, which facilitates agency reporting for these required data collections.

Limitations

The recency of the state-wide data collection limits the data available for monitoring trends over time. However, the BTOM has the potential to be a valuable monitoring tool in the future. Biases may be introduced since state-wide data is only available for: one type of treatment modality, public opioid pharmacotherapy treatment programs; and 'new' clients (not seen in the past month) to drug and alcohol treatment. Therefore for methadone patients who have been on the program long-term, this data will not be collected. It is also important to note that causal attributions between the provision of treatment and significant improvement on the BTOM cannot be made with this data alone and would require further investigation before making this assumption.

Future developments

As the NMDS evolves, so will the BTOM. Expansion of the data collection will be trailed in the Correctional setting. NGO's are seeking to implement the BTOM. Attempts will be made to encourage private sector agencies to utilise the tool. Originally a paper collection, an electronic database version is available. This database enables clinics to send data directly to NSW Health and produce reports on their data. The BTOM is also currently being scoped for building into the Community Health Information Management Enterprise (CHIME).

Reference (s):

Personal communication with Devon Indig (NSW Health DPB) and Peter Lawrinson (NDARC).



Causes of Death Collection (COD)

Data Custodian	Australian Bureau of Statistics (ABS).
Purpose	Monitor the cause of all deaths in Australia. The primary purpose of causes of death coding is to identify the underlying cause or circumstance of death. This is defined as the condition, disease or injury which initiated the train of events leading directly to death.
Sample	All deaths, drug-induced, registered with the Registrar of Births, Deaths & Marriages in each state and territory. A drug-induced death comprises any death where the underlying cause of death was due to: an acute episode of poisoning or toxicity to drugs (included are deaths from accidental overdoses due to the misuse of drugs, intentional self-harm, assault or deaths undetermined as to intent); and an acute condition caused by drug use where the deceased person was identified as drug dependent.
Data items held	Date of death, cause of death (ICD - underlying & contributory causes [since 1997]), certification, post-mortem flag, sex, age, state of registration, usual state and SLA of residence, year of registration, occupation, birthplace, duration of Australian residence, marital status, date of marriage, duration of marriage & number of children. An indigenous identifier has been progressively introduced since 1980.
Data format	Unit of measurement = case; unit of time = date of death; coding system used = used ICD-9 (International Classification of Diseases, 9th revision) from 1979-1998 and ICD-10 (10th revision) from 1997.
Geographic level	State/Territory, SLA.
Years referenced	1968 – 2002 in an electronic format (1907-1967 in a paper based format).
Sample size	In 2001 no. of deaths due to opioids in Australia = 306 (for 15-44 years). In 2000 no. of deaths due to opioids in Australia = 725 (for 15-44 years). In 2001 no. of deaths due to opioids in NSW = 138 (for 15-44 years). In 2000, no. of deaths due to opioids in NSW = 249 (for 15-44 years).
Data collection	Information from the Medical Certificate of COD (COD items) and the Death Information Form (demographic items) is collected from each state & territory Registrar's of Births, Deaths and Marriages, usually on a monthly basis. All deaths registered from 1979 to 1998 have been coded by the ABS to ICD-9, with previous editions being used for deaths prior to 1979. Deaths registered from 1st January 1997 have been coded using the tenth revision, ICD-10. Deaths registered in 1997 and 1998 were dual coded in both ICD-9 and ICD-10 to enable the production of comparability factors between the two series.
Reporting	Data are collected and processed on a calendar year basis with their release scheduled for November following the reference year (i.e. approximately 12 month time lag). Data are released via media releases and publications available online at the ABS website (www.abs.gov.au).
Access	Data are available as a consultancy from the ABS.
Data Uses	Number of illicit drug-related deaths with breakdowns (e.g. state/territory, age, sex, type of drug, SLA); crude death rates; age-specific death rates; standardised death rates; and years of potential life lost.

Strengths	<p>With the introduction of the tenth revision of ICD (ICD-10) and the Automated Coding System (ACS) for processing deaths registered from 1st January 1997, more detailed information is now available for deaths where the use of drugs was a direct cause or contributory factor. The ACS has enabled efficient production of multiple causes of death statistics, together with more consistent coding practices. The introduction of ICD-10 has enabled the ABS to provide more detail on drugs than was previously available from earlier revisions of the ICD. From 1997, data for deaths involving drugs are available for the underlying cause which directly led to death (drug-induced) as well as any associated conditions, such as poisoning by particular drugs that contributed to death (multiple causes). Although ICD-10 does not have a unique poison code for all drugs, many drugs of interest can be identified by cross-tabulating the appropriate external cause of death code (underlying cause) by poison code (multiple cause). For example, of a coroner determined the death to be an accidental cocaine overdose, the death would be assigned ICD-10 codes of X42 as the underlying cause (accidental poisoning) and T40.5 as the poison code (poisoning by cocaine). The ABS employs a series of quality control checks to ensure compilation of reliable causes of death statistics.</p>
Limitations	<p>There are a number of conditions and constraints which affect mortality coding and need to be taken into account when analysing or interpreting drug-induced death data. Among these factors are ICD coding rules, the availability of toxicology results, the inconsistent terminology used by medical certifiers and the completeness of data provided within the medical certificate. For drug-related deaths, the ICD does not focus on the identity of the drug(s) involved, rather on the circumstance of death. For example, drugs that were determined to be directly caused by drug use could be classified as being due to external causes (assault, accident, suicide) or due to mental disorders associated with drug use. As a result of this different focus the codes assigned may not be unique to any specific drugs. For example, under ICD-10 rules, deaths due to an accidental overdose of cannabis, cocaine or heroin would all be assigned an underlying cause code of X42 (accidental poisoning by narcotics and hallucinogens). The extent to which specific ICD codes can be used to identify individual drugs depends on the nature of the death. Prior to 1997 only the underlying cause of death was coded. Comparability of COD data over time is affected by a number of factors including the introduction of ICD-10 and ACS.</p>
Future developments	<p>ABS will provide ICD-10 codes to from 2000 onwards to the NCIS. However, there will be a 12-month time lag.</p>
Reference (s):	<p>Personal correspondence with Peter Burke (ABS).</p> <hr/>

Children's Court Information System (CCIS)

Data Custodian	NSW Department of Juvenile Justice (DJJ).
Purpose	To identify and record details of criminal matters finalised in the NSW Children's Court; and to monitor the performance, effectiveness, efficiency and equity of the NSW criminal justice system.
Sample	Young People (aged 10 – 18 years) appearing before all NSW Courts for a criminal matter.

Data items held	Local/Children's Court; District/Appeal; Supreme/Committal. Court name; Surname; given names; DOB; sex; Address; ATSI; Type of case; Date of earliest offence; Date of earliest court appearance; offence (law code); date of final court appearance; alias; prosecuting agency; police bail granted; plea; no. of counts; bail status prior to final court appearance; outcome & severity.
Data format	Unit of measurement = finalised court appearances; unit of time = date; ASOC (ABS 1997, Cat. No. 1234.0) used in 2000; previous reporting used ANCO (ABS 1985, Cat. No. 1234.0).
Geographic level	LGA or postcode.
Sample size	n/a
Years referenced	Since 1991.

Data collection The data is supplied to DJJ on court collection forms. It is supplied to DJJ on a daily basis. It is entered by 3 Information Services officers from DJJ.

Reporting Statistics are released via the DJJ's Annual Report which is available at the DJJ website online at: <http://www.djj.nsw.gov.au/publications.htm>. Data is only released to BOCSAR (1x per year) and Judicial Commission and DJJ staff (when requested). An annual report that describes Local Court, Higher Courts and Children's Court outcomes is published annually by BOCSAR – New South Wales Criminal Court Statistics - at the end of July and can be accessed online at the BOCSAR website: <http://www.lawlink.nsw.gov.au/bocsar1.nsf/pages/courtstatsindex>.

Access Requests for information from government agencies need to be submitted in writing to the DJJ Manager of IM&T.

Data Uses Number of juveniles charged with an illicit drug offence; outcome of illicit drug charges; penalty imposed for proven illicit drug charges; type of principal offence; characteristics or persons convicted of illicit drug offences.

Strengths Dataset records information on all finalised juvenile court appearances.

Limitations The majority of cases do not state what type of drug the juvenile was in possession of or their ATSI status. Although data is available since 1991, the most accurate data is from 1999 onwards.

The database relates to court data and cannot inform on trends or patterns in the level of offending. Offenders not brought before Court are not included in the collection. Thus persons who are diverted from court by way of a caution or warning are not included in these data.

The counting units are finalised court appearances. The dataset does not distinguish distinct persons within the counting period. If a person has more than one court appearance during the counting period, such a person will be counted more than once in the report.

Future developments n/a

Reference (s): Personal communication with Pam King and Liz Henderson (DJJ).

Clients of Treatment Service Agencies (COTSA)

Data Custodian	National Drug and Alcohol Research Centre (NDARC).
Purpose	To monitor changes over time in the characteristics of the clients being treated for alcohol and drug problems, or that of their close friends or family members identify the characteristics of clients attending drug and alcohol treatment services and to monitor changes in the drug and alcohol problems being treated since the first census in 1990.
Population	The census included all alcohol and other drug treatment agencies across Australia, including agencies providing outpatient treatment services, inpatient rehabilitation programs, detoxification services, and therapeutic communities. The agency list was obtained from each State/Territory health authority
Data items held	<p><i>Client Information:</i> type (self/other), age, sex, country of birth, ATSI status, language spoken at home, employment status, main service provided, main drug problem, drugs injected by user in past 12 months, residential postcode.</p> <p><i>Agency Information:</i> representativeness of census sample; number of clients seen on typical day; type of service(s) offered; no. of beds, admissions & length of stay for residential services; average no. treatment sessions per client, frequency of visits & average duration of visits for non-residential services.</p>
Data format	Unit of measurement: case (client); unit of time: census day; nil coding system used.
Geographic level	State/territory & metropolitan/non-metropolitan.
Years referenced	1990, 1992, 1995 and 2001.
Sample size	In 2001 there was a 90.3% response rate – 458 agencies and 5304 clients.
Data collection	Irregular. One day census of clients of all drug and alcohol treatment agencies (excluding methadone maintenance treatment services) across Australia. Agencies complete census form for all clients seen on census day. Each client is counted once only. Data entry and cleaning was undertaken by NDARC.
Reporting	De-identified state/territory data released to the relevant health authorities within six months of the census date. A national report is published in conjunction with Commonwealth Department of Health and Ageing and available within 12 months of the census date.
Access	Applications for data from external agencies should be directed to NSW Health Department Chief Health Officer. Internal enquiries should be directed to NSW Health, DPB.
Data Uses	Description of, and changes in, demographics, drug & alcohol problems being treated, drugs injected in past 12 months, specific groups, and treatment provision (e.g. inpatient versus outpatient). Can't be used as lead indicator of problematic use; best to interpret in conjunction with estimates of use in the general community.
Strengths	Procedure and questions consistent across all 4 censuses (1990, 1992, 1995, 2001) so outcomes can be compared from 1990 to 2001. Good response rate from treatment agencies (approximately 90%). Client information is reliable; agency

information is less so (approximately 30-40% missing data). Agencies tend to record more than one main drug problem so data is entered according to the sequence of drugs listed in this field (i.e., primary, secondary, tertiary drug problem).

Limitations	Sporadic data collection. Under-represents outpatient relative to inpatient treatment. Misses some intermittent treatment programs. Does not include methadone treatment. Does not capture treatment by GPs. ATSI agencies are less likely to respond and hence probably under represented in sample.
Future developments	Unlikely to continue as data now collected routinely through the NMDS-AODT.
Reference (s):	Personal communication with Fiona Shand (NDARC)

Computerised Operational Policing System (COPS)

Data Custodian	NSW Police Service.
Purpose	Manage the operational aspects of policing in NSW, collation of intelligence & management of investigations.
Sample	NSW
Data items held	Incident Category, Location, Date of Incident, Date of Report, Offender, Legal Action Taken.
Data format	Unit of measurement = criminal incident; unit of time = date of reporting/detection; offences classified using ASOC (ABS, 1997, Cat. No. 1234.0).
Geographic level	State, Postcode, Suburb, (ability to link through GIS to statistical divisions & subdivisions of NSW as defined by ABS), Address of Incident (restricted by privacy policy).
Years referenced	COPS introduced in 1994; previous system dates back to 1989 (data not retrievable); Legal Actions data available from 1999.
Sample size	No. of illicit drug-related incidents (Drug Detection Incidents) for 2001 = 27127 Incidents, 20811 Events. No. of illicit drug-related arrests (Legal Actions for ASOC Illicit Drug Offences) for 2001 = 16164. No. of cannabis cautions (subset of Legal Actions) for 2001 = 4171. No. of illicit drug-related seizures for 2001 (2000/01 AIDR Data – refer to ABCI definition) = (approx 15,000).
Data collection	Continuous. Data is entered daily for each criminal incident reported to, or detected by, NSW Police, as it becomes available.
Reporting	Quarterly download of Incidents to BOCSAR for official NSW crime statistics.
Access	Restricted to NSW Police personnel and limited authorised users.
Data uses	Number and type of recorded criminal incidents; number and type of outcomes from recorded criminal incidents; number and weight of seizures.
Strengths	Data are able to provide a broad indication of the patterns of offending in NSW. Very comprehensive database containing information on a wide range of variables with reliable data available since 1994.
Limitations	The COPS database is a law enforcement tool, which is not designed for public health uses such as illicit drug-related indicator monitoring. COPS contain Drug Detection incidents recorded by Police and these are used as the basis of performance indicators. Associated Factor 'Drug related' field not always completed by Police Officers (it is not generally possible to identify "drug related" associated factor in many incident types). Detection rates are subject to shifts in policing policy/activity and public willingness to report crime (particularly for drug offences).

Future developments Monitoring and reporting of indicators by the Drug Trends Monitoring Group (DTMG), collaboration between NSW Health and NSW Police for the exchange of information relating to licit and illicit drugs.

Reference (s): Personal communication with Jim Baldwin (NSW Police)

Corrections: Admissions to Hospital

Data Custodian	NSW Corrections Health Service (CHS).
Purpose	To monitor the number of admissions to public hospitals and reasons for admissions. Identifying and monitoring precipitating trends that will be a basis of the design and implementation of suicide prevention programs, and effective drug and alcohol education and rehabilitation programs.
Population	Inmates in NSW adult correctional centres and selected police/court cell complexes that are under the guardianship of the Department of Corrective Services.
Data items held	Name of person; main index number; reason of admission to hospital; age; sex; date; correctional facility.
Data format	Unit of measurement = inmate; unit of time = date; coding system used = nil used.
Geographic level	NSW Correctional centre.
Years referenced	Since 2001.
Sample size	Available upon request.
Data collection	Data is collected upon patient's admission to hospital.
Reporting	The data is released to the CHS Board every six weeks in table format and published in the CHS Annual Report.
Access	Applications for data should be directed to the Chief Executive Officer, NSW Corrections Health Service.
Data Uses	Number of illicit drug-related non-fatal overdoses by demographic breakdowns.
Strengths	Data is reliable. Assist in identifying and monitoring precipitating trends that may assist in minimising the number of admissions to hospitals by overdose in NSW Correctional centres.
Limitations	Variations in data although possible are highly improbable.
Future developments	Dataset will be reviewed and modified as evaluation of needs becomes evident.
Reference (s):	Personal correspondence with Dr Richard Matthews (CHS) & Ms Christine Callaghan

Corrections: Duty Officers Incident Log

Data Custodian	NSW Department of Corrective Services (DCS).
Purpose	To monitor incidents (such as illicit drug detection and overdose) in adult correctional centres. This information is used for statistical research, reporting and intelligence purposes.
Population	Inmates in NSW Adult correctional centres.
Data items held	<i>Demographic:</i> Drugs general, alcohol, drug implements, drug overdose, non-prescribed medication, syringe find, tablet find.
Data format	Unit of measurement = incident/inmate; unit of time = daily; coding system used = nil used.
Geographic level	Correctional centre, State.
Years referenced	Current database since 01/01/00.
Sample size	In 2001, N of drug overdoses & illicit drug detections – available upon request.
Data collection	The data is supplied to the duty officer verbally in real time, followed up in written form by all locations. It is immediately entered onto the system by the Duty Officer.
Reporting	The information is primarily for intelligence and research and is released in the DCS annual report and statistical series.
Access	Personnel from external agencies can request information from DCS.
Data Uses	Number and type of illicit drugs found and overdoses.
Strengths	Data is reliable. Can be used to indicate trends in drug use and harms in NSW Correctional centres as well as the effectiveness of interdiction methods.
Limitations	All data is included however it may be entered under an unrelated listing. The limitations of the storage of the information are as most computer programs; they are only as good as the information placed into them.
Future developments	A new database is currently being created. This database will allow the various Correctional Centres to be online and provide input directly into the system.
Reference (s):	Personal correspondence with Laurie Sobhi (DCS)

Corrections: Urinalysis Program

Data Custodian	NSW Department of Corrective Services (DCS).
Purpose	To detect illicit drug use in adult correctional centres. This information is used for punitive, referral for treatment, statistical and tactical intelligence purposes.
Sample	The Urinalysis Program in adult correctional centres randomly selected 5% of inmates each month for compulsory testing. Any persons suspected of being drug affected are also tested. Many pre-release programs include regular urinalysis testing.
Data items held	<p><i>Demographic:</i> Inmates name, inmates identification number, date sample collected, name of correctional centre, date inmate was incarcerated (applies only to cannabis), whether drugs detected were prescribed by medical staff, if inmate is to be charged, what penalty was incurred if charged.</p> <p><i>Urinalysis results:</i> Seal number, lab number, drug, dilution of sample, adulteration of sample.</p>
Data format	Unit of measurement = incident/inmate; unit of time = daily; coding system used = nil used.
Geographic level	State
Years referenced	Current urinalysis program system: July 2001 – 2002. Previously the recording process was different and not comparable to current system.
Sample size	Proportion of urine screens testing positive to illicit drug screens is available upon request.
Data collection	Data is entered on a daily basis by clerical support staff and correctional officer within the urinalysis unit into an Access database. Information is collected from correctional centres and results received from the laboratory.
Reporting	Results are released on a monthly basis to appropriate personnel within the DCS as well as the Commissioner, Corrections Health Service and the Drug Detection Unit. The amount of time between data collection and release of results is approximately 2 months.
Access	Personnel from external agencies can request information contained with the DCS Urinalysis Program Database via the DCS Freedom of Information Unit, however the information is limited. The data can be as recent as required. For external agencies, the processing of the request can take up to a two-week period. The cost of this request from external agencies is calculated via the DCS Freedom of Information Unit.
Data Uses	Demographics of illicit drug users, prevalence of illicit drug use, prevalence of injecting drug use, availability of illicit drugs in custody.
Strengths	The random facet of the urinalysis program allows for comparable trend analysis. Very minimal missing data – possibly 6x results per year (maximum). Current database is adequate for the detection of illicit drugs.
Limitations	The limitations of the storage of the information are as most computer programs; they are only as good as the information placed into them.

Future developments

A new database is currently being created. This database will allow the various Correctional Centres to be online and provide input directly into the system. The new database will also serve as a major component in the detection and monitoring of illicit drugs.

Reference (s):

Personal correspondence with Angela Bendeich (DCS)

Crime and Safety Survey (CSS)

Data Custodian	Australian Bureau of Statistics (ABS).
Purpose	To obtain information on the perception of crime problems in the neighbourhood, fear of crime, the incidence of selected categories of crime and reporting behaviour.
Population	Residents, aged 15 years and over, of private dwellings throughout Australia. (Conducted in NSW in 1990 - 1992, 1994 - 1997, 1999 - 2001. Australia 1993, 1998 and 2002)
Data items held	<p><i>Demographic Information:</i> age, sex, marital status, household type, country of birth, year of arrival in Australia, labour force region, labour force status.</p> <p><i>Incident Information:</i> re break & enter, attempted break & enter, motor vehicle theft, robbery, assault & sexual assault: whether an incident occurred in the last 12 months, number of incidents in last 12 months & number reported to police, whether last incident was reported to police and if not why not, where the most recent incident occurred, what happened / what the offender did in the last incident, location of the last incident, whether a weapon was used, occurrence of physical injury, how many offenders there were, whether the offenders were known to the victim and how they were known to the victim, whether anything was stolen in the last incident and what was stolen.</p> <p>Perceptions of crime or public nuisance problems.</p>
Data format	Unit of measurement = incident/person; unit of time = annual; coding system used = ASOC (1997)
Geographic level	State (Sydney Statistical Division/Balance of NSW for most data items. Can break down further for perceptions of crime as this is asked of everyone).
Years referenced	In NSW the survey has been conducted every year since 1990. Nationally, the survey has been conducted in 1983, 1993, 1998, 2002 and next run in 2005.
Sample size	<p>In 2001, approximately 9,201 individuals (73% response rate) from 4,502 households (74% response rate) were surveyed.</p> <p>In 2001, Proportion of people reporting that illicit drugs were a problem in their local area in NSW = 19.1%, with 5.6% perceiving it to be the main problem.</p> <p>In 1998, Proportion of people reporting that illicit drugs were a problem in their local area in Australia = 11.3% compared with 13.3% for NSW.</p>
Data collection	Annual (March to April). Information is collected from individuals and households as a supplement to the Monthly Population Survey. Each household received one questionnaire containing questions relating to the household as a whole, a questionnaire for each person aged 15 or other relating to their personal experiences of crime, and a questionnaire for each female aged 18 or over relating to their personal experiences of sexual assault only.
Reporting	State survey results are published annually around December following the April enumeration, approximately 8 months following data collection. National survey results are published every 3 years, the most recent being the 1998 survey.

Access	Information on perceived problems in the neighbourhood is available as a special data service from the ABS.
Data uses	Proportion of people who perceive illicit drugs to be a problem in their local area (broken down by Sydney statistical division and balance of NSW). Perceived problems in the neighbourhood can be broken down by whether the person has been a victim of crime or not and by selected demographic characteristics (such as age). Only a limited breakdown is available by geographic location.
Strengths	Because it measures the prevalence of both reported and unreported crime the CSS survey provides a more accurate picture of the true prevalence of crime than crime statistics based solely on reports of crime to police. Estimation and imputation procedures were employed to reduce the effect of non-response.
Limitations	Estimates are subject to non-sampling and sampling errors. Community surveys are confounded by factors, such as: the media; visibility of police initiatives; and individual's values and personal experiences of illicit drug use. Results of these surveys need to be interpreted within the context of other data since people's perceptions do not necessarily reflect the size of the drug problem.
Future developments	n/a
Reference (s):	Personal correspondence with Michael Clarke (ABS).

Crime Stoppers

Data Custodian	NSW Police Service.
Purpose	Crime Stoppers allows for people in the community to anonymously report information about illegal activity or suspected perpetrators; if the call results in an arrest a reward is provided.
Population	Calls made to Crime Stoppers about drug-related crime in NSW.
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Data items held	Date of call; Locality of call; caller demographics; Total calls to Crimestoppers broken down by: answered; unanswered; drug related; non-drug related; reports generated from answered calls (i.e. calls that result in action taken by police); charges resulting from answered calls; value of drugs recovered; arrests resulting from answered calls.
Data format	Date; call; nil coding system used.
Geographic level	State/Territory (local level data collected but not available for analysis).
Years referenced	1999 – 2003.
Size of sample	In 1999, total no. of all calls = 46,536; total no. of drug related reports = 1481. In 2000, total no. of all calls = 27867; total no. of drug related reports = 2926. In 2001, total no. of all calls = 34353; total no. of drug related reports = 2851.
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Data collection	Calls are downloaded on a daily basis from the Crimestoppers database.
Reporting	Data is only released publicly to promote Crime Stoppers. Data is collated monthly for monitoring purposes and for reports to the TCO.
Access	Available to external agencies on a limited basis only.
Data Uses	Number of drug-related calls to Crimestoppers; number of drug-related reports; number of drug-related charges; value of drugs recovered; number of drug-related arrests.
Strengths	Monitoring of drug summit project on drug crime reporting; evaluating community responses. Data is presumed to be highly reliable.
Limitations	Calls are influenced by several factors, including: public awareness of Crimestoppers; public willingness to report crime and campaigns. Campaigns include: November 1999 – end of Australia’s most wanted; May 2000 – launch of Drug Crime Reporting Campaign to regional NSW; January 2001 – launch of Drug Crime Reporting Campaign to Sydney metro; July 2002 – launch of Drug Crime Reporting Campaign. All data is present – however, figures for the final 2002 are likely to be incomplete due to relocation of Crime Stoppers from discrete unit to a unit of Police Assistance Line.
Future developments	n/a
Reference (s):	Personal correspondence with Carolyn Pappas (NSW Ministry of Police) and Michael Chesworth (NSW Police).

Division of Analytical Laboratories (DAL)

Data Custodian	NSW Health Division of Analytical Laboratories (DAL), Drug Programs Bureau (DPB), and the NSW Police Service.
Purpose	To monitor the drug and alcohol constituents found in persons who died or were driving a motor vehicle while using illicit and other drugs. To monitor the purity, constituents & locality of illicit substances seized by NSW Police.
Population	Persons who died in drug related circumstances. Persons who died in a motor vehicle accident. . Persons who are drug intoxicated while driving a motor vehicle. Illicit substances seized by NSW Police.
Data items held	Registration number, age, sex, coroner suburb, date received, postcode of death, suburb of death, drug type found, weight of seizure, purity, constituents, physical appearance, date & location.
Data format	Unit of measurement = person or seizure; unit of time = daily; coding system used = internal.
Geographic level	Suburb (of coroner and of death), postcode of death & location of seizure.
Years referenced	Death & driver data is available since 1992 & drug seizure data is partially available since 2000.
Sample size	Number of suspected drug related deaths in 2001: 168. Number of illicit substance cases in 2001: 6000 Number of drug intoxicated drivers in 2001: 800
Data collection	Continuous. Collected through the Toxicology and Drug databases maintained by Division of Analytical Laboratories.
Reporting	Drug related death information is reported to NSW Health DPB on a monthly basis. Statistics are collated for the Opiate Overdose Bulletin. Statistics are also reported to the IDRS. Seizure information is continuously reported to the NSW Police State Crime Command (formerly NSW Police Crime Agencies) for charge and intelligence purposes and for inclusion in the Australian Illicit Drug Report.
Access	Applications for data from external agencies should be directed to NSW Health Department Chief Health Officer. Internal enquiries should be directed to NSW Health, DPB. There is no cost associated with requests for data. Requests for seizure data are to be made to the NSW Police.
Data uses	Number of illicit drug seizures, number of illicit drug-related deaths, number of illicit drug driver intoxications.
Strengths	Toxicology results are requested for all deceased persons who die suddenly or in suspicious circumstances, by the Coroner. It represents an effective early warning system for trends in drug related deaths. Drug testing of intoxicated drivers reveals current drug taking habits of drug taking population. The composition and availability of illicit substances helps interpret other illicit drug-related data.
Limitations	DAL provides a different classification to cause of death compared with the ABS for overdose deaths. The listing for the Division of Analytical Laboratories (DAL) drug related overdose deaths departs from most of the definitions used for overdose as the cause of death has not been specifically assigned. This data

collection is indicative only as it is not the same as that determined by a final inquiry. The decision of 'heroin death' is not usually made available until the Coroner has looked at all the evidence associated with the death. Intoxicated drivers and illicit substances are sampled randomly and may only reflect vigilance in certain areas.

The major limitation of purity data is that not all illicit drugs seized by NSW Police are subjected to forensic analysis. Seized drugs are usually only analysed in a contested court matter (i.e. large indictable quantity) or when the nature of the drug is in dispute. Prices increase and purity decreases as you go down the distribution chain to the street level. Street purity is what is most interesting but it is almost never analysed. In addition, if you do not know where in the distribution chain (i.e. high level/wholesale versus lower level/retail) the samples are drawn and what type of sample changes occur over time, it is difficult to interpret the data in an effective and useful manner.

The drug seizure data is partially available electronically since 2000, however further retrospective data capture (prior 2000) will not be possible without additional data entry staff to go through the thousands of hardcopy files.

Future developments

Funding of a position at DAL to manage (extract and implement additional fields to meet identified needs) the drug seizure data.

Reference (s):

Personal communication with Allan Hodda (NSW Health DAL) and Suzie Forell (NSW Police)

Drug and Alcohol Performance Indicator Reporting (DAPIR)

Data Custodian	NSW Health Department, Drug Programs Bureau (DPB).
Purpose	To monitor the activity and expenditure of drug and alcohol projects that are funded by NSW Health Drug Programs Bureau.
Population	Activity of drug and alcohol services, staff and projects.

Data items held	<p><i>Methadone</i>: number of non-dosing service contacts, No. of clients' assessed on the 8 case management domains, number of new treatment plans written, number of new treatment contracts signed, Percentage of individual case managers files reviewed, number of clients on program, additional capacity, number of clients commencing program (monthly, quarterly, 6-monthly).</p> <p><i>Detoxification (Home, ambulatory, outpatient, inpatient)</i>: number of clients assessed, number of clients admitted, number of clients completed, number of service contacts. (monthly, quarterly, 6-monthly)</p> <p><i>D&A Counsellor (rural)</i>: number of clients seen, number of service contacts (monthly, quarterly).</p> <p><i>Pharmacotherapy prescribers accreditation course</i>: number of training courses, number of medical practitioners trained, number of medical practitioners approved (quarterly).</p> <p><i>Residential rehabilitation</i>: number of assessments, number of admissions, number of completions, bed occupancy rate (quarterly, 6-monthly).</p> <p><i>GP Project</i>: number of consultation meetings, number attending GP training, number of calls to GP consultancy service, number of GP's sent resources, number of patients receive shared care (quarterly).</p> <p>Indicators exist for other projects which apply only to one or two Area Health Services, including Corrections Health.</p>
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Data format	unit of measurement = unit of activity; unit of time = point in time, monthly summary, quarterly summary, 6-monthly summary; coding system used = internal
Geographic level	AHS of treatment
Years referenced	Since 2001.
Sample size	Varies according to the project and indicator.

Data collection	Monthly, quarterly and 6-monthly (depending on the project). Data is collected from the AHS and entered on the DAPIR website.
Reporting	Performance indicator reports are provided regularly to the Minister for Health, the Office of Drug Policy and Treasury Department.
Access	Applications for data from external agencies should be directed to NSW Health Department Chief Health Officer. Internal enquiries should be directed to NSW Health, DPB. There is no cost associated with requests for data.

Data uses	A wide range of statistics from the programs such as Methadone, GP project, AOD Counsellor, AOD Clinical Nurse Consultant, pharmacotherapy prescribers course, ADIS, Corrections Health.
Strengths	Aligns performance activity with expenditure data enabling NSW Health to make more informed decisions about its resource allocation.
Limitations	Is not an effective measure of the quality of the services provided. Is only a summary data collection so investigating information at a client level is not possible.
Future developments	Revision to indicators including the establishment of baseline and targets.
Reference(s):	Personal communication with Devon Indig (NSW Health DPB)

Drug and Alcohol Specialist Advisory Service (DASAS)

Data Custodian	St Vincents Hospital Alcohol and Drug Information Service (ADIS). Formerr Custodian – Royal Prince Alfred Hospital, Specialist Advisory Service.
Purpose	Provide a 24 hour telephone consultancy service (via paging service) for health professionals (particularly doctors and nurses) providing specialist advice on the management of drug and alcohol problems in rural and isolated areas.
Population	Health Professionals (predominantly doctors and nurses) in NSW, ACT and NT.
Data items held	<p><i>SAS Consultation Form:</i> id no., date, start time of call, duration of consultation service, name of consultant, caller details (name, position, organisation, suburb, postcode, telephone no.), caller type (professional occupation), problem/request (text field), advice provided (text field), service/agency type; drugs involved (can be more than one); focus of call (can be more than one), materials faxed or emailed.</p> <p><i>Paging System Report:</i> date, time, health professional v public, time frame of request (eg urgent), name of caller, telephone number of caller, position/title of caller, organisation of caller, town/suburb of caller, postcode of caller, subject of enquiry, event number</p>
Data format	Unit of measurement = case (call); unit of time = date; nil coding system
Geographic level	AHS (caller), postcode (caller)
Years referenced	Current system since 1995/96 financial year; previous data available only as annual report since 1991/92 financial year
Size of sample	During July 98 –June 99 period, SAS received 1,051 requests for assistance.
Data collection	Monthly. Consultants complete consultation form following each call received and forward to the Project Officer at the end of each month. Forms received are checked against the paging system report. Data is entered and cleaned by the Project Officer during the following month.
Reporting	Annual report (financial year) presented to consultants at the AGM that occurs approximately 3 months following the end of the financial year. A copy of the report is also forwarded to Drug Programs Bureau, NSW Department of Health. Report is not released to the public domain.
Access	Requests for data should be made through the Manager, DASAS. Time frame to process depends on the type of request but as data is readily available, requests are generally processed within 2 working days. There is a 1 month time lag re currency of information. No cost associated with request.
Data uses	Number of illicit drug-related calls by potential breakdowns, such as type of drug, type of caller, area of caller, date of call, type of agency etc.
Strengths	The focus of the service is on general practitioners and rural health staff, so as to provide a rough indicator of drug misuse and concern within this sample. Presumed highly reliable; all data entered and cleaned by the same person; missing data is followed up by phone call or check against daily paging system report and is randomly distributed across data fields.

Limitations	Some missing data due to missing call sheets from doctors on call. Six-month time lag for data publication.
Future developments	Scope and format of service currently under review. Relocating to St Vincents Hospital (with ADIS) in early 2003.
Reference (s):	Personal communication with Sarah Hutchinson (Royal Prince Alfred Hospital).

Drug Use in Prison Survey (DUIP)

Data Custodian	NSW Department of Corrective Services (DCS).
Purpose	To obtain data on the patterns of drug use by inmates prior to and while serving a custodial sentence and to provide a greater understanding of the social context of drug use in prison.
Population	Random sample of inmates serving a full-time sentence of at least 1 month in a NSW adult correctional facility who are shortly to be released to the community. The sample was stratified by region and correctional centre security classification.
Data items held	Demographic: criminal & drug use histories; current offence characteristics concerning drug-offence links; patterns of drug use in the 6 months prior to imprisonment, including motivation for drug use using a standard scale and treatment enrolment; patterns of drug use in custody, including a detailed examination of first and last occasion of drug use in custody; perceptions on prison life, including general atmosphere, social practices, tensions, coping strategies, general and drug trade; scales on inmate code adoption and adjustment to staff.
Data format	unit of measurement = person, unit of time = biennial, coding system used = nil.
Geographic level	ASGC statistical divisions
Years referenced	1998 and 2001.
Sample size	235 (230 males, 15 females) in 1998 288 (254 males, 34 females) in 2001.
Data collection	Biennial (<i>note: 30 months elapsed between the late 1998 & mid 2001 collections - it is a 2 yearly project</i>). Data collected by way of personal interview using a structured questionnaire over a 2 month period. The data is entered and cleaned by DCS research and statistics unit staff.
Reporting	Final report published approximately 12-18 months following the end of the data collection period (<i>results are released prior to final report by way of conference/seminar presentations & research summaries</i>).
Access	Data analyses are performed on a consultation basis. Quotes and copies of the report are available from DCS.
Data Uses	Demographics of illicit drug users, prevalence of illicit drug use, injecting drug use, drug-related offending, availability of illicit drugs in custody.
Strengths	Data collection and analysis undertaken by research staff. Uses self report measure of illicit behaviours, but the 1998 survey demonstrated a low refusal rate (5.5%) and high reported rate of drug use (58.2%) as well as surveying participants towards the end of their prison term.
Limitations	The 1998 questionnaire includes scales not yet validated. The 2001 survey over-samples female prisoners (since they represent only 6% of prison population).
Future developments	The next survey will be conducted in 2003. Over-sampling of female prisoners. Additional survey items on the effectiveness of deterrence/interdiction strategies.
Reference(s):	Personal communication with Maria Kevin (DCS)

Drug Use Monitoring in Australia (DUMA)

Data Custodian	Australian Institute of Criminology (AIC) and NSW Bureau of Crime Statistics and Research (BOCSAR).
Purpose	To monitor drug use and drug related crime among police detainees and to detect shifts in drug use patterns.
Population	Adult police detainees in 7 designated sites in 4 jurisdictions (Southport & Brisbane, QLD; East Perth, WA; Bankstown & Parramatta, NSW, Elizabeth & Adelaide, SA). Juveniles are interviewed in the NSW sites only.
Data items held	<p>Detainee details: sex, age, ethnicity, education level, marital status, residential situation, source of income, gambling behaviour, previous arrest/prison history, mental illness, residential suburb, offence description (ASOC or violent, property, drug, drink driving, traffic, disorder, warrants, other).</p> <p>Drug Use: Urinalysis results (amphetamines, benzodiazepines, cannabis, cocaine, opiates, methadone), self-reported drug use history (eg age first tried, age of regular use, injecting history, used in the past 48 hrs for alcohol, cannabis, heroin, cocaine, amphetamines, street methadone, street benzodiazepines, ecstasy, hallucinogens), drug market information (cannabis, heroin, cocaine, amphetamines) and drug treatment history.</p>
Data format	Unit of measurement = detainee; unit of time = quarter; nil coding system used.
Geographic level	International, National, and Local: Parramatta and Bankstown, NSW (data held by BOCSAR and AIC); Also conducted at Southport & Brisbane, QLD, East Perth, WA, Elizabeth & Adelaide, SA (data for these sites held by AIC and local agencies). Comparable data are collected at various sites in a range of other countries.
Years referenced	Southport and East Perth data collection commenced in January 1999, NSW in July 1999, Brisbane in January 2002, and Elizabeth and Adelaide in April 2002.
Sample size	<p>N = 5440, in 1999-2001 N = 1919, in 2001.</p> <p>About 100 detainees interviewed in Bankstown, Parramatta and Southport, 150 detainees interviewed in Brisbane, Adelaide and Elizabeth and 200 detainees interviewed in East Perth each quarter.</p>
Data collection	Data are collected over a three-four week period each quarter and involves structured interviews and urinalysis of detained persons conducted by trained interviewers. Participation in both the interview and provision of a urine sample are voluntary. All urinalysis testing is carried out in Sydney and results are forwarded directly to the AIC. Questionnaires are also forwarded to the AIC directly after interviewing is complete for data entry and cleaning.
Reporting	The AIC releases DUMA data to a protected website. In NSW, BOCSAR and the NSW Police Service have access to this site. Urinalysis results are available within 2 weeks of interviewing being complete and unit record data within six weeks. Specific reports are produced for local sites. An annual report is published approximately three months after the end of the calendar year which is available on the protected website and in printed form directly from the AIC.

Access	Requests for state-national comparisons should be addressed to the AIC. State data can be accessed through local agencies (eg. BOCSAR in NSW).
Data Uses	Demographics of police detainees, prevalence of illicit drug use, age of first use, demand for treatment, illicit drug market information, offending profile, measure the extent of drug related crime among police detainees
Strengths	Very little missing data. Validity checks indicate that the sample is representative of detainees at the collection sites. The use of addendums each quarter to address key issues. Core set of questions on drug use and offending has remained consistent. Confirms self-reported drug use with urine tests. Data on response rates is known and published. Provides internationally comparable data.
Limitations	Only about 70% of NSW participants agree to provide a urine sample for drug testing. Findings are not directly generalisable to areas of Sydney or NSW outside Parramatta or Bankstown. Sites differ with regard to the actual dates of the data collection period within each quarter, due to specific operational requirements at local police stations. In NSW the data are collected sequentially in the two NSW sites.
Future developments	Three additional sites commenced data collection in 2002: Queensland (Brisbane City) in February 2002 and South Australia (Elizabeth & City) in April 2002.
Reference (s):	Personal communication with Toni Makkai (AIC) and Jackie Fitzgerald (BOCSAR).

Emergency Department Collection (EDC)

Data Custodian	NSW Health, Information Management and Support Branch.
Purpose	To facilitate the management of Emergency Departments in NSW hospitals by providing: (a) information to assist in the planning of an efficient and equitable distribution of health services in order to provide acceptable access to emergency health care; (b) indicators to support the monitoring of health outcomes; and (c) statistical information to monitor the utilisation of NSW Emergency Departments.
Population	Clients of 51 of the 143 public hospital Emergency Departments in NSW. These include most urban and the larger rural Emergency Departments.
Data items held	<p>A wide range of data are collected from EDIS. However, not all data items are mandatory for supply to the Department of Health. The non-mandatory data items are indicated with a ‘*’ in the list below.</p> <p><i>Patient Demographics:</i> Aboriginality, age*, country of birth, date of birth, need for interpreter, preferred language, street address locality & postcode, marital status, patient identifier, sex, compensable status, insurance status.</p> <p><i>Episode Specific Data:</i> ambulance case number, patient arrival date/time, mode of arrival, actual departure date/time, departure destination*, departure ready date/time, departure status, first seen by doctor date/time, principal procedure, additional procedures, referred by*, referred to, sequence number, triage date/time, emergency department visit number*, type of visit.</p> <p><i>Diagnosis information:</i> primary emergency department diagnosis, 5 additional emergency department diagnoses, (Note: Procedure codes are not useful for diagnosis or injury surveillance. Injury surveillance data may be collected at the local level, but these are not supplied routinely to the Department. Diagnoses only give information about the pathological results of the injury, not its external causes)</p> <p><i>Other:</i> hospital code</p>
Data format	Unit of measurement: treatment presentation; Smallest unit of time: time of day. Coding system used: ICD-9-CM.
Geographic level	State, Postcode of residence
Years referenced	Since July 1996 (information going back to 1994 could be obtained if necessary, but this is not recommended because it was the very early days of the collection)
Sample size	Complete census of participating hospital ED attendances for any reason; approximately 1.2 million attendances per year. Approximately one third of NSW hospitals participate. These are larger hospitals and represent the major proportion of ED attendances.
Data collection	Data is entered either by clinical staff or clerical staff, “live” or retrospectively depending on the hospital concerned. Data is electronically transmitted from AHS Health Information Exchanges (HIE) to the central state-wide HIE held by the Department on a monthly basis. The Centre for Epidemiology and Research of the NSW Health Department extracts a copy of the EDC from the NSW HIE each month for reporting and research purposes in its own statistical data system, HOIST. The previous month's data are available for analysis 1-3 weeks after the end of that month in both the HIE and HOIST.

Reporting	Data on ED attendances are supplied to NSW Health each month. Information is usually updated on the Internet within 6 weeks of the end of the month. No other regular reporting mechanisms exist.
Access	Applications for data from external agencies should be directed to NSW Health Department Chief Health Officer. Internal enquiries should be directed to the Director of the NSW Health, Information Management & Support Branch. The release of information is subject to the approval of the data custodian. Same day response to requests for data. 2-3 weeks time lag with regard to the currency of the information. If the Cabinet Office had need of a regular, standard report, this can be arranged and automated for collation and release at regular intervals.
Data Uses	The principal diagnosis variable in the EDC can be used to select presentations assigned a principal diagnosis relating to illicit drugs. Time series by year, month, week, day, hour. Sub-group analyses: age, gender, triage category. Coarse analyses only – related groups of diagnoses, large geographic areas (e.g. Sydney, metro/rural), or individual hospital. Data is best aggregated at a state level due to inconsistent coding practices between hospitals, unless looking at a hospital that is geographically close to a phenomenon of interest. For reliable trend information it is best to group presentations by drug type rather than drug-related health problem. Data could be analysed by postcode of residence, but this is probably of limited use for illicit drug reporting. “ Diagnoses are not always completed by some hospitals. Some hospitals use their own local diagnosis classification system that prevents their data being included in analyses based on the standard diagnosis classification used in EDs. (Note: a descriptive 'presenting problem' field is collected at most hospitals, but is not included in the mandatory information provided to the NSW HIE)
Strengths	Provides quick information on hospital activity. Raises questions/hypotheses for further study.
Limitations	The figures reported by the EDC are likely to underestimate the true incidence of drug-related presentations to emergency departments (read following section) and should be considered indicative only. The circumstances of the presentation, such as drunken fighting or being hit by a car while drunk, cannot be determined if the principal diagnosis was an injury code. Furthermore, the accuracy and consistency of the recorded diagnosis is questionable because it is often entered by a variety of Emergency Department staff during the course of their work. This differs from the admitted patient data collection that has diagnoses and external causes entered by trained clinical coders. Furthermore, some emergency departments have their own locally developed diagnosis tables to suit local preferences, which makes it difficult to use their information in combination with information from other hospitals. In addition, the actual diagnosis may not be determined in the emergency department, and therefore may be recorded as a symptom rather than a diagnosis. Some hospitals do not enter diagnoses for every patient, and there are inconsistent diagnosis coding practices between hospitals. For example, in a recent analysis by the Centre for Epidemiology and Research, EDC data from Westmead Hospital, all Wentworth Area hospitals, and the Children’s hospital at Westmead could not be reported because of missing or non-standard diagnosis information.
Future developments	Developing web based reporting of non-fatal overdose events. Have access to ambulance attendances and NCIS data to complement EDC information for reporting. An ICD-10 coding frame has been developed for emergency department reporting, however there is no timeline for ICD-10 implementation.

Reference (s):

Personal correspondence from David Muscatello, Lee Taylor (NSW Health Department Centre for Epidemiology and Research) and Dr Nick Shiraev (NSW Health Department Information Management and Support Branch).

Family Drug Support (FDS) Help Line

Data Custodian	Family Drug Support (FDS).
Purpose	To provide 24-hour telephone support for family members affected by drug issues. Specialise in providing support, information type calls are usually referred on.
Population	Australian residents.
Data items held	<p><i>Caller Information:</i> name, address, postcode, telephone number, gender, relationship of caller to drug user, COB, previous contact, source of referral.</p> <p><i>Drug User Information:</i> living arrangement, age, gender, occupation, crime/dealing, problematic drugs involved, length of drug use, extent of drug use, method of use.</p> <p><i>Call Information:</i> date, time, duration of call, type of call, referral to FDS services, referral to other services. FDS referral field options relating to treatment include referral to: ADIS, drug and alcohol service, hospital and other treatment service.</p> <p><i>Call Analysis:</i> no. of calls, time of day of call, origin of call (telephone exchange), no. successful calls, no. of unsuccessful calls, no. of no answer calls, no. of busy calls, duration of calls.</p>
Data format	Unit of measurement: call; Smallest unit of time: time of day. Coding system used: nil.
Geographic level	National, state, postcode or AHS
Years referenced	Since March 1998.
Sample size	N = 12,233 in 2001 of which 11,511 were information, referral or support (the remaining were nuisance or hang-ups).
Data collection	Continuous. Call record sheet (forced choice fields (tick boxes)) completed by volunteer during call and form is then faxed/mailed to FDS. Data is entered by FDS volunteers. Call analysis reports are received from the telephone carrier monthly.
Reporting	Annual report published by end of August each year. Distributed widely & available to the public. Data feeds into the Illicit Drug Reporting System.
Access	Requests for data to FDS; requests processed within a couple of working days; recent data is available at the level of day of the week; metropolitan (regions) and country.
Data Uses	Number of illicit drug-related calls by drug type and caller and user demographics.
Strengths	Callers are referred to ADIS for available treatment services. Telephone analyser can determine the number of missed calls. Call record sheets have become more specific over the course of the service.
Limitations	Call record sheets completed to varying degrees of accuracy between volunteers; sensitive/confidential information not directly asked for. Accuracy also depends on disclosure and awareness. For example type and extent of drug use is subjective; family members may not be aware of exact drug usage.

Future developments Specialisation of major telephone lines so as to increase utility and efficiency: FDS promoted as a support service, ADIS promoted as an information service and parent line promoted as a counselling service.

Reference(s): Tony Trimmingham (FDS).

Higher Courts Database (HCD)

Data Custodian	NSW Bureau of Crime Statistics and Research (BOCSAR)
Purpose	To identify and record details of criminal matters finalised in the NSW Higher Courts; and to monitor the performance, effectiveness, efficiency and equity of the NSW criminal justice system.
Population	People appearing before the NSW District Court or the NSW Supreme Court for a criminal matter.
Data items held	Type of court; offences charged; outcome of charges; penalty for proven charges; legal representation of defendant; bail status; type of principal offence; type of drug involved in drug offences; defendant characteristics; ATSI status; sex; age; LGA of residence.
Data format	Unit of measurement = finalised court appearances; unit of time = date; ASOC (ABS 1997, Cat. No. 1234.0) used in 2000; previous reporting used ANCO (ABS 1985, Cat. No. 1234.0).
Geographic level	LGA (of residence), location of court.
Years referenced	Current system commenced 1988; previous data is not readily accessible.
Sample size	In 2001, 710 persons appeared and 985 charges were finalised in the Higher Courts for illicit drug offences. In 2000, 688 persons appeared and 911 charges were finalised in the Higher Courts for illicit drug offences.
Data collection	Information for Higher Court matters is entered into the Case Tracking System by District Court Registry staff and then forwarded to BOCSAR.
Reporting	An annual report – New South Wales Criminal Court Statistics - (in calendar years) is released at the end of June every year and can be accessed via the BOCSAR website.
Access	Requests for Higher Court statistics can be made through BOCSAR. BOCSAR can extract specific information according to the request made. Requests for data have a timeframe of 10 days to process although. Cabinet Office data requests, if urgent, would be prioritised and processed as soon as possible (usually within 24 hours). Requests made by non-government agencies may incur a fee.
Data Uses	Number of persons charged with illicit drug offences; outcome of illicit drug charges; penalty for proven illicit drug charges; characteristics of persons for whom illicit drug offences are their principal offence.
Strengths	This database is used to inform on the performance of the Supreme Court and District Court jurisdictions. It provides details of defendants and allows the monitoring of patterns in the administration of justice. It offers an insight into sentencing, conviction rates, bail status and court delay all by offence type. Data is validated and checked for inconsistencies by BOCSAR staff.
Limitations	The database relates to court data and cannot inform on trends or patterns in the level of offending. Offenders not brought before Court are not included in the collection.

The counting units are finalised court appearances. The dataset does not distinguish distinct persons within the counting period. If a person has more than one court appearance during the counting period, such a person will be counted more than once in the report.

Reference (s): Personal communication with Tracy Painting (BOCSAR). Reviewed by Jackie Fitzgerald.

Illicit Drug Reporting System (IDRS)

Data Custodian	National Drug and Alcohol Research Centre (NDARC).
Purpose	Strategic early warning system for emerging illicit drug trends of a local and national concern. It provides a coordinated approach to the monitoring of the price, purity and availability, of the main illicit drug types (i.e., opiates, amphetamine, cannabis and cocaine), with a particular emphasis on injecting drug users in Australian capital cities.
Population	The sample of injecting drug users includes a group of those attending sentinel metropolitan needle and syringe programs or treatment centres over a 2-week period in every state/territory.
Data items held	<p><i>User Survey:</i> demographics, drug use patterns, price purity & availability of drugs, criminal activity, risk-taking behaviour, general health status.</p> <p><i>Key Informant Survey:</i> drug use patterns, drug availability, criminal behaviour, health issues.</p> <p><i>Indicator data:</i> no. enquiries to telephone help lines, drug seizure information (weight, no. & purity)</p>
Data format	Unit of measurement: participant; Smallest unit of time: year. Coding system used: nil.
Geographic level	State/Territory
Years referenced	1996 – 2002. 1996 was the year of the initial pilot; a multisite trial of the IDRS was conducted in 1997. From 2000, the IDRS was conducted in every Australian State and territory.
Sample size	Samples of IDU vary from between 100 to 150 in each jurisdiction.
Data collection	Annual. Data collated from 3 sources: 1. interviews with 100-160 injecting drug users recruited by advertisements & peer referral; 2. telephone interviews with 25-60 key informants (health, community, research, law enforcement, counselling, NSP) in each capital city; and 3. analysis of existing drug-related indicator data (telephone help lines, ABCI seizure data, NDSHS, NSMHW, ANSPS, NHMD, NMD)
Reporting	Brief report released quarterly; annual national publication plus annual publication for each State and Territory released in February for previous calendar year. Early release of results at an annual symposium held in NSW in November.
Access	Technical reports summarising state and national data are available from NDARC on Tel. (02) 9385 0333. Access to data is limited to NDARC researchers working on the project. Each state and territory can use their own data as they wish. Access to national data and jurisdictional data sets remains to be discussed.
Data Uses	Description of drug trends, changes in price, purity and availability of illicit drugs, changes in risk behaviours of illicit drug users.
Strengths	Data is collected in every state and territory in Australia using the same methodology. It serves as a strategic early warning system so emerging drug trends are detected in a timely fashion and issues that require additional research can be

examined. Information from this group of heavy users – IDU – may also indicate emerging trend in illicit drug markets for those who do not inject.

Limitations

Inherent in its function as an early warning system, the design of the study does not allow the results to be utilised as an indicator of illicit drug use and related harms among the general population or regional/rural areas. Uses respondent initiated sampling rather than random sampling. 1996 data available for Sydney only; 1997 data available for Sydney, Melbourne, Adelaide; 1999-2000 IDU survey data available only for Sydney, Melbourne, Adelaide; 2001 data missing for Darwin.

Future developments

A benzodiazepine module was added to the IDRS in five jurisdictions (NSW, VIC, TAS, QLD and NT) in 2002 to monitor the policy change with regards to the prescription of temazepam gel caps. The report will be completed in March 2003.

Reference(s):

Personal communication with Courtney Breen (NDARC).

Illicit Drug Reporting System (IDRS) Party Drugs Module

Data Custodian	National Drug and Alcohol Research Centre (NDARC).
Purpose	Strategic early warning system for emerging illicit drug trends in ecstasy and other party drugs. It provides a coordinated approach to the monitoring of the price, purity and availability, of the party drugs (i.e. ecstasy, amphetamine, cocaine, ketamine and GHB).
Population	Ecstasy users in capital cities of NSW, QLD & SA recruited through advertisement in entertainment magazines and snowballing
Data items held	<p><i>User Survey:</i> demographics, drug use patterns, price purity & availability of drugs, criminal activity, risk-taking behaviour, general health status.</p> <p><i>Informant Survey:</i> drug use patterns, drug availability, criminal behaviour, health issues.</p> <p><i>Indicator data:</i> no. enquiries to telephone help lines, drug seizure information (weight, no. & purity).</p>
Data format	Unit of measurement: participant; Smallest unit of time: 6 months. Coding system used: nil.
Geographic level	Capital city of state
Years referenced	NSW –1997, 2000-2002, Qld 2000-2001, SA 2000-2002
Sample size	Sample size varies from 50 to 163.
Data collection	Annual. Data collated from 3 sources: 1. interviews with party drug users recruited by advertisements & peer referral; 2. telephone interviews with key informants (health, community – including people in entertainment promotion, research, law enforcement, counselling) in each capital city; and 3. analysis of existing drug-related indicator data (telephone help lines, ABCI seizure data, NDSHS, NSMHWA, ANSPS, NHMD, NMD)
Reporting	Annual jurisdictional reports. A feasibility report using data from all three states from 2000-2001.
Access	Technical reports summarising state data are available from NDARC on Tel. (02) 9385 0333. Access to data is limited to NDARC researchers working on the project.
Data Uses	Description of characteristics of party drug users, patterns of use, drug trends, and information on the price, purity and availability of party drugs.
Strengths	Data is collected using the same methodology. Has the ability to detect emerging issues. Provides a timely data collection and is can be used as an early warning system for issues that warrant further investigation.
Limitations	Inherent in its function as an early warning system, the design of the study does not allow the results to be utilised as an indicator of illicit drug use and related harms among the general population or regional/rural areas. The project uses respondent initiated sampling rather than random sampling.

Future developments Continuing in NSW – possible expansion into other jurisdictions dependent on funding.

Reference(s): Personal communication with Courtney Breen (NDARC).

Inmate Health Survey (IHS)

Data Custodian	NSW Corrections Health Service (CHS)
Purpose	Describe the health status of adult inmates, to develop indicators allowing comparisons to be made with the health status of the general population, and to develop health goals and targets for the inmate population based on the findings, identify risk factors associated with poor health status.
Population	Stratified random sample of all NSW prisoners from each of the 27 jails.

Data items held	<p>Demographic details; physical health details; self-assessment of health; chronic diseases; recent symptoms & health complaints; medication; health services utilisation; dental health; hearing test; asthma & lung function; diabetes & blood sugar; infectious diseases; vaccination history; fitness & sun protection; diet & nutrition; men's health; women's health; mental health history; mental health assessment; suicide & self-harm; behavioural risks; sexual health; health service evaluation; comments on health care.</p> <p><i>Behavioural risks:</i> alcohol and drug use. Lifetime prevalence of drug use; prevalence and frequency of drug use in year prior to imprisonment; age first injected drugs; consumption of drugs in prison; lifetime prevalence of IDU in prison; time since last injection; needle & injecting kit sharing practices; injecting for the 1st time in jail; unconsciousness due to drugs; drug use while offending; drug treatment prior and during imprisonment</p> <p><i>Infectious Diseases:</i> hepatitis C/HIV and risk factor of IDU.</p> <p><i>Mental Health:</i> the survey also administered the National Survey of Mental Health and Wellbeing (NSMHWB) to the 2001 participants which can be used to generate ICD 10 and DSM IV diagnoses, including substance used and substance dependence diagnoses.</p>
Data format	Unit of measurement = person, unit of time = every 5 years, coding system used = nil.
Geographic level	ASGC statistical divisions.
Years referenced	1996 & 2001.
Sample size	In 1996, N = 789 (657 males and 132 females) out of approximately 6000 males and 300 females. In 2001, N = 914 (747 males and 167 females).

Data collection	Face to face interview using a standardised questionnaire covering physical and mental health issues administered by CHS nurses. Data entered by external data entry concern using punch and verify methods; cleaned by CHS Research Unit staff.
Reporting	A summary of the 1996 survey's findings has been published and is available on the NSW CHS website. Detailed analysis of the 1996 survey has occurred through the publication of a number of journal articles. The 2001 report is currently being written.
Access	Applications for data should be directed to the Chief Executive Officer, NSW Corrections Health Service.

Data Uses	Lifetime prevalence of illicit drug use; prevalence of illicit drug use in prison; frequency of illicit drug use; availability of drugs in prison; IDU history; needle sharing practices; Hep C; offences & treatment.
Strengths	Data is collected using a random sample of prisoners and includes inmates from all NSW correctional centres. Use of interviewers with extensive experience of working with prisoners helps to ensure that the data are reliable. The survey is conducted by health staff rather than the custodial authorities which is likely to ensure reliable responses i.e. there is no fear of repercussions from reporting drug use, particularly in prison.
Limitations	Illicit drug use may be underreported in an open interview. As with all surveys which collect data on illegal activities (i.e. drug use in both the community and prison) it is likely that the estimates under-report the true prevalence.
Future developments	The next survey will be conducted in 2006.
Reference(s):	Tony Butler (CHS).

Inpatient Statistics Collection (ISC)

Data Custodian	NSW Health, Information Management and Support Branch.
Purpose	The collection is primarily used by the NSW Health Department, Area Health Services and Hospitals to: monitor health and health service trends; allocate resources fairly across the State; monitor the performance of hospitals against benchmarks; plan for specialty services; review demand for services by population groups and location; determine the appropriate distribution of services within an area; monitor hospital utilisation; medical and epidemiological research; report to National Minimum Data Sets.
Population	The Inpatient Statistics Collection is a continuous collection of all admitted patient services provided by New South Wales Public Hospitals, Public Psychiatric Hospitals, Public Multi-Purpose Services, Private Hospitals, and Private Day Procedures Centres.
Data items held	<p><i>Patient Details:</i> identifier, name, street address, suburb, postcode, date of birth, sex, country of birth, language spoken at home, indigenous origin, marital status, health insurance status & details, legal status, payment status on separation, financial program on separation, dva card type and number.</p> <p><i>Episode Details:</i> admission time, date & status, readmission within 28 days, source of referral, discharge intention, facility transferred from, service unit type on admission, ambulance client number, separation time & date, hours in intensive care unit, leave days, number of leave periods, facility transferred to, referred to on separation, total involuntary days under mental health act, DRG – mental health legal status, total hours on mechanical ventilation, private health insurance claim, service category.</p> <p><i>Clinical details:</i> principal diagnosis (& 19 additional diagnoses), first listed procedure, date and location (& 19 additional procedures), unplanned visit to theatre, palliative care status, external cause of injury or poisoning, place of occurrence and activity when injured (& 2 additional causes).</p> <p><i>Psychiatric:</i> first admission to designated psychiatric unit, last year admitted to a designated psychiatric unit, days accommodated in a designated psychiatric unit, type of usual accommodation.</p> <p><i>Neonate:</i> admission weight, unqualified bed days</p>
Data format	Unit of measurement: treatment episode &/or patient. Unit of time: time of day. Coding system used for clinical diagnoses: International Classification of Diseases, 9th revision, clinical modification (ICD-9-CM) from 1 July 1978 to 30 June 1998. ICD, 10th revision, Australian modification (10-AM) from 1 July 1998 to present.
Geographic level	SLA (patient address stored but released below postcode level).
Years referenced	Since July 1993. Since July 1996 for the current Health Information Exchange (HIE) system; July 1993 – June 1996 for the previous ISC online system. There are data going back to the late 1970s in various media.
Sample size	Total records in ISC for 1999/2000: 1,944,095. Total illicit drug related for 1999/2000: 474.

Data collection	Data is continuously entered into patient administration system at each hospital which in turn electronically transfers the information to the AHS HIE on a regular basis which is in turn regularly transferred to the NSW Health Department HIE.
Reporting	No regular reporting mechanisms currently exist.
Access	Applications for data from external agencies should be directed to NSW Health Department Chief Health Officer. NSW Health offers a consultancy service managed by the Information Dissemination and Analysis Unit for admitted patient information requirements that are not served by published information. The consultancy service may involve a charge depending upon the size and nature of the request. Requests for unpublished data from outside the NSW Health system must be fully justified and approved by an ethics committee before information can be released. Annual data is released 6 to 9 months after the end of the year depending upon the nature of the request for release.
Data uses	Number of illicit drug-related inpatient hospital separations in NSW by breakdowns (such as age, sex, geography, etc).
Strengths	Reliability is high because of the editing of data and the use of clinical coders. Nil missing data.
Limitations	<p>There are several potential confounds illicit drug-related data from ISC:</p> <p>(1) Data is limited to what is reported in medical records, that is, data depends on accurate and complete recording by clinicians;</p> <p>(2) Data is coded using ICD-10-AM (and ICD-9-CM for earlier years) which has inherent limitations: the main ones being that ICD-10-AM does not focus on the identity of the drug(s) involved, rather on the circumstance of morbidity such as poisoning or mental & behavioural disorders due to drug use; ICD codes are limited by their lack of specificity for illicit drugs (e.g. ICD-10-AM is unable to distinguish between amphetamines, ecstasy and emerging drugs such as ketamine & GHB)</p> <p>(3) Data only relate to inpatients and as a result are likely to underestimate the number of acute illicit drug-related morbidities requiring treatment since the majority of these types of cases will be treated within accident and emergency departments;</p> <p>(4) A record is included for each separation, not for each patient, so patients who separate more than once have more than one record in the database; and</p> <p>(5) The actual health data definitions used by data providers may vary from year to year and between and sectors.</p>
Future developments	The ISC is a dynamic data collection and changes are made on a frequent basis to meet government requirements and the needs of users.
Reference(s):	Personal correspondence with John Agland (NSW Health).

Kids Help Line (KHL)

Data Custodian	Kids Help Line (KHL).
Purpose	KHL is a national telephone counselling service for young people aged 5 to 18 years. The Kids Help Line data is used for a wide variety of purposes such as: provides the basis for Kids Help Line's research agenda and advocacy platform; highlights possible gaps in service provision; provides valuable information for policy development across both government and non-government areas; used in planning and targeting of resources.
Population	KHL client group is 5 to 18 year olds. However, all calls that are received are recorded, therefore the dataset includes younger children and some adults.

Data items held	Transaction number, date call was received, start time of call, clients name/alias, city client is calling from, clients postcode location, regional classification system, gender of caller, age of caller, where client is calling from, where did the client hear about KHL, school status, ethnic background, who client is living with, how long the client has been living with, parental status, clients source of income, clients call sequence, agency client was referred to, number of minutes spent talking to the client, problem class, main reason client called, problem severity, secondary reason client called, problem severity of 2nd problem, counsellor code, state client is calling from. Note. KHL referral options are automatically generated after selecting the appropriate option in the database. All of these telephone services search for referral options via agency databases.
Data format	Data is stored on a call by call basis. Each call receives a unique identifier (i.e. transaction number) to maintain database integrity.
Geographic level	Postcode.
Years referenced	Since 1991.
Sample size	10,000 units of drug and alcohol related text between 1994 and 2001.

Data collection	Each counsellor has a personal computer at their desk. Data entry is conducted by counsellors electronically via their PC at the time of the call or immediately afterwards. Data cleaning and screening is conducted twice yearly.
Reporting	Major data analyses are conducted in January each year reporting on the previous calendar year. Analysed data is released in the form of national and state based reports which are released before the end of January each calendar year.
Access	Access to KHL raw data is limited to KHL research staff and senior management. Response times for data requests vary according to the complexity of the request. A simple request (such as the breakdown of the types of calls for an area) can be turned around within 48 hours. Two page reports can be completed within one to two weeks. Timelines for major reports require negotiation. KHL will conduct both the quantitative and qualitative analysis on a consultancy basis.
Data Uses	Data can be used to monitor the proportion of drug and alcohol related calls state-wide and on a region by region basis. Analysis of drug and alcohol calls by demographic data, nature of drug and alcohol calls (broken down into 5 severities) and drug type.

Strengths	Anonymous statistical information is collated which is invaluable for research into youth problems and needs throughout Australia. KHL receives 1.2 million attempts to access the service nationally every year. Almost 1,000 of these calls are from NSW young people with concerns about drug and alcohol use. Data is cleaned and screened prior to use – the integrity of the data is extremely high.
Limitations	Problem classification includes a category for drug use which refers to nicotine, prescription or illegal drugs. Then drug type is entered as free text and not offered to the telephone counsellor. Therefore the extraction of data is resource extensive since thematic programs and double checking (misspelling) needs to be done to ensure all appropriate data is extracted. As data collection is opportunistic, it is not possible for all data fields to be completed. For example, postcode is logged in 12% of calls and in 39% of counselling calls. State is logged in 36% of calls and 97% of counselling calls.
Future developments	Incoming calls are identified as coming from one of 39 geographical regions (vectors) across Australia. Vectors are largely based on telephone number area codes. This field was included in May 2002 – currently there is insufficient data to report on logging rate.
Reference(s):	Personal communication with Ian Thomas (KHL).

Local Courts Database (LCD)

Data Custodian	NSW Bureau of Crime Statistics and Research (BOCSAR)
Purpose	To identify and record details of criminal matters finalised in the NSW Local Criminal Courts; and to monitor the performance, effectiveness, efficiency and equity of the NSW criminal justice system.
Population	People appearing before the NSW Local Court for a criminal matter.
Data items held	Local Court; offences charged; outcome of charges; penalty for proven charges; legal representation of defendant; bail status; type of principal offence; type of drug involved in drug offences; ATSI status; sex; age; LGA of residence.
Data format	Unit of measurement = finalised court appearances; unit of time = date; ASOC (ABS 1997, Cat. No. 1234.0) used in 2000; previous reporting used ANCO (ABS 1985, Cat. No. 1234.0).
Geographic level	LGA (of residence), local court.
Years referenced	Current system commenced 1990; previous data is not readily accessible.
Sample size	In 2001, 11,370 persons appeared and 15,561 charges were finalised in the Local Courts for illicit drug offences. In 2000, 11,228 persons appeared and 15,229 charges were finalised in the Higher Courts for illicit drug offences.
Data collection	Information for Local Court matters is entered onto the General Local Courts (GLC) computer system or provided by the Clerks of the Court who complete coding forms for each person appearing before court which are then forwarded to BOCSAR.
Reporting	An annual report – New South Wales Criminal Court Statistics - (in calendar years) is released at the end of July every year and can be accessed via the BOCSAR website.
Access	Requests for Local Court statistics can be made through BOCSAR. BOCSAR can extract specific information according to the request made. Requests for data have a timeframe of 10 days to process. Cabinet Office data requests, if urgent, would be prioritised and processed as soon as possible (usually within 24 hours). Requests made by non-government agencies may incur a fee.
Data Uses	Number of persons charged with an illicit drug offence; outcome of illicit drug charges; penalty imposed for proven illicit drug charges; type of principal offence; characteristics or persons convicted of illicit drug offences.
Strengths	The vast majority of criminal matters in NSW are heard in the Local Court. This database is used to inform on the performance of the jurisdiction, give details of defendants and monitor patterns in the administration of justice. It offers an insight into sentencing, conviction rates, bail status and court delay all by offence type. Data is validated and checked for inconsistencies by BOCSAR staff.
Limitations	The database relates to court data and cannot inform on trends or patterns in the level of offending. Offenders not brought before Court are not included in the collection. Thus persons who are diverted from court by way of a caution or warning are not included in these data.

The counting units are finalised court appearances. The dataset does not distinguish distinct persons within the counting period. If a person has more than one court appearance during the counting period, such a person will be counted more than once in the report.

Future developments n/a.

Reference (s): Personal communication with Tracy Painting (BOCSAR). Reviewed by Jackie Fitzgerald

Magistrates Early Referral Into Treatment (MERIT)

Data Custodian	NSW Health Department, Drug Programs Bureau (DPB).
Purpose	To maintain a client database of referrals to the MERIT program for program monitoring, mandatory reporting and operational purposes. MERIT is a pre-plea drug court diversion program targeting offenders with a drug problem.
Population	Clients of the NSW MERIT program (to be operating in all AHS by June 2003). To be eligible for MERIT the accused must have a demonstratable drug problem, be willing to participate in the program and reside in the catchment area. The scheme is voluntary and restricted to adult offenders. Defendants with serious violent or sexual offences or indictable drug offences are excluded from the scheme.

Data items held	NSW Minimum Dataset for Alcohol and other Drug Treatment Services: all data items in this dataset are held in the MERIT Data Collection.
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Criminal justice data items: charge type, client final plea, court location, current court orders, date of court appearances, date of finding of court, date of initial court appearance, date of last conviction, date of most serious charge, date of most serious offence, date of program entry by court, date of referral to MERIT, drug quantity for drug-related charge, drug type relating to drug-related offence, finding of court, notes (court appearances), notes (sentence outcomes), past convictions (number), periodic detention, postcode of most serious offence, probation/parole service ID, report type, sentence outcomes, served time in gaol, source of referral, suburb of most serious offence, total adult time served in gaol, unique identifier (CNI).

MERIT Team data items: Additional services purchased, additional services purchased (cost), administrative notes, case management issues, case worker name, client address, client name, client phone number (s), client postcode, client suburb, date of MERIT assessment outcome, date of MERIT eligibility screen, date of transfer from another MERIT team, date of transfer to another MERIT team, emergency contact name, emergency contact phone number, emergency contact address, emergency contact relationship, drug – frequency of use, highest level of education, drug – length of use (years), marital status, medicare number, MERIT establishment ID – transferred from, MERIT establishment ID – transferred to, MERIT program episode number, MERIT team suitability outcome, MERIT team eligibility screen outcome, message OK, number of children, number of dependants, number of others residing with client, drug – pattern of use, program entry status, program exit date, program exit status, reason non-acceptance into MERIT, referral contact – name, referral contact – phone number.

External agency treatment: D&A non-residential treatment (type of treatment, provided during MERIT, continued at MERIT program exit), D&A residential treatment (type of treatment, provided during MERIT – agency name, provided during MERIT – date of commencement, provided during MERIT – date of cessation, provided during MERIT – MERIT bed, continued at MERIT program exit), Other Health non D&A treatment (type of treatment, provided during MERIT), Other non-health service (type of treatment, provided during MERIT), Pharmacotherapy treatment (type of treatment, provided at MERIT program entry, initiated or modified during MERIT, continued at MERIT program exit).

Diagnostic tests: Drink check score, DSM IV, GHQ 28, ICD10, RCQ, Other diagnostic test, Urinalysis.

Data format	Unit of measurement: Treatment episode, smallest unit of time: 1 day, coding system used: conforms to National Health Data Dictionary codes, ABS codes, Australian Standard Offence Classification codes and Local Courts Data Dictionary codes.
Geographic level	AHS (treatment), postcode (offence), SLA (treatment)
Years referenced	Since July 2000 (commencement of program).
Sample size	(As At 30/06/02): 997 referrals into MERIT, 638 accepted into MERIT program for all MERIT programs operating in NSW.
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Data collection	Data is entered daily or as appropriate. Data is collected from: client assessment proforma, case notes, police and court documents. The data is entered by data administration officer.
Reporting	Statistical reports are issued on a quarterly basis which involve a series of quarterly descriptive profiles of participants, measuring the intake rate and monitoring the performance of participants in the program. Miscellaneous statistics are also issued on an ad-hoc basis. These paper reports are all released internally. Data is fed into other reporting systems such as the NSW Minimum Dataset for Alcohol and Other Drugs and to be fed into the COAG Court Diversion Dataset which has not been implemented yet.
Access	Applications for data from external agencies should be directed to NSW Health Department Chief Health Officer. Internal enquiries should be directed to NSW Health, DPB. There is no cost associated with requests for data.
Data Uses	Variables relating to program entry (e.g. referral characteristics including referring offence and problem drugs; referral sources), progress on program (e.g. graduated/breached/removed, external health services received, time on program); court-related information (e.g. sentence outcomes); reoffending whilst on program and post-program.
Strengths	A quality assurance process is in place whereby the data is scrutinised for outliers, missing elements, validity and logic. Collection of large amount of client related information (> 100 variables) on a relational database enables complex data manipulation. Data is of a high quality.
Limitations	Much of the data is self-report. It relies on correct reporting/recording by clinicians. Collection is limited to MERIT referrals in the local area. Restricted information available only on clients not accepted into the program. MERIT is likely to capture only a small proportion of the population using illicit drugs.
Future developments	The MERIT program is presently being rolled out to sites in all health areas in NSW and the MIMS database is being implemented in them as each site becomes operational. This will allow for the collection and comparative analysis of state-wide MERIT program data. It is planned that all remaining AHS (South Eastern Sydney, Central Sydney, Wentworth, Southern, New England, Western Sydney and Far West) will be operational during the course of the 2002/03 financial year. As a result data from these sites will not be available until 2003. The dataset will allow for the reporting of COAG diversion data. The content and functionality of the database are being reviewed for enhancement.
Reference(s):	<ol style="list-style-type: none"> 1. Magistrates Early Referral into Treatment (MERIT) Program. Data Dictionary and Collection Guidelines. NSW Department of Health, 2002. 2. COAG Diversion Dataset (in preparation).
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3. 'MERIT', A Cooperative Approach Addressing Drug Addiction and Recidivism.
J. Scantleton, J. Linden, B. Boulton & P. Didcott. 2nd Australasian Conference on
Drugs Strategy, Perth 2002.

Methadone/Buprenorphine Client Statistics (MCS)

Data Custodian	Commonwealth Department of Health and Ageing (DHAC).
Purpose	General monitoring of the number of clients in methadone or buprenorphine treatment
Population	Clients registered with public and private prescribers and correctional institutions in each state and territory.
Data items held	<p>Number of clients registered with public and private prescribers and correctional institutions in each state/territory; number of clients collecting doses at pharmacies, public clinics, private clinics, correctional facilities or other facilities in each state & territory. Prior to 1999, only client numbers in public clinics and private clinics in each state & territory.</p> <p>Since 2001, statistics for buprenorphine clients have also been collected.</p>
Data format	Unit of measurement: client; unit of time = date, internal coding system used.
Lowest geographic level	State
Years referenced	Since 1986.
Size of sample	<p>In 2001, total no. of clients registered nationally for methadone & buprenorphine as at 30 June = 32,516.</p> <p>In 2001, total no. of clients registered in NSW for methadone & buprenorphine as at 30 June = 15,069.</p>
Data collection	The states and territories provide their local data to the DHAC in October each year.
Reporting	State and territory data is collated and provided back to the Methadone and Other Treatment Subcommittee in November each year. Data is reported for each financial year. Data on methadone clients is not regularly published.
Access	External agencies can request data from DHAC. There are no restrictions or costs associated with requests for data.
Data uses	Number of patients registered to methadone maintenance and buprenorphine treatment.
Strengths	Reflects the number of clients who are registered with a prescriber, and who are collecting doses of both buprenorphine and methadone, nationally. For some states, this can be broken down separately into buprenorphine and methadone clients.
Limitations	National Statistics cannot be broken down separately into buprenorphine and methadone statistics, as some States do not separate their collection. No client details are recorded.
Future developments	n/a.
Reference (s):	Personal communication with Sonya Jackson (DHAC).

National Ambulance Non-fatal Opioid Overdoses	
Data Custodian	Turning Point Drug and Alcohol Centre.
Purpose	To provide a national compilation of the prevalence, patterns and characteristics of ambulance attendances at opioid overdose events.
Population	Clients who receive assistance from jurisdictional Ambulance Services relating to opioid overdose.
Data items held	<p><i>Patient Details:</i> age, sex.</p> <p><i>Episode Details:</i> Postcode, date & time of attendance, transportation details.</p> <p><i>Clinical details:</i> narcotic overdose markers (including whether naloxone was administered), Glasgow Coma Score – 1st - last.</p>
Data format	Unit of measurement = ambulance attendance; unit of time = time of day; coding system used = internal.
Geographic level	Postcode of attendance.
Years referenced	Since 1998.
Sample size	No. of ambulance attendances for non-fatal opioid overdoses in Australia in 2000: approx 9500.
Data collection	Continuous. Collected through various systems of computerisation of ambulance patient care records operational in various jurisdictions. Variable reliability dependent upon data under consideration and jurisdiction.
Reporting	First presentation at APSAD conference in November – quarterly bulletins from this time.
Access	Unit record access restricted to project investigators – report dissemination strategy to be determined.
Data uses	Number of ambulance attendances at non-fatal opioid (in particular heroin) overdoses. Breakdowns of interest include: national, state, date, age, sex and postcode.
Strengths	Information is collected in an ongoing manner and has some reliability in capturing opioid overdose and heroin overdose in particular (dependent upon jurisdiction). Numbers are sufficient to be of use in local-area level analysis in contrast to other secondary data sources.
Limitations	Jurisdictional differences in management, treatment and recording of opioid overdose mean that interpretation of differences across jurisdictions is difficult. For example, hospitalisation rates are much higher in SA compared to NSW but non-hospitalised cases are not recorded in the SA dataset. Further co-ordination of data collection across different jurisdiction poses logistic difficulties.
Future developments	Development and implementation of standardised data collection and reporting frameworks.
Reference	Personal communication with Paul Dietze (Turning Point Drug & Alcohol Centre).

National Coroners Information System (NCIS)

Data Custodian	<p>Monash University National Centre for Coronial Information (MUNCCI).</p> <p>MUNCCI is a consortium of three Monash University bodies. The consortium is comprised of the Victorian Institute of Forensic Medicine (VIFM); Monash University Department of Epidemiology and Preventative Medicine; and the Monash University Accident Research Centre (MUARC). VIFM is the leading consortium member and MUNCCI is co-located within the Institute.</p>
Purpose	<p>The NCIS is a valuable hazard identification system and research tool for government agencies and researchers with a role or interest in public health and safety, death and injury surveillance and policy development. The NCIS is also designed to facilitate the role of coroners across Australia in obtaining more timely and efficient access to coronial data and it is hoped that it will contribute to a reduction in preventable death and injury in Australia. The drugs module contains information on deaths related to alcohol, illicit drugs, pharmaceuticals and other poisons.</p>
Sample	<p>All coronial cases in Australia from July 2000 to the present, except for Queensland cases, which commenced being uploaded to the NCIS in January 2001.</p> <p>A coronial case is one in which the death has been sudden and unexpected, or violent and unnatural. This includes all suicides, homicides, traffic fatalities, work place fatalities, sporting fatalities, product related fatal injuries, drownings & adverse events in hospitals.</p>
Data items held	<p>Name; date of notification of death; age; sex; date of birth; place of residence; place of usual residence; period of residence in Australia; country of birth; employment status; usual occupation; work-related incident; occupation at the time; industry; marital status; indigenous identification; time/location of incident; activity at the time of incident; police narrative of circumstances; intent (both suspected at time of death & final); mechanism of injury (primary, secondary & tertiary); object or substance involved (primary, secondary & tertiary); cause of death (primary, secondary & tertiary); where the death is related to a motor vehicle accident (vehicle type, driver/passenger, context); ICD-10 cause of death codes (yet to be provided by the ABS); key reports include (pathology report, toxicology report & finding).</p>
Data format	<p>Unit of measurement = coronial case; unit of time = time of day; coding system used = MUNCCI has fostered a reciprocal arrangement with the ABS Cause of Death Unit who are currently utilising NCIS data, to aid the coding of their records. In return ABS will code cause of death, location and activity for NCIS using the ICD-10 clinical classification. In a similar arrangement NOHSC has already commenced coding occupation at time of death and industry at time of death for work related deaths on the NCIS.</p>
Geographic level	<p>National, State/Territory, Suburb, postcode and street address</p>
Sample size	<p>Total sample for Australia as at 30th June 2002 = 36,378 Total alcohol and drug-related (including illicit and pharmaceutical drugs) sample for Australia as at 30th June 2002 = 1816. Total sample for NSW as at 30th June 2002 = 11,885. Total alcohol and drug-related (including illicit and pharmaceutical drugs) sample for NSW as at 30th June 2002 = 666</p>
Years referenced	<p>The NCIS has a complete dataset from participating jurisdictions from 1st July 2000 for states and territories except QLD where data commenced from 1st January 2001</p>

for QLD. Access to the Queensland data is presently not available to users, as the License Agreement permitting MUNCCI to release the data is in the process of being finalised.

Data collection	The database is maintained at a central location at MUNCCI. Data entry is undertaken locally by coronial clerks in each of the Coroners' Offices across Australia and the data is then up-loaded to the NCIS on a regular basis.
Availability	Data retrieval is via the internet with a high level of security to prevent unauthorised access. Payment of a fee entitles authorised applicants to receive a CD-Rom containing sub-sets of raw data available on the NCIS and extracted according to criteria specified by the applicant.
Access	Access is restricted to individuals or organisations with a legitimate interest in public health and safety research and/or policy development (such as coronial death investigation users, researchers, policy makers & medical scientific community). Access needs to be approved by the MUNCCI Research Committee and the Standing Committee on Ethics in Research Involving Humans (SCERH) Monash University. State coronial ethics committees may also be involved in applications for access. It is likely that from 1 st July 2002 MUNCCI will be required to manage access to the NCIS on a fee for service basis.
Data Uses	Number of drug and alcohol related deaths with possible breakdowns including: place of incident, time of incident, day of week, suburb, age, sex, ATSI status, type of death, significance of drug & cause of death which includes drugs contributing to death. The NCIS contains an object category which can be searched, namely "Drugs" (including alcohol and pharmaceuticals), which is further broken down into sub-categories: alcohol, amphetamine, cannabis, heroin, methadone, other specified (including multiple substances) and unspecified drugs (including alcohol and pharmaceuticals).
Strengths	NCIS is a world first electronic national database for coronial information. It has the potential to enhance the amount, consistency, accessibility and timeliness of data available on the role of drugs in coronial deaths in Australia. The NCIS Drugs module is able to identify key risk factors and monitor outcomes which will contribute to the reduction in preventable deaths and making better health care decisions. A comprehensive quality assurance (QA) program, undertaken by the QA officer, is in place with three areas of focus: completeness, timeliness and validity and reliability.
Limitations	As data is uploaded to the NCIS following local entry from each of the eight jurisdictions in Australia, there are occasional instances of coding errors, missing fields and documents not being attached to records. Quality assurance however, is a primary focus for MUNCCI. A dedicated Quality Assurance Officer, with considerable coding experience in a health environment has been seconded to MUNCCI and is implementing the NCIS QA plan. Furthermore, a MUNCCI Senior Project Officer has commenced visiting the coronial offices of each state and territory with the aim of identifying and resolving problems in the jurisdictions.
Future developments	Data to be upgraded on a daily basis from each jurisdiction. ICD-10 codes to be added from ABS. Proposal to implement a National Standard Police form for reporting of coronial deaths, which includes a section regarding deaths from drugs, alcohol and poisons. Addition of new fields to the NCIS, following the

introduction of the standard police form. MUNCII will formulate a user pays system for access to NCIS by the end of 2002.

Reference(s): Personal communication with Kerryn Mulvenna (NCIS).

National Deaths in Custody Program (NDICP)

Data Custodian	Australian Institute of Criminology (AIC).
Purpose	The examination of long-term trends and patterns in custodial deaths in Australia and changes that occur over time. Findings impact on procedures for holding persons in custody.
Population	Deaths in prison, police custody and juvenile detention in Australia.
Data items held	Location of death; age of deceased; cause and manner of death; legal status; most serious offence; indigenous status, gender etc. Collects information on approximately 40 different variables
Data format	Unit of measurement = case; unit of time = time of day; coding system used = internal.
Geographic level	State and location of death.
Years referenced	Since 1980 (ongoing monitoring program).
Sample size	In 2001, No. of illicit drug overdose deaths in Australian adult correctional centres = 0. In 2001, No. of illicit drug overdose deaths in NSW adult correctional centres = 0. In 2001, No. of illicit drug overdose deaths in Australian juvenile detention centres = 0. In 2001, No. of illicit drug overdose deaths in NSW juvenile detention centres = 0.
Data collection	Data is collected and organised on an annual basis from prison, police and juvenile justice records, and Coronial Inquests, toxicology and pathology reports from the National Coronial Information System.
Reporting	Publishes annual report (for example – Deaths in custody in Australia: 2001 National Deaths in Custody Program (NDICP) annual report) other documents and conference papers which are available from the AIC website: http://www.aic.gov.au/research/dic/publications.html . Data collection begins in January and published information is usually released mid-year. Data is reported on a calendar year basis.
Access	The NDICP publishes general information on an annual basis and occasionally thematic papers are also produced. These papers are readily accessible to all. Data requests for more specific information from stakeholders are accepted. The stakeholders are the Police/Corrections/Juvenile Justice contacts from every State/Territory that provide the NDICP with information regarding individual deaths in that jurisdiction. Similar requests are accepted from other Government organisations.
Data Uses	National and state breakdowns on the numbers of illicit drug overdose deaths in adult correctional centres and juvenile detention centres and the patterns and trends observed with these deaths in custody.
Strengths	Provides comprehensive and authoritative data on all Australian deaths in custody. The provision of timely and accurate information is essential in assisting stakeholders to identify shifts in "at risk" populations and to monitor the effects of changes in policy and operational standards. The NDICP plays an important role in the monitoring, research and dissemination of information on deaths in custody

and is thought to be the only such program in the world. Very reliable, since information is taken from a number of government and criminal justice/court sources and cross checked. Only such monitoring program on deaths in custody in Australia.

Limitations

There are very few deaths in custody that are directly attributable to illicit drug use in Australia. Even though we hold long-term trend data the figures may be too small to make any assumptions based on these figures. In addition, there is missing data; however the most important variables (e.g. ATSI status and cause of death) are nearly always obtained).

Future developments

Improve information on drug/alcohol involvement (as a cause of death and an individual's history with substance use/abuse) and other such 'personal history' data. Continuous quality checks and retrospective changes are made when new or more reliable information comes to hand.

Reference (s):

Personal communication with Lisa Collins (AIC).

National Drug Strategy Household Survey (NDSHS)

Data Custodian	Commonwealth Department of Health and Ageing (DHAC) and Australian Institute of Health and Welfare (AIHW).
Purpose	The aim of the series of surveys has been to monitor and evaluate issues relevant to the National Drug Strategic Framework, formerly called the National Drug Strategy and before that the National Campaign Against Drug Abuse. That is, to monitor the public's awareness, experience of, attitudes and behaviours relating toward drug use.
Population	National random selection of people aged 14 years and over. Households were selected by a multi-stage, stratified areas sample design. A supplementary sample of ATSI peoples was included in 1994.

Data items held	<p><i>Socio-demographic Information:</i> sex, age, marital status, education, country of birth, languages spoken, income, and employment status.</p> <p><i>Drug Information:</i> AOD-related attitudes, awareness, knowledge & behaviour; age of first use, place of use, form and amount of use (2001), where the drug was obtained, prevalence of use among friends, days lost from work or education because of drug use and health problems experienced, perceptions of problems associated with drug use, attitudes towards changes to regulations related to the use of drugs and treatments available.</p>
Data format	Unit of measurement: participant; unit of time = approximately triennial, internal coding system used.
Geographic level	National, State/Territory and part of state
Years referenced	1985, 1988, 1991, 1993, 1995, 1998, and 2001.
Sample size	In 1985, N = 2,791; in 1988, N = 2,255, in 1991, N = 2,850; in 1993, N = 3,500; in 1995 N = 3,850; in 1998, N = 10,030; in 2001, N = 26,744.

Data collection	Approximately triennial. 1985 – Face to face (i.e. personal interview) technique. 1988 – Face to face and self completion component for more sensitive issues. 1991 – Face to face and self completion component for more sensitive issues. 1993 – Face to face and self completion component for more sensitive issues. 1995 – Face to face and self completion component for more sensitive issues. 1998 – Three collection modes: (i) Face to face and self completion component for more sensitive issues; (ii) self-completion by youngest [other] person in household aged 14 years or over; (iii) self-completion by drop-and-collect method. 2001 – Three collection modes (i) Face to face and self completion component for more sensitive issues; (ii) self-completion by drop-and-collect method; (iii) introduced computer assisted telephone interview (CATI). Data is entered and checked by staff at market research company, with further checking and analysis by the data custodians
Reporting	National and State/Territory results published approximately 12 months following end of data collection period; available in hard copy, or from the AIHW website.
Access	Unit record data is available by application to the Social Science Data Archives (SSDA) at the Australian National University.

Data Uses	Trends in prevalence, patterns and attitudes relating to illicit drug use. The five surveys from 1993 to 2001 have comparable questions pertaining to illicit drug use.
Strengths	Provides comprehensive national overview of perceptions, attitudes and behaviours relating to illicit drug use. Allows for the monitoring of prevalence of illicit drug use over time. Multistage editing and weighting procedures were utilised to increase the reliability of responses.
Limitations	The exclusion of persons from dwellings and institutional settings and the difficulty in reaching marginalised persons, are likely to have affected estimates. It is known from past studies of alcohol and tobacco that respondents tend to underestimate actual consumption levels. Dependant users may be underrepresented as their lifestyle makes them less likely to be part of the conventional household targeted by this survey and because they are concentrated in a small number of geographic areas where drugs are readily available. The random methodology of all surveys tend to be compatible. However, the possibility that systematic biases have been introduced due to changes in sampling methodology cannot be dismissed. There was also a change in the wording of questions used to determine 'ever use' of illicit drugs. From 1985 to 1998 the questions were in the form 'ever tried' whereas in 2001 the questions were in the form 'ever used'. The use of comprehensive logic and edit checks in the 1998 and 2001 surveys (used to increase the reliability of estimates of ever use of drugs) may have produced marginally higher estimates when compared with the earlier surveys. Sample size in earlier surveys too small to provide reliable data at sub-state level.. Response rate in 2001 survey was approximately 50%.
Future developments	n/a.
References:	Personal correspondence with Mark Cooper-Stanbury (AIHW). 2001 National Drug Strategy Household Survey: First results. Canberra: AIHW. Roy Morgan Research 2002: 2001 National Drug Strategy Household Survey: Final technical report. Melbourne: Roy Morgan Research.

National HIV Database

Data Custodian	National Centre for HIV Epidemiology and Clinical Research (NCHECR).
Purpose	To monitor the pattern of HIV transmission in Australia through national surveillance for newly diagnosed HIV infection in Australia, including cases of newly acquired HIV infection. Newly acquired HIV infection is defined as newly diagnosed HIV infection with evidence of a negative or indeterminate HIV antibody test result, or a diagnosis of HIV seroconversion illness, within one year of HIV diagnosis. Newly diagnosed HIV infection is a notifiable condition in all State/Territory health jurisdictions in Australia.
Sample	All cases of newly diagnosed and acquired HIV infection in Australia.
Data items held	State/Territory of diagnosis; name code (based on the first two letters of the family name and the first two letters of the given name); sex; date of birth; Indigenous status; date of HIV diagnosis; CD4+ cell count at diagnosis; source of exposure to HIV and evidence of newly acquired HIV infection.
Data format	Unit of measurement = case number (client/patient); unit of time = month; no clinical diagnostic coding system used.
Geographic level	State, postcode.
Years referenced	1985 – 2001.
Sample size	In 2001, no. of newly diagnosed HIV Infections in Australia = 777; % attributable to a history of IDU = 5.5%. In 2001, no. with newly acquired HIV infection in Australia = 202; % attributable to IDU = 3.5%. In 2001, No. of newly diagnosed HIV infections in NSW = 370, no. with newly acquired HIV infection in NSW = 99.
Data collection	Cases of newly diagnosed HIV infection are notified on a monthly basis through State/Territory health authorities to the NCHECR on the first occasion of diagnosis in Australia.
Reporting	HIV data is published in quarterly – <i>Australian HIV Surveillance Report</i> – and annual reports - <i>HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report</i> - both of which are available on the internet at http://www.med.unsw.edu.au/nchechr/ .
Access	National data is available upon request through the Head of the Surveillance Program. State/Territory data is best accessed via the relevant health authority as NCHECR need permission from the State/Territory body to release their data.
Data Uses	The number of HIV notifications by exposure category (injecting drug user – approximately 3.3% of newly acquired HIV infection between 1997-2001 was attributable to a history of injecting drug use, however HIV transmission continues to predominantly occur among homosexually active men).
Strengths	The national HIV surveillance system provides information on more recent patterns of HIV transmission than does the national AIDS surveillance and hence, provides useful information for developing and evaluating HIV prevention programs.

Limitations	HIV notifications are based on voluntary testing and therefore represent a biased sample.
Future developments	n/a
Reference(s):	Personal correspondence with Ann McDonald (NCHECR). National Centre in HIV Epidemiology and Clinical Research. HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2002. National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, Sydney, NSW. 2002 National Centre in HIV Epidemiology and Clinical Research. Australian HIV Surveillance Report.

National Hospital Morbidity Database (NHMD)

Data Custodian	Australian Institute of Health and Welfare (AIHW).
Purpose	Health monitoring and health service use analysis.
Population	It is a collection of electronic confidentialised summary records for admitted patients separated from almost all public (acute & psychiatric) and private (acute, psychiatric & free standing day facility) hospitals in Australia.
Data items held	<p><i>Establishment data:</i> state or territory of hospital; sector (public or private); RRMA (rural, remote & metropolitan area) classification & other characteristics of the hospital; ARIA (accessibility/remoteness index for Australia) classification of the hospital.</p> <p><i>Demographic data of patient:</i> sex; date of birth; age; age group, country of birth; indigenous status; state & local area of the patient's usual residence (SLA, statistical subdivision, statistical division); RRMA of patient's usual residence.</p> <p><i>Administrative data:</i> funding source (admitted patient election status, Department of Veterans' Affairs patient, Medicare eligibility status, compensable status), insurance status and urgency of admission.</p> <p><i>Length of stay data:</i> admission & separation dates; leave days; same day flag.</p> <p><i>Clinical & related data:</i> principal diagnosis; additional diagnoses; procedures; Major Diagnostic Category (MDC) & Australian Refined Diagnosis Related Group (AR-DRG); estimated average cost for the AR-DRG; care type ; admission mode; separation mode; intended length of stay; external causes of injury or poisoning; place of occurrence of external cause; activity when injured.</p>
Data format	Unit of measurement: episode of care. Unit of time: days. Coding system used for clinical diagnoses: ICD-9-CM from 1993/1994 to 1998/1999. ICD-10-AM from 1998/1999 to present. Coding system used for non-clinical data: National Health Data Dictionary.
Geographic level	Australia. Data are available for individual States and Territories; and smaller area data may be available.
Years referenced	1st July 1993 – present. That is 1993/94 – 2000/01 (2001-02 will be available on 30 June 2003).
Size of sample	Total records in NHMD for 2000/2001: N = 6,138,398 (excludes newborns without qualified days, borders & posthumous organ procurement). Total illicit drug related for 2000/2001: N = 206,285.
Data collection	Data is collected from each of the State and Territory Health authority.
Reporting	Data are published in the AIHW publication Australian Hospital Statistics, which is released on 30 June each year. Thus, data for each year are published within 12 months of the end of the collection period. This and other AIHW publications are available online (www.aihw.gov.au/publications/health.html) or can be ordered from the AIHW.
Access	Data are available for a fee from the AIHW. Information about the Institute's data request service can be found at: http://www.aihw.gov.au/hospitaldata/index.html

Data uses	Data are available on the number of hospital separations with a principal (or additional) diagnosis related to illicit drug use. Up to 30 additional diagnoses are available. The number of patient days is also available.
Strengths	Data is presumed to have high reliability because of the use of trained clinical coders for coding diagnoses, procedures and external causes. The National Health Data Dictionary definitions form the basis of the database, ensuring a high standard of data comparability.
Limitations	<p>There are several potential confounds illicit drug-related data from NHMD:</p> <p>(1) Data is limited to what is reported in medical records, that is, data depends on accurate and complete recording by clinicians;</p> <p>(2) Data is coded using ICD-10-AM (and ICD-9-CM for earlier years) which has inherent limitations: the main ones being that ICD-10-AM does not focus on the identity of the drug(s) involved, rather on the circumstance of morbidity such as poisoning or mental & behavioural disorders due to drug use; ICD codes are limited by their lack of specificity for illicit drugs (e.g. ICD-10-AM is unable to distinguish between amphetamines, ecstasy and emerging drugs such as ketamine & GHB)</p> <p>(3) Data only relate to inpatients and as a result are likely to underestimate the number of acute illicit drug-related morbidities requiring treatment since the majority of these types of cases will be treated within accident and emergency departments;</p> <p>(4) A record is included for each separation, not for each patient, so patients who separate more than once have more than one record in the database; and</p> <p>(5) The actual health data definitions used by data providers may vary from year to year and between jurisdictions and sectors. Comparisons between States and Territories, reporting years and hospitals sectors should therefore be made with caution.</p> <p>Several hospitals do not provide data to the NHMD (such as a the Private hospital in the NT, and some Private hospitals and Private day hospital facilities in other jurisdictions) however the exclusion of these hospitals data is not thought to influence the reliability of data within the NHMD.</p>
Future developments	n/a
Reference (s)	Personal communication with Katrina Burgess (AIHW) and Narelle Grayson (AIHW).

National Minimum Data Set – Alcohol and Other Drug Treatment Services (NMDS-AODTS)

Data Custodian	Australian Institute of Health and Welfare (AIHW)
Purpose	To aggregate standardised Commonwealth, State and Territory data so that national information about clients accessing alcohol and other drug treatment, service utilisation and treatment programs can be reported. The data from the national collection will be considered with information from other sources (e.g. inpatient hospital data and national surveys) to inform debate, policy decisions and strategies that occur within the alcohol and other drug treatment sector.
Population	Clients with closed treatment episodes from all publicly funded government and non-government agencies that provide one or more specialist alcohol and/or drug treatment services.

Data items held	<p>Twenty-six (26) data elements and four (4) supporting data concepts held under four major data groups: administrative data elements, social and demographic data elements; drug use data elements and treatment data elements.</p> <p><i>Establishment-level data elements</i> – state identifier; establishment sector; region code; establishment number; establishment type; & geographical location of establishment.</p> <p><i>Client-level data elements</i> – client type; country of birth; date of birth; date of cessation of treatment episode; date of commencement of treatment episode; establishment identifier; indigenous status; injecting drug use; main treatment type; method of drug use for principal drug of concern; number of service contacts within a treatment episode; other drugs of concern; other treatment type; person identifier; preferred language; principal drug of concern; reason for cessation of treatment episode; sex; source of referral; treatment delivery setting.</p> <p><i>Supporting data concepts:</i> cessation of treatment episode; commencement of treatment episode; service contact; treatment episode.</p>
Data format	Unit of measurement: closed treatment episode. unit of time: daily. Coding system used: conforms to National Minimum Dataset Alcohol and Other Drug Treatment Services and National Health Data Dictionary codes.
Geographic level	SLA of treatment agency.
Years referenced	Since 2000/2001 (financial year) – collection began 1st July 2000.
Sample size	2000/01 data has been supplied but this was for client registrations rather than treatment episodes. Approximately 80,000 client registrations for 2000/01. Expecting to get between 200,000 to 300,000 treatment episodes for 2001/02 financial year.

Data collection	The AIHW is responsible for collating data from the jurisdictions Health Departments who in turn receive data from the service providers.
Reporting	The AIHW is responsible for producing a comprehensive annual report on the NMDS – AODTS. The annual report will be available in hardcopy and electronic form via the AIHW website (www.aihw.gov.au). 2000/01 report will be released Nov 02 and 2001/02 data will be reported in September 03.

Access	The AIHW may consider ad-hoc research requests to data, subject to confidentiality constraints and ethical clearance.
Strengths	Data undergoes a rigorous validation process by each jurisdiction's Health Department. The AIHW validates the unit record file data received from the states and territories and sends a summary report (which includes all queries and identified problems) to each health department for resolution and clarification. Responses from the states/territories are incorporated in the national database.
Limitations	Relies on clinicians providing the correct information. New data collection and hence data quality may be less. Does not include clients: from methadone maintenance program who are not receiving any other form of treatment; clients whose treatment episodes are still open; clients of preventative & education agencies (such as needle and syringe exchanges); clients of correctional treatment services; and clients that receive inpatient treatment (this group report to NHMD).
Future developments	Development of the NMDS – AODTS will be ongoing and directed by the IGCD and states and territories, in consultation with the AIHW and the commonwealth. Development will include amending existing data elements and formulating new data elements when the need arises.
Reference (s):	Personal Communication with Dr Bradley Grant (AIHW).

National Notifiable Diseases Surveillance System (NNDSS)

Data Custodian	Commonwealth Department of Health and Ageing (DHAC), Surveillance and Epidemiology section, Communicable Diseases and Health Protection Branch, Population Health Division. NNDSS is managed by the Commonwealth on behalf of the Communicable Diseases network of Australia, a network of communicable diseases epidemiologists from all Australian jurisdictions.
Purpose	NNDSS is a national collection of data on cases of notifiable communicable diseases from every Australian jurisdiction. NNDSS exists to describe the epidemiology of important communicable diseases in Australia and to inform national policy for communicable disease control.
Population	All cases of 56 types of communicable diseases are reported under the public health legislation to state and territory health departments.
Data items held	<p><i>From 1991-2001 only the following 12 items were collected:</i> state/territory; notification ID; disease code; confirmation status; resident postcode; true onset date; notification date; date of birth; age at onset; sex; and indigenous status.</p> <p><i>From 2002, the expanded dataset is being collected:</i> organism code; organism name; serogrouping subtype; laboratory diagnosis method; vaccination status; vaccination validation; vaccine doses; resident location; specimen date; notification receive date; died; outbreak reference; case found by; and imported from overseas.</p> <p><i>In addition to this core dataset, from 2001 additional data is collected in 'enhanced' datasets for priority diseases (pneumococcal disease, TB and incident hepatitis C). Enhanced data items collected for hepatitis incident C include:</i> HCV seroconversion diagnosis; HCV clinical diagnosis; HCV perinatal diagnosis; HCV date last negative test; HCV IDU risk factor; HCV other risk factor and HCV other risk details.</p>
Data format	Unit of measurement: notification, smallest unit of time: date, coding system used: ICD9-CM codes and internal codes.
Geographic level	State/territory and statistical division level (there is the capacity to report to the SLA level, but this analysis will require state/territory approval).
Years referenced	1991-2002.
Size of sample	920, 000 records.
Data collection	Data are forwarded to the commonwealth from state and territory health departments at fortnightly intervals at present. Data are manually uploaded to the NNDSS by a data manager.
Reporting	Data are presented on Communicable Disease Australia Website available online at http://www.health.gov.au/pubhlth/cdi/cdihtml.htm . Data are updated fortnightly. Data are also released in the bulletin Communicable Diseases Intelligence (CDI) which is published in hard copy and electronic copy each quarter available online at http://www.health.gov.au/pubhlth/cdi/cdicur.htm . NNDSS provides hepatitis notification data to the National Centre for HIV Epidemiology and Clinical Research (NCHECR) which is published in the "HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia: Annual Surveillance Report" available online at http://www.med.unsw.edu.au/nchechr/Downloads/02ansurvprt.pdf .

Access	State and Territory health departments have access to their own data. The general public can access data via the website. CDI is available free of charge.
Data uses	Number of unspecified notifications for hepatitis A, incident notifications for hepatitis B & incident notifications for C (broken down by state/territory, year, age & sex). Number of incident hepatitis C cases where IDU was identified as a risk factor (broken down by state/territory, age group, sex and year). Incident infections refer to recently acquired infections. They can be distinguished from unspecified infections (where the timing of infection is unknown).
Strengths	NNDSS is a collection of communicable disease data. Of the 56 communicable diseases collected, injecting drug users are at a significantly increased risk of: Hepatitis A, B, C and HIV. E.g. in 2000, between 50 & 100% of incident cases of hepatitis B in Australian states & territories were IDU related. IDU use is recorded as a risk factor in the 'enhanced' incident hepatitis C dataset. Completeness of data in the years 1991 to 2001 is high (>90%) for a limited range of data fields (age, sex, disease type, date of onset, postcode).
Limitations	<p>The quality and completeness of notifications compiled in the NNDSS is influenced by a number of factors. The compiled by the NNDSS may be influenced by a number of factors that should be considered when interpreting the data. Due to under-reporting, notified cases are likely to only represent a proportion of the total number of cases that occurred. This proportion may vary between diseases, between states and territories and with time. Methods of surveillance may vary between jurisdictions, each with different requirements for notification by medical practitioners, laboratories and hospitals. In addition, the list of notifiable diseases and the case definitions may vary between jurisdictions. As no personal identifiers are collected in records, duplication in reporting may occur if patients move from one jurisdiction to another and were notified in both.</p> <p>The new data fields introduced in 2002 have more missing information since implementation of this data has not been completed in all jurisdictions. The dataset does not contain information on risk factors for all diseases, except in 'enhanced' datasets (such as hepatitis C). Data are likely to be unreliable as: only a fraction of incident hepatitis C cases are reported; and data are supplied by a doctor given by the patient, which may be unreliable. NNDSS only reports on limited HIV information (The NCHECR receives notifications of HIV/AIDS directly from the states/territories).</p>
Future developments	On implementation of a new data acquisition system, daily updates from states/territories would become possible by automatic data transfer system. Data from 2001 enhanced surveillance has not yet been analysed and are not yet available electronically. Revised case definitions will be implemented on a national basis in 2003. As a result QLD will begin reporting on both incident and unspecified hepatitis C cases.
Reference (s):	Personal correspondence with Paul Roche (DHAC).

National Prisoner Census

Data Custodian	Australian Bureau of Statistics (ABS).
Purpose	To provide nationally comparable statistics on the characteristics of all adult prisoners who were in custody on 30 June each year.
Population	A census of all prisoners held in all gazetted adult prisons in Australian as at midnight on 30 June each year. The adult prison population comprises persons aged 17 and over in Queensland and Victoria and 18 and over in the other states and territories.
Data items held	No. of prisoners, most serious offence, age, sex, indigenous status, expected time to serve, aggregated sentence, country of birth, prison location, known prior imprisonment, date received, level of court, state, security, legal status, type of sentence, earliest release.
Data format	Unit of measurement = person, unit of time = 30 June each year, coding system used = nil.
Classifications	The Australian Standards Offence Classification (ASOC) is used from 2001. From 1993 to 2000 the Australian National Classification of Offences (ANCO) was used.
Geographic level	National, State/Territory
Years referenced	1982 – 2002.
Sample size	Available upon request.
Data collection	Annual (snapshot 30 June). The census is based on data extracted from administrative records held by corrective service agencies within each State/Territory.
Reporting	The AIC published the <i>Australian Prisoners</i> series from 1982 to 1993. The ABS assumed responsibility from 1994 and the National Prisoner Census statistics were released as annual reports to the Corrective Services Minister's Council from 1994-1999. From 2000, the statistics contained in this collection have been produced as an ABS catalogued publication. The publication <i>Prisoners in Australia</i> , cat. no. 4517.0 is available for a small fee from the ABS and the 2002 edition is scheduled for release in February 2003. Companion tables disaggregated by state and territory are also available.
Access	The National Prisoner Census results will be available less than 8 months after the 2002 census. It is intended that the data will be released 6 months after the census in the future. Unpublished data are available, cost on application.
Data Uses	Number of prisoners whose most serious offence is an illicit drug offence (broken down by state/territory, demographic characteristics, and other data items such as sentence length).
Strengths	To ensure that the statistics are as reliable as possible the ABS has employed a number of quality assurance measures. For example, a range of edit checks identify erroneous data and these are queried and resolved by the ABS in consultation with the relevant State and Territory Corrective Services representative.

Limitations	The prison census is not representative of the flow of prisoners. That is, the majority of prisoners in the Prisoner Census are serving long sentences for relatively serious offences, but the flow of offenders in and out of prisons consists primarily of persons serving short sentences for relatively minor offences. In addition, because the national prison census categorises prisoners according to most serious offence, subsidiary or subordinate offences which might include drug offences are not shown. Accordingly, the data under-represents total drug-related sentences.
Future developments	The ABS intends to publish a wider range of socio-demographic variables such as marital status and educational attainment.
Reference(s):	Personal correspondence with Robert Letheby (ABS).

National Survey of Community Satisfaction with Policing

Data Custodian	ACNielsen for NSW Police Service.
Purpose	Monitors levels of community satisfaction with policing.
Population	ACNielsen Survey: target sample of 4000 respondents drawn equally from 10 regions in NSW (see geographic level above). ABS Survey: multi-stage area sample; target sample for NSW of 2,500 and effective sample of 1,800 per annum.
Data items held	Region; week number; gender; age group; member of the police force; satisfaction with the police; safety by yourself; safety by yourself but people may be around; problems at state/territory and local area levels (family violence, sexual assault, physical assault, illegal drugs, housebreaking, motor vehicle theft, speeding cars &/or dangerous or noisy driving, graffiti or other vandalism, louts or gangs, drunken or disorderly behaviour); worried about being a victim of specific crimes; statements about the police image; driven a motor vehicle in the last 12 months (when over the speed limit by 10 km/hr or more, when you felt that you might have been over 0.05 alcohol limit, when you might have been over tired, when you might have been impaired by medication or other drugs); contact with police in the last 12 months (number of contacts, number of times initiated contact, number of police initiated contacts, initiated the most recent contact, reason contacted police, reason why police were in contact); reason for satisfaction with most recent contact; reason for dissatisfaction with service received; work status; occupation; NESB status; ATSI status.
Data format	Microsoft Excel & SPSS files; unit of measurement = person; unit of time = week number; coding system used = nil
Geographic level	ACNeilson Survey: National, State/Territory and Police Regional Divisions (In NSW these are: City-Endeavour, Georges River, Greater Hume, Macquarie, Northern Metropolitan, Hunter, Northern, South Eastern, Southern River, Western). ABS Survey: National, State/Territory.
Years referenced	Previous format from September 1995 to November 2000 conducted by ABS as part of the Population Survey Monitor. Current format since July 2001 conducted by ACNielsen.
Sample size	Response rates and the proportion of people reporting that illicit drugs were a problem in their local area are available upon request.
Data collection	ACNielsen Survey: continuous; uses computerised assisted telephone interviewing technique (CATI). ABS Survey: quarterly (Feb, May, Aug, Nov); face to face interviews.
Reporting	Not published; internal reporting use only. Information from the Survey is included as part of the NSW Police Service Annual Report and in the Report on Government Services. Previously, ABS results were available May and Nov each year. ACNielsen results will be made available to Police Services within 2 months from the end of the financial year.
Access	External enquiries for data should be directed to NSW Police. ACNielsen Survey: unavailable (first year of survey currently being undertaken). ABS Survey: quarterly aggregates at state level only.
Data uses	Proportion of people who perceive illicit drugs to be a problem in their local area.

Strengths	Frequency of data collection (i.e. continuous); and it provides a measure of community concern regarding illicit drugs.
Limitations	The main limitations of this dataset are that: data from the two time periods of the survey are not comparable due to changes in the methodology; non random sampling technique; sample size and coverage. Data from the ABS and ACNielsen surveys are not comparable; the ACNielsen survey contains additional questions and also deleted or reworded other questions. In the transition between survey formats, there was a 7 month period (Dec 2000 to Jun 2001) during which no survey was undertaken. Generally community surveys are confounded by factors, such as: the media; visibility of police initiatives; and individual's values and personal experiences of illicit drug use. Results of these surveys need to be interpreted within the context of other data since people's perceptions do not necessarily reflect the size of the drug problem.
Future developments	n/a
Reference(s):	Personal correspondence with Jim Baldwin (NSW Police).

NSW Inmate Census

Data Custodian	NSW Department of Corrective Services (DCS).
Purpose	a) To provide information on all inmates in the custody of the NSW Department of Corrective Services as at the 30 th June each year. b) to provide data for the National Prisoner Census conducted by the Australian Bureau of Statistics.
Population	A census of all inmates/detainees held in all gazetted adult correctional centres (including periodic detention, transitional centres and 24 hour court cells) in NSW as at midnight on 30 June each year.
Data items held	For each inmates/detainees: Demographic data (age, sex, indigenous status, country of birth, marital status, postcode of last known address, known prior imprisonment as adult), Criminogenic/legal data (legal status, type of sentence, level and state of court of most serious offence, most serious offence, federal offence (Y/N), code for breach of parole/escapee, length of non-parole and aggregate sentence terms, date of reception, correctional centre location, inmate security classification, time at large (for escapees only).
Data format	SPSS data set (other formats available eg. Excel, SAS, text file)
Geographic level	State
Years referenced	Since 1982.
Sample size	No. of inmates/detainees in NSW on 30 th June 2002= 8759. No. of inmates/detainees in NSW on 30 th June 2002 whose most serious offences was related to an illicit drug offences = 1017.
Data collection	Annual (30 th June each year). Census of all inmates/detainees held in gazetted adult correctional centres in NSW as at midnight on 30 June each year. Census conducted by NSW Department of Corrective Services via data extracted from the Offender Management System.
Reporting	Annual statistical publications “NSW Inmate Census” (approximately 18 month lag between collection and publication) and contributes to the “National Prisoner Census” publication published by the ABS. Other ad-hoc data requests must be approved by the Director, Research and Statistics and must not breach confidentiality guidelines.
Access	Statistical publications are free to general public/libraries, publication available on Departmental website. Applications for more detailed data requests should be directed to DCS.
Data Uses	Number of inmates/detainees whose primary offence is an illicit drug offence (broken down by demographics/criminogenic characteristics).
Strengths	The inmate census provides a picture of the persons in correctional centres at a point in time, linked to a time series dating back to 1982. Linked to National comparisons.
Limitations	The inmate census is not representative of the flow of inmates through the correctional system. Compared with the flow of inmates into the system, the Census population includes a higher proportion of inmates with longer sentences and relatively more serious offences as these persons are held within the system for longer periods, their numbers “building up” over time. The “flow” population

consists of a much larger proportion of short-term remand (the majority stay less than 2 weeks) and sentenced inmates serving short sentences (less than 6 months) for relatively minor offences. In addition, use of the most serious offence only has limitation in that inmates with subsidiary or subordinate offences which might include a drug offence are not identified. Accordingly, the data under-represents total drug-related sentences.(NB. The Department also collects reception and discharge data which is published.)

Future developments n/a.

Reference (s): Personal Correspondence with Simon Corben (DCS).

NSW Methadone/Buprenorphine Client Statistics (MCS)

Data Custodian	NSW Health, Pharmaceutical Services Branch (PSB) and Drug Programs Bureau (DPB).
Purpose	To monitor the authorities issued for prescribing of Schedule 8 drugs such as methadone and buprenorphine.
Population	Clients, prescribers and dosing points participating in the NSW Methadone/Buprenorphine program.

Data items held	<p><i>Client details:</i> client identifier, Name, address, suburb, postcode, DOB, gender, ATSI status, main source of income, COB, primary opioid drug of dependence, other drugs perceived by client to be health concern, previous treatment for opioid dependence other than methadone/buprenorphine maintenance/withdrawal, pregnant client, HIV status of client or client's opioid-using partner, treatment agreement signed.</p> <p><i>Prescriber details:</i> current prescriber, prescriber name, prescriber suburb, prescriber postcode, prescriber AHS, prescriber address, prescriber code, prescriber funding,</p> <p><i>Dosing point details:</i> current dosing point, dosing point name, dosing point suburb, dosing point postcode, dosing point AHS, type of dosing point, dosing point funding, historical dosing point.</p> <p><i>Administrative information:</i> ID verified, currently on program, purpose of application (increase dose, transfer from methadone/buprenorphine), buprenorphine main use (withdrawal, maintenance), date of last dose of buprenorphine/methadone, last dose (mg), client transferring from gaol, date of last dose in gaol, last dose in gaol (mg), previous methadone/buprenorphine program, transferring from another state/territory, proposed starting dose; proposed starting date; expected maximum dose, program number, first date on program.</p>
Data format	Unit of measurement: client; unit of time = date, internal coding system used.
Geographic level	AHS (residence, prescriber, dosing point) and Postcode (residence, prescriber, dosing point).
Years referenced	Current system since 1999.
Sample size	Total clients on program as at 30 June 2002: 15,471.

Data collection	Continuous; database is 'live' so is constantly updated. Applications for methadone prescription, and notifications of termination or a change in program details, are faxed to the Pharmaceutical Services Branch of NSW Health by the prescribing doctor for each patient on MMT or buprenorphine. PSB staff enters information as it is received. Inconsistent information is checked with the prescribing doctor.
Reporting	Drug Programs Bureau (NSW Health) has the responsibility of reporting on methadone client statistics and has direct electronic access to the data set (de-identified). There are no published reports. Data feeds into the DHAC reporting system (collected in October each year). National statistics reported to members of the Methadone and Other Treatment Subcommittee in November each year.
Access	Applications for data from external agencies should be directed to NSW Health Department Chief Health Officer. Internal enquiries should be directed to NSW

Health , DPB. There is no cost associated with requests for data. Access to data at the level of client postcode is restricted and would need specific ethical approval.

Data uses	Number of people registered for methadone and buprenorphine treatment (broken down by demographics).
Strengths	Data entry is reliable. As methadone and buprenorphine are schedule 8 drugs, this database accurately reflects the clients who are receiving these drugs and who prescribed them in NSW.
Limitations	Provision of updates from prescribers related to client exits and transfers is often late or not received. As such more recent figures are often a slight overestimate of the number of patients actually on the program at the end of each month.
Future developments	The database is currently being redeveloped into a web-based reporting system. This system will enable prescribers to enter their application forms for new clients and clients transferring directly and will improve the speed of their approval. It will also enable them to produce some reports on the clients they are currently managing. Monthly report for internal purposes is currently under development.
Reference (s):	Personal communication with Devon Indig (DPB) and Kanan Gandecha (PSB).

NSW Minimum Data Set – Alcohol and Other Drug Treatment (MDS-AODTS)

Data Custodian	NSW Health, Drug Programs Bureau (DPB).
Purpose	To monitor the drug and alcohol treatment service sector (excluding methadone). Collection mechanism for information on publicly funded government and non-government alcohol and drug treatment agencies. Follows on from COTSA to provide more systematic and standardized data collection.
Population	Clients of publicly funded government and non-government drug and alcohol treatment agencies (excluding methadone).

Data items held	<p>Thirty-two (32) elements held under four major data groups: administrative data elements, social and demographic data elements; drug use data elements and treatment data elements.</p> <p><i>Administrative data elements</i> – establishment identifier (agency code); state identifier (state code); establishment sector (agency sector); region code; establishment number (agency number); agency location; person identifier (client code).</p> <p><i>Social and demographic data elements</i> – date of birth; date of birth status; sex; ATSI origin; country of birth; preferred language; principal source of income; living arrangement; usual accommodation.</p> <p><i>Drug use data elements</i> – client type; principal drug of concern; other drugs of concern; method of use for principal drug of concern; injecting drug use.</p> <p><i>Treatment data elements</i> – treatment delivery setting; date of commencement of treatment episode; source of referral to treatment; previous treatment; main treatment type; other treatment types; service contact date; number of service contacts; date of cessation of treatment episode; referral to another service</p>
Data format	Unit of measurement: treatment episode. Unit of time: daily. Coding system used: conforms to National Minimum Dataset Alcohol and Other Drug Treatment Services and National Health Data Dictionary codes.
Geographic level	SLA of treatment agency.
Years referenced	Since 2000/2001 (financial year) – collection began 1st July 2000.
Size of sample	2001/02 financial year there were 33, 606 episodes of treatment.

Data collection	Data is submitted by agencies to the Area Health Service to the state on a monthly basis via electronic means. Data is collected by clinicians at commencement and completion of treatment and entered into a database by administrative staff at either the agency or AHS level.
Reporting	Internal reporting (to regional offices) on the data is undertaken on a quarterly basis. This forms part of the quality assurance process. At this stage there is no public reporting, although it is proposed that annual public reporting will be undertaken in the future. Data is reported through the NSW Opiate Overdose Bulletin on a 6-monthly basis. Data is also reported on an adhoc basis at the request of the Minister. Data feeds into the NMDS at the conclusion of the financial year. It is intended that data will eventually be fed into the IDRS.

Access	Applications for data from external agencies should be directed to NSW Health Department Chief Health Officer. Internal enquiries should be directed to NSW Health, DPB. There is no cost associated with requests for data.
Strengths	Collecting data from clinicians which enable them to monitor treatment services. This information is then fed back into planning to improve the overall service quality. A quality assurance is in place whereby the data is scrutinised for outliers, missing data, validity and logic checks.
Limitations	Relies on clinicians providing the correct information. Data only covers publicly funded (government and non-government) agencies. Methadone is excluded (has own collection – may eventually be included into standardised system). New data collection and hence data quality may be less.
Future developments	An annual report for 2000/01 data is expected to be produced in the near future. The electronic tool MATISSE (Monitoring and Other Drug Treatment Information System for Services Everywhere) will be introduced for data collection, validation and analysis. The database will also allow for the automatic generation of monthly reports in the appropriate format for submission. MATISSE has been developed as an interim reporting tool until the Community Health Information Management Enterprise (CHIME) is implemented by agencies.
Reference (s):	Personal Communication with Devon Indig (DPB). NSW Minimum Data Set- Alcohol and Other Drug Treatment. Data Dictionary – version 2.

NSW NMDS-AODTS – Diversion

Data Custodian	NSW Health, Drug Programs Bureau (DPB).
Purpose	To monitor the Council of Australian Governments (COAG) drug diversion schemes operating in NSW. These schemes include the Cannabis Cautioning Scheme, the Youth Drug Court, the Young Offenders Act, and the Magistrates Early Referral into Treatment. This data collection includes the National Minimum Dataset for Alcohol and Other Drug Treatment Services plus a number of additional criminal justice data items.
Population	Clients of NSW COAG diversion schemes.
Data items held	<p>National Minimum Dataset for Alcohol and other Drug Treatment Services: all data items in this dataset are held in the NMDS Diversion.</p> <p><i>Police/court data items:</i> unique identifier, date of offence, postcode of offence, drug type, concurrent offence, diverted to education or assessment date, expiated or not (date), criminal justice system</p> <p><i>Treatment (including assessment and education) data elements:</i> postcode of residence, compliance or non-compliance, date of education session.</p>
Data format	Unit of measurement: treatment episode. Smallest unit of time: daily. Coding system used: conforms to National Minimum Dataset Alcohol and Other Drug Treatment Services and National Health Data Dictionary codes.
Geographic level	SLA (treatment agency), postcode (residence and offence).
Years referenced	Varies by COAG diversion scheme (starting in 1999 for Cannabis Cautioning Scheme).
Size of sample	Varies depending on COAG diversion scheme.
Data collection	Data is collected by each agency (Health, Police, Attorney General's, Juvenile Justice) for persons diverted from police or court to treatment. NSW Health is responsible for collating and linking these separate databases to meet the reporting requirements of the National Minimum Dataset for Diversion collection.
Reporting	Quarterly statistical and qualitative reports on this data is collated by NSW Health and provided to the Office of Drug Policy and the Commonwealth. The unit record NMDS Diversion is provided on an annual basis.
Access	Applications for data from external agencies should be directed to NSW Health Department Chief Health Officer. Internal enquiries should be directed to NSW Health, DPB. NSW Health will have to liaise directly with any other agencies (eg. Police) about provision of their data. There is no cost associated with requests for data.
Strengths	Utilises the NMDS AODTS data, which is thought to be of good quality.
Limitations	Unlike the NMDS AODTS, the NMDS Diversion has had no discussion among jurisdictions about the definition of the data items. Hence, as the diversion schemes vary per state, these data items will not be consistent and should not be reported as one data collection by the Commonwealth. NSW has developed definitions for its own data but some of these vary between diversion schemes as

some apply to police schemes and some apply to court schemes and the exit criteria is different.

Future developments

The Commonwealth has hired an external evaluator to analyse the NMDS Diversion data and advise on the effectiveness of the diversion schemes which will inform their future funding. This evaluation should be completed before the end of 2002. The outcome of that evaluation will inform upon the future collection of the NMDS Diversion.

Reference (s):

Personal Communication with Devon Indig, (DPB).

NSW Notifiable Diseases Database (NDD)

Data Custodian	NSW Health, Communicable Diseases and Control Branch.
Purpose	To monitor notifiable diseases, such as IDU related – Hepatitis A, B, C and HIV. Hepatitis C is the most commonly reported notifiable infection in NSW and the rest of Australia.
Population	Notifications of persons who have tested positive to infectious diseases such as Hepatitis C.

Data items held	<p><i>Client details:</i> aboriginality, identifier, AHS residence, age, country of birth, person deceased, language spoken at home, LGA of residence, occupation, postcode of residence, sex, SLA of residence.</p> <p><i>Clinical details:</i> admission date, admitted to hospital, disease category, condition caused persons death, condition notified, disease name, NDD ICD9 code, Public Health Unit (PHU) assigned flying doctor, date notification reported, CDC epiweek, CDC epiyear, PHU assigned notifying hospital, hospital admitted to, method of identification, PHU assigned notifying laboratory, laboratory confirmed, notified to PHU by, date notified by doctor, date notified by hospital, date notified by laboratory, date notified by other source, date of onset, date of onset per doctor, date of onset per hospital, date of onset per laboratory, date of onset per other source, organism, PHU assigned other notifying source, PHU which recorded notification, responsible PHU based on residence, date notification received, date notification received from doctor, date notification received from hospital, date notification received from laboratory, date notification received from other source, hospital separation date, specimen date, type of specimen, sub-organism.</p>
Data format	Unit of measurement: notification, smallest unit of time: 1 day, coding system used: ICD9-CM codes and internal codes.
Geographic level	postcode (residence) SLA (residence), LGA (residence).
Years referenced	Since 1993.
Size of sample	Total Notifications 2001: 32, 331. Of the 8689 reported HCV cases in 2001, 302 (5%) were identified as acute viral. In those acute cases where risk factor was collected, 85% had IDU as a primary risk factor

Data collection	Laboratories report cases of hepatitis C to the local public health unit. The public health unit then sends a form back to the client's doctor asking whether the HCV is new or old. If it is new the public health unit then sends another form to the doctor asking about HCV risk factors.
Reporting	NSW Data is reported monthly in the NSW Public Health Bulletin and forwarded to the Commonwealth on a fortnightly basis.
Access	Applications for data from external agencies should be directed to NSW Health Department Chief Health Officer. Internal enquiries should be directed to NSW Health, Communicable Diseases and Control Branch. There is no cost associated with requests for data.
Strengths	Results of the enhanced surveillance in 2001 support the wider literature as well as key findings from the Australian Needle and Syringe Program Survey.

Limitations

Notified cases are likely to only represent a proportion of the total number of cases that occurred. This is because notifications are a reflection of testing patterns rather than true disease incidence. In addition, persons in D&A programs are more likely to be tested and therefore there is an inherent bias of persons with IDU risk.

Under the NSW Public Health Act, laboratories have been required to notify diagnoses of HCV since 1991 to their local public health unit. However, acute HCV infections are poorly reported and account for approximately 5% of cases notified. In 2001, NSW Health undertook enhanced surveillance through local public health units to determine newly acquired infections in the previous 24 months. The surveillance is being revised due to limited resources and poor data quality. Thus, enhanced surveillance is time and resource consuming and of limited benefit.

Future developments

The enhanced Hepatitis C Surveillance system is currently being evaluated. A draft report has been circulated for comment recommending a scaling down of enhanced surveillance to sentinel sites. Due to the large amount of resources of the system, as well as the results to date (i.e. that the majority of new incidences of hepatitis C have IDU as an exposure category and that this corresponds to other data such as the Australian Needle and Syringe Program Survey) it is unlikely the system will continue on a state-wide basis. Instead it will most probably operate on a sentinel basis.

Reference (s):

Personal communication with Valerie Delpeche (NSW Health).
The NSW Health Public Health Bulletin (monthly and yearly reports),
NSW Public Health Bulletin, Hepatitis C in NSW, 1991-1999. Volume 12, Number 5, May 2001, p 139-141.
National Centre in HIV Epidemiology and Clinical Research. Annual Surveillance Report: HIV-AIDS, Hepatitis C and Sexually Transmittable Infections in Australia. Sydney: National Centre in HIV Epidemiology and Clinical Research, 2000.

NSW Young Offenders Drug Use Survey

Data Custodian	NSW Department of Juvenile Justice (DJJ) and National Drug and Alcohol Research Centre (NDARC).
Purpose	The three major aims of the study were to: identify patterns and correlates of drug use amongst NSW juvenile justice detainees for the month prior to their detention; compare trends in such data from previous studies; and inform departmental policy and clinical guidelines.
Sample	NSW juvenile detainees.
Data items held	<p><i>Demographics characteristics:</i> gender, ages, living arrangement prior to detention, ethnicity, sexual orientation and educational history;</p> <p><i>Psycho-social and health:</i> general health, depression and suicidal behaviours, legal history, family history of violence and substance abuse;</p> <p><i>Drug and alcohol history:</i> lifetime and current use, treatment need and help seeking;</p> <p><i>HIV risk-taking behaviour:</i> knowledge and attitudes, the HIV risk-taking behaviour scale of the Opiate Treatment Index.</p>
Data format	Unit of measurement = person, unit of time = every 5 years, coding system used = nil.
Geographic level	ASGC statistical divisions.
Years referenced	1989, 1994 and 1999.
Sample size	N = 300 in 1999.
Data collection	Face to face semi-structured interview using a standardised questionnaire administered by four experienced academic research staff as well as a small number of additional trained interviewers.
Reporting	A summary of the 1989 and 1994 survey's findings have been published in peer reviewed journals. The findings from the three studies are summarised in a report currently submitted for publication.
Access	Applications for access to data should be directed to NDARC.
Data Uses	Patterns of drug use (lifetime prevalence, heavy use, IDU), drug-related problems etc (broken down by demographics).
Strengths	Juvenile offenders are a sentinel population of emerging trends in illicit drug use trends in the wider community. There is a paucity of data available on this population. All of the behavioural questions relate to the period immediately prior to detention.
Limitations	Uses respondent initiated sampling rather than random sampling. Illicit drug use may be underreported in an open interview. The infrequency in which the survey is conducted does not allow for regular monitoring of illicit drug use trends over time. Illicit drug use whilst in a juvenile detention centre is not covered in the survey.

Future developments It is hoped that the study will be conducted again within another 5 years.

Reference(s): Personal correspondence with Jan Copeland (NDARC).

Pacific Laboratory Medicine Service (PaLMS) Toxicology

Data Custodian	NSW Health Pacific Laboratory Medicine Service (PaLMS) and Drug Programs Bureau (DPB).
Purpose	To monitor drug and alcohol use among clients of the public pharmacotherapy program. The Toxicology Unit is the New South Wales reference laboratory for drugs of abuse testing. The laboratory can test for a wide range of illicit and therapeutic drugs. Routine drug testing for methadone and other treatment programs is to be used for clinical purposes only. Results are an adjunct to patient treatment and compliance.
Population	A sample of clients from the public pharmacotherapy program. The laboratory provides a clinical service to the NSW Methadone program (i.e. all public methadone clinics), residential drug treatment centres and hospitals. In addition, the laboratory provides a medico-legal drug testing service to a number of institutions including correctional centres, NSW Probation and Parole Service and a number of industries utilising workplace drug testing programs.
Data items held	Client name, clinic name, clinic type, date of test, result of test for each drug type; date of birth.
Data format	Unit of measurement: case (i.e. test). Unit of time: daily. Coding system used: internal.
Geographic level	AHS of clinic
Years referenced	1984-1995 archived. 1996 – 2002 on computer database. 1996 to be archived in the next 2-3 months.
Size of sample	In 2001, approx. 19,000 methadone cases (tests) from 43 clinics.
Data collection	Continuous. Collect specimens from testing sites on a regular basis. Screens are performed and results are continuously updated onto the database by experienced clerical staff.
Reporting	In August 2002, a reporting system to NSW Health DPB was implemented.
Access	Applications for data from external agencies should be directed to NSW Health Department Chief Health Officer. Internal enquiries should be directed to NSW Health, Pacific Laboratory Medicine Service and DPB. There is no cost associated with requests for data.
Data Uses	Percentages of samples testing for each drug. Can report on individual methadone clinics or groups of clients such as all methadone clinics or prisoners by selecting an attribute to describe the organisation. For example, monitor clinics that do screen regularly in various regions to give an overview of drug use.
Strengths	Methadone program toxicology is a good indicator of people who are trying to get off heroin, which is in turn a good catchment of what is on the street.
Limitations	Methadone data is skewed because of non-random testing. Between 1984-89 there was consistent random testing across methadone program sites. Since 1990 non-random testing has been the norm with a wide variation in the approaches to testing from none to consistent. Non-random testing leads to the screening of a select group of problematic users who are visiting the clinics more often than

clients accessing take-away doses. There are no demographics (such as age & gender) or unique identifiers. The lack of unique identifiers decreases the precision (but it is still possible since first and last name are collected) for matching up the sample or tracking patients over time.

Future developments Number of people who are using is a far more reliable indicator of use but currently not possible. Attempting to implement a unique identifier to enable tracking of samples to client. May occur late 2002.

Reference (s) Personal communication with John Lewis (PaLMS Toxicology Unit).

Parent Line

Data Custodian	Parent Line and Centrecare.
Purpose	Professional and confidential telephone counselling service for all of children 0 to 18 years of age living in NSW. Service is available between 9am and 4.30pm Monday to Saturday each week. Provide statistical data on the operation of Parent Line for strategic planning and for reporting to funding body – Department of Community Services.
Population	NSW parents calling about children aged from 0-18 years.
Data items held	<p>Number; counsellor ID; date.</p> <p>Time of call: start time; finish time; total time.</p> <p><i>Caller ID:</i> (name/alias); town/suburb; postcode; number of children in the family; parent/caller age; who called; family structure; age of child(ren); gender of child(ren); source of call; ethnicity; call was referred to.</p> <p><i>Problems:</i> main problem (code); severity; secondary problem (code); severity of second problem; printed information sent.</p> <p><i>Previous call:</i> service needed but not available; client comments; referred to; rating.</p>
Data format	Unit of measurement: call; Smallest unit of time: time of day. Coding system used: nil.
Geographic level	Postcode
Years referenced	Since August 1994.
Size of sample	Number of illicit drug-related calls = 378 in 2001.
Data collection	Ongoing continuous data collection entered by the person taking the call.
Reporting	No formal reporting periods. Provide data when required.
Access	Normally data is released upon request to the NSW Department of Community Services, but other requests would be considered. Requests are normally processed within a few days. No cost involved at present. Data is not available to the general public.
Data Uses	Number of illicit drug-related calls. Data can be broken down into child/parent drug use as well as specific type of drug.
Strengths	Data is reasonably accurate. There is no missing data. Not all calls are screened for drug use – data reflects calls where specific drug use was mentioned.
Limitations	Illicit drug use is appropriate to a proportion of callers only – mainly the calls are to do within general parenting issues of which drug and alcohol concerns form a part. Accuracy of illicit drug information depends on two factors: parent calling informing the counsellor that drugs are an issue for the call; and the counsellor accurately recording that illicit drugs are a problem for the parent, given that 60%

of calls are to do with concerns about adolescents, many parents fail to recognise that drugs are involved.

Future developments Currently involved in a complete rewrite of the database. It is hoped that current data will be able to be transferred onto the new database.

Reference (s): Correspondence with Barbara Adair (Parent Line).

Private Needle and Syringe Distribution

Data Custodian	NSW Health, Aids and Infectious Diseases Branch (AIDB)
Purpose	To monitor pharmacy sales of injecting equipment in NSW.
Population	Pharmacies who distribute needle and syringe equipment.
Data items held	1. Number of fitpacks exchanged 2. Total volume of purchases made
Data format	1. Monthly aggregates 2. Annual (monthly aggregates possible but not recommended)
Geographic level	1. State only 2. State (AHS possible but not recommended)
Years referenced	1. Since 01/07/1990 2. Since mid 1996 (however, financial records could be examined for earlier periods if required)
Size of sample	Total exchanged to pharmacies in 2001: 2,851,792
Data collection	1. Provided by the Pharmacy Guild each month 2. Tracked through the Department's financial invoices as the Department subsidises the private sector. Data is entered as invoices are received.
Reporting	Data is released to internal reporting systems only. Estimate the size of drug injecting population.
Access	Applications for data from external agencies should be directed to NSW Health Department Chief Health Officer. Internal enquiries should be directed to NSW Health, AIDB.
Strengths	Relies on accurate data entry of pharmacists, assumed to be reliable in general. Nil missing data. Data is dependent on level of authenticity of pharmaceutical wholesalers records and claims for payment. Nil missing data.
Limitations	n/a.
Future developments	n/a.
Reference (s)	Personal communication with Owen Westcott (NSW Health, AIDB).

Public Needle and Syringe Distribution

Data Custodian	NSW Health, Aids and Infectious Diseases Branch (AIDB).
Purpose	To monitor needles and syringes distributed in the public Needle and Syringe Program.
Population	Units of needles and syringes distributed from public NSW Needle and Syringe Exchange Program outlets.

Data items held	Dates of quarter, AHS/District, total number of client visits recorded (including return visits), number of new client visits, number of needles dispensed and returned per NSEP type (primary/fixed, secondary, mobile, vending machines) and the return rate (number of needles returned x100/number of needles dispensed), number of condoms distributed, number of clients disposing of needles by type (returned to this exchange, returned to other exchange [including pharmacies], public disposal unit, burn, unsafe disposal, unknown), sex by age group, frequency of provision of service type (written/audio/audiovisual materials, safe IDU education, safe sex education), referrals to (health/medical, welfare, legal, drug treatment/counseling, other), description of services provided by NSP this quarter, Police liaison/interactions, other NSP and related agency liaison, staff development and inservice activities, positive/negative community/media responses to NSP (including complaints about waste disposal).
Data format	Unit of measurement: distribution figures, unit of time: quarter.
Geographic level	AHS of treatment
Years referenced	1988 – present.
Size of sample	Total number dispensed in 2001: 4,012,269 (or 7,854,652??).

Data collection	Quarterly reports (standard proforma) are completed by each Area Health Service and forwarded to NSW Health. Reports are held in paper form by the AIDB and only the data re needles/syringes distributed is entered into an excel spreadsheet for monitoring purposes.
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Reporting	Data is released to internal reporting systems only. Lag time is 6 months behind.
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Access	Applications for data from external agencies should be directed to NSW Health Department Chief Health Officer. Internal enquiries should be directed to NSW Health, AIDB. The AIDB will provide aggregate data at the level of AHS and annual (financial or calendar year). Requests for local level data may be provided depending on the purposes for which the data is to be used. Generally data is available three months following the end of each quarter.
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Data Uses	Breakdowns on numbers of needles and syringes distributed for the 17 AHS. Recommend a summary of data from 1988-1993 due to the variable consistency. Recommend data analyses on data from 1994 – 2002 because the data is of a very high quality. Critical dataset may be used for heroin shortage analysis purposes.
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Strengths	The current reporting system was implemented in 1994 and provides more reliable data than its predecessor (i.e. 1988-1993). Quarterly reports are the standard reporting frequency, however; monthly reports are available on needle and syringe distribution from January to December 2001. This data would be useful for examining, in context with other indicator data, the course of the heroin shortage.
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Limitations	Data from 1988-1993 may not be able to be broken down by AHS or by month. Proforma not always completed in full by some AHS.
Future developments	The AIDB has funded a project on the development of a NSP Minimum Data Set. Expected completion date is end June 2002.
Reference (s)	Personal communication with Owen Westcott (NSW Health, AIDB).

Recorded Crime Statistics Database (RCD)

Data Custodian	NSW Bureau of Crime Statistics and Research (BOCSAR).
Purpose	The Computerised Operational Policing System (COPS) is the data recording system of the NSW Police. It is constructed principally as a policing tool, however, a secondary function is use as a an indicator of broader patterns of offending. Extracts from the COPS system form the basis for the Bureau's Recorded Crime Statistics database.
Sample	All criminal incidents recorded in NSW by NSW Police.
Data items held	The counting units include: <u>Recorded criminal incidents</u> (offence categories include: possession or use; dealing or trafficking; importing or exporting; manufacture or cultivating; and other illicit drug offences); premises of criminal incident, drug type for drug offences (narcotics, cocaine, cannabis and other drugs), whether offence is drug related (y/n, this field has questionable reliability), clearance of criminal incident, <u>Persons of interest</u> ; age, gender, ATSI status, legal status (eg, charged, issued cannabis caution, referred to conference) <u>Victims</u> of personal crime; age, gender, ATSI status.
Data format	Three main units of measurement = 1. criminal incident, 2. persons of interest; 3. victims; unit of time = date of reporting; Incidents are classified into police incident categories, BOCSAR recodes into other offence types.
Geographic level	State, LGA, Statistical divisions and subdivisions of NSW as defined by ABS.
Sample size	In NSW in 2001 there were over 1,300,000 criminal incidents recorded by the NSW Police.
Years referenced	COPS was introduced in early 1994, however, data is only reliable from January 1995.
Data collection	Data on every criminal incident in NSW reported to, or detected by, police, is entered daily into the database by police officers. Data is downloaded quarterly to a secure domain for BOCSAR to access.
Reporting	Annual (calendar year) reports on recorded crime statistics are released by BOCSAR three months after the end of the reporting period. These can be accessed via the internet. Data feeds into the RCD maintained by the ABS and the ACID maintained by the ABCI.
Access	Requests for recorded crime statistics can be made through BOCSAR. BOCSAR can extract specific information according to the request made. Standard requests for data are available at the level of LGA and have a timeframe of 10 days to process. Cabinet Office data requests, if urgent, would be prioritised and processed as soon as possible (usually within 24 hours). Requests made by non-government agencies may incur a fee.
Data Uses	Offence breakdowns are available for: possession and or use; dealing and trafficking; manufacture and cultivating; importing and exporting; and other drug offences. Illicit drug breakdowns are available for: cocaine, cannabis, narcotics and other drugs.

Strengths	The Recorded Crime Statistics database provides an indication of trends in crime in NSW. It can be used to inform ascertain whether particular crimes are increasing, decreasing or stable, particularly for offences likely to be reported to the NSW Police. Recorded Crime Statistics also offer a means to compare crime rates in different areas of the State by considering the number of criminal incidents recorded relative to the population.
Limitations	<p>The Recorded Crime Statistics database only includes incidents reported to, or detected by, police. Changes in recorded crime therefore, can represent underlying factors that influence the detection, reporting and recording of crime, as well as changes in the true level of crime in the community.</p> <p>In the case of drug offences the COPS database better reflects policing behaviour rather than offending levels. Trends in the number of recorded incidents of some offences, such as motor vehicle theft, are more reliable than others, such as cocaine possession.</p>
Future developments	n/a
Reference (s):	Personal communication with Marilyn Chivers (BOCSAR). Reviewed by Jackie Fitzgerald

Service Access Information System (SAIS)

Data Custodian	NSW Health, Drug Programs Bureau (DPB).
Purpose	To facilitate client access to treatment through drug and alcohol treatment services providing their daily treatment availability.
Population	Places and unfilled appointments in drug and alcohol treatment agencies which can be filled by other agencies who need to refer a client into treatment.
Data items held	<p><i>Agency directory:</i> AHS of agency, agency postcode, agency suburb, agency name, agency address, AHS centralised intake line, agency phone, agency fax, agency web address, agency e-mail address, agency hours, agency services, agency client population, agency clinical details, agency category, accept referrals, agency service area.</p> <p><i>Call registration:</i> call taken by, intake site, call date, call time, phone line, caller type, other caller type, client sex, client age, client suburb, client postcode, primary drug of concern, other drug of concern, service requested, other service requested, outcome of call, referral to another service, comments.</p> <p><i>Treatment availability:</i> treatment availability type, agency name, agency postcode, agency suburb, operational capacity, actual capacity, available, estimated waiting time, estimated waiting time unit, constraints, comments.</p>
Data format	Unit of measurement: varies. Unit of time: daily. Coding system used: internal.
Geographic level	AHS (treatment and residence)
Years referenced	Since 2001
Size of sample	Varies according to the section of the database.
Data collection	Continuous. Collected through drug and alcohol workers in agencies across NSW through the SAIS website.
Reporting	There are no reports currently using data entered into SAIS.
Access	Applications for data from external agencies should be directed to NSW Health Department Chief Health Officer. Internal enquiries should be directed to NSW Health, DPB. There is no cost associated with requests for data.
Strengths	The agency directory is felt to be very useful by agencies.
Limitations	There have been many technical problems with the SAIS website, which has had an impact upon the consistency and quality of the information collected. The delays in getting the reporting module built in the SAIS website has also decreased agency commitment to entering data in, because they could not get their information out. The quality of the data currently in SAIS is therefore thought to be of low quality and is not believed to be consistent and reliable.
Future developments	A review of SAIS is currently underway to improve its functionality and ensure it is the best method of collecting this information.
Reference (s)	Personal communication with Devon Indig (NSW Health DPB).

Youth Drug Court Program (YDCP)

Data Custodian	NSW Department of Juvenile Justice (DJJ) and Attorney General's Department (AGD).
Purpose	To monitor and describe activity in the Youth Drug Court.
Population	Juvenile (14-17 years) referrals and participants in the Youth Drug Court referred after appearing in the Children's Court on a criminal matter

Data items held	Demographics; Charges; Court details; Sentence outcomes.
Data format	Specially designed database
Geographic level	Greater Western Sydney region – comprising basically the three health areas of Western Sydney; South Western Sydney and Wentworth - 24 Police LAC's.
Years referenced	Since July 2000.
Sample size	N = 184 since July 2000.

Data collection Data is obtained by DJJ from the Court database on a quarterly basis and collects additional information from JART records. The database contains criminal justice items, demographic and referral patterns. Treatment information is no longer included. It is a flat screen database so there is no way of aggregating data.

The Youth Drug Court also has a database which covers court information and does not record or monitor indicators related to other aspects of the YDCP (such as treatment type).

Reporting Systematic reporting commenced in March 2001. Reporting format has changed twice since commencement. DJJ provide quarterly reports to the Attorney General's Department based on the information in their database. DJJ does not report directly to DPB NSW Health for the COAG Illicit Drug Diversion Initiative. Reporting on the YDC to DPB is by the Attorney General's Department and the South Western Sydney AHS.

Access External requests for data should be made to the Director General of the AGD. Internal requests for data should be directed to the Principal Policy Officer, AGD.

Data Uses Activity Monitoring. Number of young offenders referred to YDCP. Number of young people accepted to YDCP. Number of young people completing YDCP. Descriptive profile of participants.

Strengths Population coverage; flexible reporting.

Limitations It is difficult to identify indicators for the program because most of the program dimensions are not operationally defined/definable. For example, determining whether a young person has successfully completed the program is based on how far the young person has come since the commencement of the program. There are no pre-determined criteria for determining achievement at any stage through the program. Urinalysis is used for therapeutic purposes not to measure program compliance. Sanctions are not used. It is very much an individualised approach and this makes comparisons between individuals within the program very difficult.

Future developments The UNSW Social Policy and Research Unit will publish the YDCP evaluation.

Reference (s): Personal communication with Melissa Clarence (DJJ) and Bruce Flaherty (AGD).

CONTACT DETAILS

Adult Drug Court Program

External enquiries:
NSW Attorney General's Department
GPO Box 6 Sydney NSW 2000
Contact: Director General

Internal enquiries:
Drug Court of NSW
PO Box 92, Parramatta NSW 2124
Contact: Registrar
Tel. (02) 9895 4515
Fax. (02) 9895 4545

Alcohol and Drug Information Service

Alcohol and Drug Service, St Vincents Hospital
366 Victoria St, Darlinghurst NSW 2010
Contact: Manager ADIS
Tel. (02) 9361 8051
Fax. (02) 9361 8073

Ambulance Service of NSW

External enquiries:
NSW Health Department
LMB 961, North Sydney NSW 2059.
Contact: Chief Health Officer
and Deputy Director General, Public Health.

Internal enquiries:
NSW Health Department, DPB.
LMB 961, North Sydney NSW 2059
Contact: Manager.
Tel. (02) 9391 9220
Fax. (02) 93919042

Australian Illicit Drug Report

Australian Bureau of Criminal Intelligence
GPO Box 1936, Canberra City ACT 2601
Contact: Coordinator Intelligence Reporting
Tel. (02) 6243 5639
Fax. (02) 6247 5380

Australian Needle and Syringe Program Survey

National Centre in HIV Epidemiology and Clinical Research
376 Victoria Street, Darlinghurst NSW 2010
Contact: Chief Investigator
Tel. (02) 9332 4648
Fax. (02) 9332 1837

Australian School Students Alcohol and Drug Survey

External enquiries:
NSW Health Department
LMB 961, North Sydney NSW 2059.
Contact: Chief Health Officer
and Deputy Director General, Public Health.

Internal enquiries:
NSW Health Department, Centre for Health Promotion
Strategic Research and Development Branch
LMB 961, North Sydney NSW 2059
Contact: Manager

Tel. (02) 9391 9123
Fax. (02) 9391 9579

Bettering the Evaluation and Care of Health

USYD, General Practice Statistics & Classifications Unit
FMRC, Westmead Hospital, Westmead NSW 2145
Contact: Project Manager
Tel. (02) 9845 8151
Fax. (02) 9845 8155
Email: beach@fmrc.org.au

Brief Treatment Outcome Measure

External enquiries:
NSW Health Department
LMB 961, North Sydney NSW 2059.
Contact: Chief Health Officer
and Deputy Director General, Public Health.

Internal enquiries:
NSW Health Department, DPB.
LMB 961, North Sydney NSW 2059
Contact: Manager.
Tel. (02) 9391 9220
Fax. (02) 9391 9042

Causes of Death Collection

Australian Bureau of Statistics, Health and Vitals Section
GPO Box 9817, Brisbane QLD 4001
Contact: Manager Output and Dissemination
Tel. (07) 3222 6069
Fax. (07) 3222 6038

Children's Court Information System

Department of Juvenile Justice
PO Box K399, Haymarket NSW 2000
Contact: Manager IM&T
Tel. (02) 9289 3303

Clients of Treatment Service Agencies

External enquiries:
NSW Health Department
LMB 961, North Sydney NSW 2059.
Contact: Chief Health Officer
and Deputy Director General, Public Health.

Internal enquiries:
NSW Health Department, DPB.
LMB 961, North Sydney NSW 2059
Contact: Manager.
Tel. (02) 9391 9220
Fax. (02) 9391 9042

Computerised Operational Policing System

NSW Police Service, Corporate Information Unit
Level 11 Police Headquarters Avery Building 14-24 College St
Darlinghurst NSW 2010
Contact: Chief Statistician
Tel. (02) 9339 5517
Fax. (02) 9339 5998

Corrections: Admissions to Hospital

Corrections Health Service
PO Box 150, Matraville, NSW 2036
Contact: Chief Executive Officer

Tel. (02) 9289 2970
Fax. (02) 9311 3005

Corrections: Duty Officers Incident Log

NSW Department of Corrective Services,
Operations Support Branch
Level 19, 24 Campbell St Sydney NSW 2000
Contact: Administrative Assistance
Tel. (02) 9289 1968
Fax. (02) 9289 1461

Corrections: Urinalysis Program

NSW Department of Corrective Services, Security and Investigations
Locked Mail Bag 3, Silverwater, NSW 1811
Contact: Deputy Superintendent
Tel. (02) 9289 5593
Fax. (02) 9748 0624

Crime and Safety Survey

Australian Bureau of Statistics, Client Services
GPO Box 796, Sydney NSW 1041
Tel. (02) 9298 4660
Fax. 1300 135 211

Crime Stoppers

NSW Police, State Crime Command, Drug Enforcement Agency
Australian Postal Institute Building, Cleveland St Strawberry Hills NSW
Contact: Manager Drug Programs Team
Tel. (02) 9384 6271
Fax. (02) 9384 6275

Division of Analytical Laboratories

External enquiries:
NSW Health Department
LMB 961, North Sydney NSW 2059.
Contact: Chief Health Officer
and Deputy Director General, Public Health.

Internal enquiries:
NSW Health Department, DPB.
LMB 961, North Sydney NSW 2059
Contact: Manager.
Tel. (02) 9391 9220
Fax. (02) 9391 9042

Drug and Alcohol Performance Indicator Reporting

External enquiries:
NSW Health Department
LMB 961, North Sydney NSW 2059.
Contact: Chief Health Officer
and Deputy Director General, Public Health.

Internal enquiries:
NSW Health Department, Drug Programs Bureau
LMB 961, North Sydney NSW 2059
Contact: Manager.
Tel. (02) 9391 9220
Fax. (02) 9391 9042

Drug and Alcohol Specialist Advisory Service

Alcohol and Drug Service, St Vincents Hospital
366 Victoria St, Darlinghurst NSW 2010
Contact: Manager
Tel. (02) 9361 8006

Drug Use in Prison Survey

Department of Corrective Services
GPO Box 31, Sydney NSW 2001
Tel. (02) 9289 1333
Fax. (02) 9289 1289

Drug Use Monitoring in Australia

NSW data enquiries:
NSW Bureau of Crime Statistics and Research
GPO Box 6, Sydney NSW 2001
Contact: Statistical Services Manager
Tel. (02) 9231 9174
Fax. (02) 9231 9187

National data enquiries:
Australian Institute of Criminology
GPO Box 2944, Canberra ACT 2601
Contact: Director of Research
Tel. (02) 6260 9231
Fax. (02) 6260 9201
Email: duma@aic.gov.au

Emergency Department Collection

External enquiries:
NSW Health Department
LMB 961, North Sydney NSW 2059.
Contact: Chief Health Officer
and Deputy Director General, Public Health.

Internal enquiries:
NSW Health Department, Information Management & Support Branch
LMB 961, North Sydney NSW 2059
Contact: Director
Tel. (02) 9391 9318
Fax. (02) 9391 9424

Family Drug Support Help Line

Family Drug Support
PO Box 226 Willoughby NSW 2068
Contact: CEO
Tel. (02) 9798 0001
Fax. (02) 9798 0005

Higher Courts Database

NSW Bureau of Crime Statistics and Research
GPO Box 6, Sydney NSW 2001
Contact: Data Quality Manager
Tel. (02) 92319164
Fax. (02) 9231 9187

Illicit Drug Reporting System

National Drug and Alcohol Research Centre
UNSW, Sydney 2052
Contact: National Coordinator
Tel. (02) 9385 0333
Fax. (02) 9385 0222

Illicit Drug Reporting System: Party Drugs Module

National Drug and Alcohol Research Centre
UNSW, Sydney 2052
Contact: National Coordinator
Tel. (02) 9385 0333
Fax. (02) 9385 0222

Inmate Health Survey	NSW Corrections Health Service, Research Unit PO Box 150, Matraville NSW 2036 Contact: Research Manager Tel. (02) 9289 2928 Fax. (02) 9289 3724
Inpatient Statistics Collection	<i>External enquiries:</i> NSW Health Department LMB 961, North Sydney NSW 2059. Contact: Chief Health Officer and Deputy Director General, Public Health. <i>Internal enquiries:</i> NSW Health Department, Information Management & Support Branch LMB 961, North Sydney NSW 2059 Contact: Director Tel. (02) 9391 9318 Fax. (02) 9391 9424
Kids Help Line	Kids Help Line, Research, Advocacy and Publications Unit PO Box 376, Red Hill QLD 4059 Contact: Manager RAPU Tel. (07) 3369 1588 Fax. (07) 3367 1266 Email: admin@kidshelp.com.au
Local Courts Database	NSW Bureau of Crime Statistics and Research GPO Box 6, Sydney NSW 2001 Contact: Data Quality Manager Tel. (02) 9231 9164 Fax. (02) 9231 9187
Magistrates Early Referral into Treatment	<i>External enquiries:</i> NSW Health Department LMB 961, North Sydney NSW 2059. Contact: Chief Health Officer and Deputy Director General, Public Health. <i>Internal enquiries:</i> NSW Health Department, DPB. LMB 961, North Sydney NSW 2059 Contact: Manager Tel. (02) 9391 9220 Fax. (02) 93919042
Methadone/Buprenorphine Client Statistics	Commonwealth Department of Health & Ageing, Illicit Drugs MDP 27 GPO Box 9848 Canberra ACT 2601 Contact: Policy Officer Tel. (02) 6289 7062 Fax. (02) 6289 7837 Email: phd.frontdesk@health.gov.au
National Ambulance Non-fatal Opioid Overdose	Turning Point Drug and Alcohol Centre 54-62 Gertrude St Fitzroy Vic 3065 Contact: Chief Investigator Tel. (03) 8413 8413 Fax. (03) 9416 3420

National Coroners Information System	Monash University National Centre for Coronial Information C/O Victorian Institute of Forensic Medicine 57-83 Kavanagh Street, Southbank VIC 3006 Contact: Project & Research Officer Tel. (03) 9684 4485 Fax. (03) 9682 7353
National Deaths in Custody Program	Australian Institute of Criminology GPO Box 2944 Canberra ACT 2601 Tel. (02) 6260 9280 Fax: (02) 6260 9201
National Drug Strategy Household Survey	Australian Institute of Health and Welfare, Data & Information Services Unit GPO Box 570, Canberra ACT 2601 Contact: Project Director Tel. (02) 6289 7027 Fax. (02) 6289 4235
National Hospital Morbidity Database	Australian Institute of Health and Welfare Hospitals and Mental Health Services Unit GPO Box 570 Canberra ACT 2601 Tel. (02) 6244 1081 Fax. (02) 6244 1299
National HIV Database	National Centre in HIV Epidemiology and Clinical Research Address 376 Victoria Street Darlinghurst NSW 2010 Contact: Head, Surveillance Program Tel. (02) 9332 4648 Fax. (02) 9332 1837 Email: recpt@nchechr.unsw.edu.au
National Minimum Data Set - AODTS	Australian Institute of Health and Welfare Functioning and Disability Unit GPO Box 570 Canberra ACT 2601 Contact: Project Manager Tel. (02) 6244 1050 Fax. (02) 6244 1299
National Notifiable Diseases Surveillance System	Department of Health and Ageing Surveillance and Epidemiology Section. MDP 6 PO Box 9848 Canberra ACT 2601 Contact: Director Tel. (02) 6289 7552 Fax. (02) 6289 7791
National Prisoner Census	Australian Bureau of Statistics, National Centre for Crime and Justice Statistics GPO Box 2796Y, Melbourne 3001 Contact: Assistant Director Tel. (03) 9615 7381 Fax. (03) 9615 7381
National Survey of Community Satisfaction with Policing	NSW Police Service, Corporate Information Unit Level 11 Police Headquarters, Avery Building 14-24 College St, Darlinghurst NSW 2010 Contact: Chief Statistician

Tel. (02) 9339 5517
Fax. (02) 9339 5998

NSW Inmate Census

NSW Department of Corrective Services, Research and Statistics Unit
Level 11 Roden Cutler House, 24 Campbell St. Sydney NSW 2000
Contact: Data Manager
Tel. (02) 9289 1552
Fax. (02) 9289 1590

NSW Methadone/Buprenorphine Client Statistics

External enquiries:
NSW Health Department
LMB 961, North Sydney NSW 2059.
Contact: Chief Health Officer
and Deputy Director General, Public Health.

Internal enquiries:
NSW Health Department, DPB.
LMB 961, North Sydney NSW 2059
Contact: Manager
Tel. (02) 9391 9220
Fax. (02) 93919042

NSW Minimum Data Set - AODTS

External enquiries:
NSW Health Department
LMB 961, North Sydney NSW 2059.
Contact: Chief Health Officer
and Deputy Director General, Public Health.

Internal enquiries:
NSW Health Department, DPB.
LMB 961, North Sydney NSW 2059
Contact: Manager
Tel. (02) 9391 9220
Fax. (02) 93919042

NSW Minimum Data Set - Diversion

External enquiries:
NSW Health Department
LMB 961, North Sydney NSW 2059.
Contact: Chief Health Officer
and Deputy Director General, Public Health.

Internal enquiries:
NSW Health Department, DPB.
LMB 961, North Sydney NSW 2059
Contact: Manager
Tel. (02) 9391 9220
Fax. (02) 93919042

NSW Notifiable Diseases Database

External enquiries:
NSW Health Department
LMB 961, North Sydney NSW 2059.
Contact: Chief Health Officer
and Deputy Director General, Public Health.

Internal enquiries:
NSW Health Department, Communicable Diseases Branch.
LMB 961, North Sydney NSW 2059

Contact: Manager of Surveillance
Tel. (02) 9391 9234
Fax. (02) 9391 9848

NSW Young Offenders Drug Use Survey

National Drug and Alcohol Research Centre
UNSW, Sydney NSW 2031
Tel. (02) 9385 0333
Fax. (02) 9385 0222

Pacific Laboratory Medicine Services Toxicology

External enquiries:
NSW Health Department
LMB 961, North Sydney NSW 2059.
Contact: Chief Health Officer
and Deputy Director General, Public Health.

Internal enquiries:
Pacific Laboratory Medicine Services
PO Box 53 North Ryde NSW
Contact: Head Toxicology Unit
Tel. (02) 9887 5666
Fax. (02) 9805 1259

Parent Line

Centacare, Parent Line
PO Box 1507 Neutral Bay 2089
Contact: Manager
Tel. (02) 8968 1106
Fax. (02) 8968 1117

Private Needle & Syringe Distribution

External enquiries:
NSW Health Department
LMB 961, North Sydney NSW 2059.
Contact: Greg Stewart, Chief Health Officer
and Deputy Director General, Public Health.

Internal enquiries:
NSW Health Department AIDS & Infectious Diseases Branch
LMB 961, North Sydney NSW 2059
Contact: Manager
Tel. (02) 9391 9253

Public Needle & Syringe Distribution

External enquiries:
NSW Health Department
LMB 961, North Sydney NSW 2059.
Contact: Chief Health Officer
and Deputy Director General, Public Health.

Internal enquiries:
NSW Health Department AIDS & Infectious Diseases Branch
LMB 961, North Sydney NSW 2059
Contact: Manager
Tel. (02) 9391 9253

Recorded Crime Statistics Database

NSW Bureau of Crime Statistics and Research
GPO Box 6, Sydney NSW 2001
Contact: Statistical Services Manager
Tel. (02) 9231 9174
Fax. (02) 9231 9187

Service Access Information System

External enquiries:
NSW Health Department
LMB 961, North Sydney NSW 2059.
Contact: Chief Health Officer
and Deputy Director General, Public Health.

Internal enquiries:
NSW Health Department, DPB.
LMB 961, North Sydney NSW 2059
Contact: Manager
Tel. (02) 9391 9220
Fax. (02) 93919042

Youth Drug Court Program

External enquiries:
NSW Attorney General's Department
GPO Box 6 Sydney NSW 2000
Contact: Director General

Internal enquiries:
NSW Attorney General's Department, Drug Crime Diversion
GPO Box 6, Sydney NSW 2000
Contact: Principal Policy Officer
Tel. (02) 9288 7260
Fax. (02) 9228 8559
