



New Road Safety Strategy
Territory and Municipal Services
Community Engagement and Communications
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**Response to 'Vision Zero'
ACT Road Safety Strategy 2011 - 2020 Discussion Paper**

To Whom It May Concern:

The Alcohol Tobacco and Other Drug Association ACT (ATODA) is the peak body representing the alcohol, tobacco and other drug sector in the Australian Capital Territory.

ATODA works collaboratively to provide expertise and leadership in the areas of social policy, sector and workforce development, research, coordination, partnerships, communication, information and resources. ATODA is an evidence informed organisation that is committed to the principles of public health and social justice.

We congratulate the ACT Government for its renewed commitment to road safety in the ACT. Please find attached ATODA's response to the *'Vision Zero' ACT Road Safety Strategy 2011 – 2020 Discussion Paper*, which focuses on the impaired driving aspects of the proposed Strategy.

We believe that the impaired driving aspects of the Strategy could be strengthened and we draw attention to the fact that, within the ACT, there is extensive expertise in this field.

As the peak body for the alcohol, tobacco and other drugs sector, ATODA stands ready to support the ACT Government in accessing and making use of this expertise in further developing the ACT Road Safety Strategy and the subsequent action plans.

We look forward to working in partnership with you on this important road safety initiative.

Sincerely,

A handwritten signature in grey ink, appearing to read 'Carrie Fowlie', is written over a light grey circular watermark.

Carrie Fowlie
Interim Executive Officer
Alcohol Tobacco and Other Drug Association ACT
carrie@atoda.org.au
30 September 2010



ATODA Response to ‘Vision Zero’ ACT Road Safety Strategy 2011 - 2020 Discussion Paper

1. Introduction

We would like to thank the ACT Government for the opportunity to respond to the ACT's Road Safety Strategy 2011 – 2020 Discussion Paper (the Strategy). This submission:

- Provides information about the Alcohol, Tobacco and Other Drug Association ACT (ATODA);
- Draws attention to some key issues relating to alcohol and other drugs and road safety;
- Responds to potential action items for the next Strategy;
- Provides, as an attachment, excerpts from the ACT Alcohol Tobacco and Other Drug Strategy that relate to road safety; and
- Contains, as an attachment, *ATODA's Submission on the Exposure Draft of the Road Transport (Drug Driving) Bill 2010*.

2. About the Alcohol Tobacco and Other Drug Association ACT (ATODA)

The Alcohol Tobacco and Other Drug Association ACT (ATODA) is the peak body representing the alcohol, tobacco and other drug sector in the Australian Capital Territory (ACT).

ATODA works collaboratively to provide expertise and leadership in the areas of social policy, sector and workforce development, research, coordination, partnerships, communication, information and resources. ATODA is an evidence informed organisation that is committed to the principles of public health and social justice.

ATODA participates in ACT and national government and non-government advisory structures and is funded by the ACT and Australian Governments. For further information please visit: www.atoda.org.au.

3. A whole of government and community approach

The discussion paper makes some references to the various agencies and community organisations that would need to be actively engaged for the effective and meaningful design and implementation of the Strategy.

However, the Strategy would be enhanced if it demonstrated the linkages within the ACT Government – particularly between legislation and law enforcement, on the one hand, and public health agencies, on the other.

The Strategy would also be enhanced if key stakeholders, such as the alcohol, tobacco and other drug (ATOD) sector, were clearly identified as partners in its development and implementation.

It is important that there is close collaboration in developing and implementing the Strategy between ACT government agencies, and that strong collaborations are made with the community sector - particularly with the ATOD sector in regards to the impaired driving aspects.

ATODA is ideally placed, as the peak ACT body for the alcohol, tobacco and other drugs sector, to support the ACT Government in developing and implementing the Strategy.

ATODA has a range of structures in place that can support the development and implementation of the Strategy including: advisory structures, regular forums, ACT Drug Action Week, annual Awards (including those that recognise exemplary practice in preventing and reducing harms associated with ATOD issues), research, policy, representation, communication, sector and workforce development. For example, ATODA could assist in seeking feedback on initiatives; identifying stakeholders who may be partners in implementation; and accessing the latest evidence regarding ATOD and road safety.

Example: Effectively Implementing the ‘Es’ of road safety require a whole of government and community approach

We believe the Strategy would be further strengthened if it articulated that road safety is, at its core, a component of the injury prevention and control field within public health¹. We support the Strategy’s reference (see page 2) to the 3Es approach within the injury prevention and control field – namely education, enforcement and engineering.

The research evidence shows clearly that the maximum cost effectiveness in injury prevention and control interventions is found with a focus on engineering solutions, followed by enforcement and then followed by education²³.

This provides a clear example of why the Strategy would require a whole of government and community approach.

4. Linkages to other strategies

Related to the issue of actively involving all key stakeholders, is the importance of articulating the ACT Road Safety Strategy with other ACT, New South Wales and national strategies.

¹ Barss, P, Smith, GS, Baker, SP & Mohan, D 1998, *Injury prevention, an international perspective: epidemiology, surveillance, and policy*, Oxford Univ Press, New York.

² Waller, JA 1985, *Injury control: a guide to the causes and prevention of trauma*, Lexington Books, Lexington, Mass.

³ We support the inclusion of the 3Es in the Strategy, however we note that the evidence supporting the fourth E - "encouragement" approach - is not strong.

As we know, it can be highly problematic having parallel strategies covering similar areas as this can perpetuate siloing within government.

Reference is made, in the discussion paper, to the national strategy and action plan but could be greatly strengthened by acknowledging the full range of ACT Government strategies with which the ACT Road Safety Strategy should operate with in synergy.

We draw particular attention to the *ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014* (<http://www.health.act.gov.au/c/health?a=dlpubpoldoc&document=1967>), which was released in June this year. In order to support reducing these silos, attachment 1 of this submission provides a summary of road safety items from this strategy.

ATODA strongly supports the bringing together of key stakeholders, both government and non-government, that have various responsibilities regarding preventing the harms associated with alcohol and other drugs and road safety in the ACT. ATODA could be a useful partner in this exercise, particularly with identifying how this might be reflected in regular action plans.

5. An evidence-based approach

One of the guiding principles of the *ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014* is 'applying evidence-informed practices'; we strongly support this principle and recommend that it also underlie the ACT Road Safety Strategy.

This is an area whereby the Strategy could be greatly enhanced and could be demonstrated through articulating data to provide an evidence base for the proposed actions within the Strategy. For example, information could be provided to:

- Reveal whether or not the incidence of serious injuries and deaths related to motor vehicles is significantly higher than the incidence of unintentional injuries from other sources.
- Show whether or not the ACT has high levels of motor vehicle related injuries and deaths compared with similarly sized large regional cities in other parts of Australia.

We strongly urge the ACT Government to include the evidence base within the Strategy.

5a. Evaluation and Monitoring

Over the proposed time period of the Strategy there will be significant changes in technology and demographics in the ACT, as well as major environmental changes. These and other factors will mean that the Strategy will need to be regularly reviewed and sound monitoring of evaluative data will be essential for this to occur.

Therefore a core component of the Strategy, that is currently missing, should be a commitment to developing, implementing and reporting on an explicit monitoring and evaluation sub-strategy. This is particularly important since it is proposed the Strategy cover a period of a decade.

5b. Biannual ACT Road Safety Action Plans

We strongly support the work the ACT Government has previously done through developing biannual ACT Road Safety Action Plans. We advocate for these plan to continue as an activity of the overarching decade long Strategy. This will enable the Strategy to be responsive to technological, environmental, social and legal changes; and to actively engage with key stakeholders as partners in its implementation.

5c. Engaging ACT based impaired driving expertise

We draw attention to the fact that, within the ACT, there is extensive expertise within the ATOD sector related to impaired driving. As the peak body for the alcohol, tobacco and other drugs sector ATODA stands ready to support the ACT Government in accessing and making use of this expertise in further developing the ACT Road Safety Strategy.

Greater engagement with ATODA would provide access to expertise that would ensure the Strategy reflects the existing scientific evidence in this domain⁴.

6. The 'impaired driving' focus of the Strategy

ATODA is highly supportive of the proposed Strategy's emphasis on addressing impaired driving (pp. 10-11,19).

As the discussion paper points out, alcohol and other psychoactive substances (including illicit drugs and prescribed medications) have the potential to impair driving skills and hence increase the risk of road crashes.

ATODA does not support impaired driving. ATODA supports evidence informed responses to reducing traffic fatalities, crashes and injuries due to impaired driving.

6a. Roadside drug testing

ATODA has stated in previous submissions, that to be an effective road safety intervention, roadside drug testing needs to focus on impaired driving rather than simply on the presence of illicit drugs in the driver's body (please see attachment 2 for the *ATODA Submission on the Exposure Draft of the Road Transport (Drug Driving) Bill 2010*).

Research does not support the assertion that any measurable amount of tetrahydrocannabinol (THC), methylene-dioxymethamphetamine (MDMA), or methamphetamine in a driver's body is evidence of impairment to such an extent that the person has a significantly elevated risk of road crash⁵. Therefore roadside drug testing is not an effective way to reduce traffic fatalities, crashes and injuries due to impaired driving.

As such, we are concerned that the references within the Strategy related to impaired driving are exclusive to the 'implementation of roadside drug testing'. Unfortunately, the current *Road Transport (Drug Driving) Bill 2010*, which is yet to commence and would underpin the actions in the Strategy, does not address impairment.

⁴ Babor, TF, Caetano, R, Casswell, S, Edwards, G, Giesbrecht, N, Graham, K, Grube, JW, Hill, L, Holder, H, Homel, R, Livingston, M, Osterberg, E, Rehm, J, Room, R & Rossow, I 2010, *Alcohol: no ordinary commodity - research and public policy*, 2nd edn, OUP, Oxford.

⁵ Lenné, MG 2007, 'Roadside drug testing: unanswered questions and future challenges', *Drug Alcohol Rev*, vol. 26, no. 2, pp. 107-8.

If the current flawed legislative approach to roadside drug testing is to proceed, we suggest that the Strategy should outline additional actions that seek to reduce harms associated with impaired driving. Examples of actions that could be highlighted include educational interventions, including those delivered through peer networks of people who use alcohol and other drugs. Such educational interventions should be evidence-based, providing accurate information about alcohol and other drugs and driving.

6b. Random Breath Testing

The discussion paper makes no mention of random breath testing (RBT) - this seems counter intuitive if the Strategy is to take impaired driving seriously. We make two points in this regard.

Cost-effectiveness

Recent research shows that RBT can be cost-effective but its relative cost-effectiveness is low compared with other interventions aiming to reduce alcohol-related harm: 'Although current alcohol intervention in Australia (random breath testing) is cost-effective, if the current spending of \$71 million could be invested in a more cost-effective combination of interventions, more than 10 times the amount of health gain could be achieved'.⁶ This could be achieved through investments in prevention.

Random Breath Testing Intensity

The research evidence shows that, for this intervention to be an effective deterrent, there needs to be a high level of high-visibility testing.⁷ The current level of testing in the ACT is too low - with just 0.37 tests per driver per annum over the last five years. An average of one test per driver per year is recommended as the minimum to be an effective deterrent.⁸

Considering that a high proportion of drivers are not on the roads during the times of the day when much roadside breath testing takes place, the actual likelihood of any particular driver being tested is very much lower than the one test every three years which is the average figure.

Furthermore, ACT Policing figures show massive fluctuations on a quarter-by-quarter basis in both the number of breath tests administered and the proportion found to have exceeded the prescribed limits. This implies a lack of coherence between targeted and non-targeted random breath testing.

Our point is that random breath testing can be an effective deterrent to impaired driving but only if it is conducted more intensively than at present and a way which reflects the research evidence as to its effectiveness and cost effectiveness.

⁶ Cobiac, L, Vos, T, Doran, C & Wallace, A 2009, 'Cost-effectiveness of interventions to prevent alcohol-related disease and injury in Australia', *Addiction*, vol. 104, no. 10, pp. 1646-55.

⁷ Homel, R 1988, *Policing and punishing the drinking driver: a study of general and specific deterrence*, Research in Criminology, Springer-Verlag, New York.

⁸ Vos, T, Carter, R, Barendregt, J, Mihalopoulos, C, Veerman, JL, Magnus, A, Cobiac, L, Bertram, MY, Wallace, AL & ACE-Prevention Team 2010, *Assessing cost-effectiveness in prevention (ACE-Prevention): final report*, University of Queensland and Deakin University, Brisbane & Melbourne.

We strongly urge the ACT Government to expand the impaired driving focus of the Strategy to include specific references to random breath testing.

7. Alternatives to driving

The World Health Organisation (WHO) states that a comprehensive traffic safety strategy will include emphasis on reducing motor vehicle traffic, encouraging use of safer modes of travel and minimising exposure to high-risk traffic safety scenarios⁹.

This is a core road safety issue – the Strategy could be greatly strengthened if it articulated the importance of providing realistic alternatives to the use of motor vehicles on the ACT's roads.

An effective and efficient public transport system, particularly one that meets the needs of young people who are at an elevated risk of driving while impaired by alcohol or other drugs, should be a core element of the ACT Road Safety Strategy.

This is another area that highlights the importance of a whole of government, cross-sectoral approach to dealing with the issue of road safety in the ACT. For example, clarifying how the Strategy relates to the ACT Public Transport Strategy (http://www.tams.act.gov.au/move/sustainable_transport/sustainable_transport_action_plan/public_transport).

8. The title of the strategy: 'Vision Zero' and 'Towards Zero'

The discussion paper invites comment on the title of the Strategy¹⁰. In our view, both proposed titles could be problematic.

Stakeholders have reported that the word 'zero' could be misconstrued and has different meanings for different members of the community. For example it could mean zero blood alcohol concentration for 'P' platers or zero tolerance to drug use.

Therefore, we caution against the use of terms that could be misunderstood – but also against the use of unattainable targets, as the Strategy itself acknowledges¹¹.

The issue is that such an approach can be an impediment to coherent strategic planning, monitoring and evaluation. To adopt a goal that we know cannot be achieved means that a whole new set of missions, objectives and performance indicators would need to be developed that are quite separate from, and inconsistent with, the stated goal.

We suggest, that alongside choosing a title and developing an evaluation and monitoring framework, that the ACT could benchmark the Strategy against other jurisdictions that exhibit

⁹ Peden, M, Richard Scurfield, Sleet, D, Dinesh Mohan, Hyder, AA, Jarawan, E & Mathers, C 2004, *World report on road traffic injury prevention*, World Health Organization, Geneva.

¹⁰ If 'Towards Zero' is selected, it will be important to acknowledge the source, which we presume comes from the 2008 OECD *Transport* report of the same name.

¹¹ 'Aspirational targets have a distinctive role, but one which is largely irrelevant in the design of a [performance monitoring] procedure; motivational targets which are not rationally based may demoralize and distort', Royal Statistical Society 2005, 'Performance indicators: good, bad, and ugly', *Journal of the Royal Statistical Society, Series A*, vol. 168, no. 1, p. 1.

good practice, and develop quantitative and qualitative targets that reflect the outcomes of the benchmarking exercise.

Perhaps, once this exercise has taken place, a more realistic title could be selected.

9. Response to potential action items for the next ACT Road Safety Strategy

The discussion paper invites comments on the specific action items listed in attachment B Please see below ATODA’s comments on four areas related to impaired driving.

What	Implement stringent controls to remove repeat and high-end offenders from the road system
How	Consider revised penalty structures for repeat and high-end offenders
ATODA Comment	<p>We are concerned about the language used (e.g. “stringent controls”) in this action item. We believe it reflects only one perspective (i.e. policing agencies across Australia) and is a narrow view of the nature impaired driving in the ACT community.</p> <p>In ATODA’s view, problems related to alcohol and other drugs are most effectively seen as health issues rather than criminal justice system issues, highlighting the importance of mutually-respectful collaborative work between the health and criminal justice sectors in the ACT Government, and between government and community agencies as well.</p> <p>Criminal justice sanctions addressing drink and drug driving rarely ‘remove offenders from the road system’ - the prevalence of people driving while unlicensed highlights this.</p> <p>The research evidence shows that the criminal justice sanctions (alone) have very little impact on the prevalence of impaired driving. What is required is a strategic mix of criminal justice and therapeutic interventions¹².</p> <p>ATODA does not support "revised penalty structures for repeat and high-end offenders" - if these penalties are simply criminal justice sanctions such as fines, loss of licence and imprisonment.</p> <p>The research evidence demonstrates that increasing penalties is not an effective way of dealing with this issue¹³.</p> <p>Instead, it is important that the Strategy recognises that a very significant proportion of repeat offenders and those with high blood</p>

¹² Babor, TF, Caetano, R, Casswell, S, Edwards, G, Giesbrecht, N, Graham, K, Grube, JW, Hill, L, Holder, H, Homel, R, Livingston, M, Osterberg, E, Rehm, J, Room, R & Rossow, I 2010, *Alcohol: no ordinary commodity - research and public policy*, 2nd edn, OUP, Oxford.

¹³ Kleiman, MAR 2009, *When brute force fails: how to have less crime and less punishment*, Princeton University Press, Princeton.

	<p>alcohol concentrations have significant alcohol related problems – which often include alcohol dependence. Evidence-informed therapeutic interventions are required for this population¹⁴¹⁵.</p> <p>We suggest that the Strategy include specific provisions relating to the use of alcohol ignition interlocks. It has been suggested in some quarters that the fitting of these interlocks should be either voluntary or mandatory for first offenders and those detected with low range blood alcohol concentrations¹⁶. Such an approach is:</p> <ul style="list-style-type: none"> • already available (if individuals choose to pay for it); and • unlikely of obtaining population level road safety outcomes and is far from cost-effective. <p>Instead, based on research evidence, ATODA advocates the mandatory use of alcohol ignition interlocks for repeat offenders and offenders with high blood alcohol concentrations.</p> <p>Alcohol interlocks should be used as part of an intervention that also incorporates criminal justice sanctions and treatment - not as a stand-alone intervention.</p> <p>A better system, of assessing offenders' need for treatment of their alcohol related problems, referring them to treatment and maximising the likelihood that treatment will be completed, is also needed.</p> <p>This is because the research evidence shows clearly that retention in treatment is a key predictor of successful treatment outcomes¹⁷. This means that a therapeutic jurisprudence orientation for dealing with impaired driving should replace the current criminal justice system approach¹⁸.</p>
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What	Continue to focus on impaired driving as a priority area in the next ACT road safety strategy
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¹⁴ Miller, PM (ed.) 2009, *Evidence-based addiction treatment*, Elsevier/Academic Press, Burlington, MA.

¹⁵ Babor, TF, Caetano, R, Casswell, S, Edwards, G, Giesbrecht, N, Graham, K, Grube, JW, Hill, L, Holder, H, Homel, R, Livingston, M, Osterberg, E, Rehm, J, Room, R & Rossow, I 2010, *Alcohol: no ordinary commodity - research and public policy*, 2nd edn, OUP, Oxford.

¹⁶ Willis, C, Lybrand, S & Bellamy, N 2004, 'Alcohol ignition interlock programmes for reducing drink driving recidivism', *Cochrane Database Syst Rev*, no. 4, p. CD004168.

Some indications exist in the research that alcohol ignition interlocks can have a positive impact in terms of reduced drink-drive recidivism for extended period after removal of the interlocks (e.g. ICADTS Working Group on Alcohol Interlocks 2005, *Alcohol ignition interlock devices, Volume 2: Research, Policy and Program Status 2005*, International Council On Alcohol, Drugs and Traffic Safety (ICADTS), n.p. This needs further research.

¹⁷ Latt, N, Conigrave, KM, Marshall, J, Saunders, J & Nutt, D (eds) 2009, *Addiction medicine*, Oxford Specialist Handbooks, Oxford University Press.

¹⁸ Wexler, DB (ed.) 2008, *Rehabilitating lawyers: principles of therapeutic jurisprudence for criminal law practice*, Carolina Academic Press, Durham, NC.

How	Finalise the review of drink driving processes and implement improvements.
ATODA Comment	ATODA is willing to contribute towards the stated process of finalising the review of drink-driving processes and implement improvements. We emphasise the importance of using evidence-informing approaches in this.

What	Continue to focus on impaired driving as a priority area in the next ACT road safety strategy
How	Work towards implementation of random roadside drug testing
ATODA Comment	As discussed above, the continued focus on impaired driving as a priority area in the next ACT Road Safety Strategy is supported by ATODA. ATODA does not support impaired driving. However, random roadside drug testing is not supported by ATODA as it targets the community at large rather than impaired drivers. Please see attachment 2 for further explanation of ATODA's position on drug driving.

What	Continue to focus on impaired driving as a priority area in the next ACT road safety strategy
How	Improve cross-agency work on addressing drink driving issues
ATODA Comment	ATODA fully supports the proposals to 'Improve cross-agency work on addressing drink driving issues' and 'Strengthen linkages between health professionals and health and driver licensing agencies in relation to medical conditions and medications which affect driving', and suggest that this be extended to driving while impaired by illicit drugs as well.

9. Conclusion

We conclude this submission by reiterating ATODA's offer to support the ACT Government in further developing the impaired driving component of the ACT Road Safety Strategy, in particular by drawing on the expertise of its members in this area. That expertise covers areas as diverse as treatment, prevention, policy analysis and research.

We also emphasise the importance, in the impaired driving section, to focus on these population groups where the most road safety gains are likely to be derived in the most cost-effective manner, namely repeat offenders and those with high blood alcohol concentrations.

We also emphasise the importance of a multifaceted intervention strategy with these people that includes case finding, systematic assessment of alcohol and other drug dependence issues, retention in treatment and use of alcohol ignition interlocks.

The resources for addressing impaired driving will always be finite hence need to be carefully targeted towards those population groups and interventions that the research evidence demonstrates unlikely to produce the best outcomes in the most cost-effective manner.

We again thank the ACT Government for the opportunity to comment on the ACT Road Safety 2012 – 2020 Discussion paper.

10. Acknowledgements and further information

This submission was consultatively developed and informed by the expertise from a range of advisory structures, including the:

- ATODA membership;
- ACT Alcohol and Other Drug Executive Directors Group;
- ACT Alcohol, Tobacco and Other Drug Workers Group;
- ACT Comorbidity Strategic Working Group; and
- Other allied stakeholders.

For information about alcohol tobacco and other drug services and support in the ACT please visit the *ACT Alcohol Tobacco and Other Drug Services Directory* at www.atoda.org.au. To keep up to date with developments in the alcohol, tobacco and other drug field subscribe to the free sector eBulletin at www.atoda.org.au.

For further information regarding this submission, the sector or ATODA please contact:

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30 September 2010

Attachment 1: Excerpts from the ACT Alcohol Tobacco and Other Drug Strategy 2010 – 2014 that relate to road safety

Roadside Drug Testing

Any introduction of roadside drug testing will require an extensive social marketing strategy utilising the internet, electronic and print media. There are a number of target audiences requiring different messages and different communication channels.

1. The community at large: most of these people do not use the targeted controlled drugs; the purpose would be to inform them about new legislation and to reinforce their continuing non-use of the target controlled drugs.
2. People who currently use the targeted controlled drugs: it is unlikely that new legislative provisions will affect their drug use and so messages should focus on any risk to road safety that research evidence shows is linked to their drug use, e.g. do not drive soon after using the drugs in question. The social marketing campaign for this target group will need to address the community at large through mass media, and include components targeted specifically at people who use the drugs in question. While peer education approaches would be part of the mix, it needs to be noted that most of the users of the targeted controlled drugs are not in touch with any helping services or with drug user organisations, primarily because they perceive themselves as experiencing little harm associated with their drug use and may have observed little harm linked to drug use among their peers.
3. People who currently use medicines capable of causing impairment: messages should focus on any risk to road safety that research evidence shows is linked to their use of medicines. Messages should include the types of medicines that are capable of causing impairment, the relationship between dose and impairment, how to recognise impairment, and where to go for help or to access further information.
4. Passengers and potential passengers in motor vehicles driven by somebody who has recently used one of the targeted drugs.

(pg.35 - 36)

Strategy Action Plan

Area	#	pg	Action	Rationale	Evaluation <i>(examples of ways in which implementation of actions may be evaluated)</i>	Lead Agency
Alcohol	7	58	Implement the outcomes of the Review of the Road Transport (Alcohol and Drugs) Act 1977.	Harm Reduction	Changes implemented relating to the Review of the <i>Road Transport (Alcohol and Drugs) Act 1977</i> .	TaMS
Alcohol	8	58	Extend the	Supply	Zero blood alcohol concentration	TaMS

			zero blood alcohol concentration limit to novice drivers (i.e. L-platers and P-platers) and drivers of public vehicles.	Reduction	limit extended to include novice drivers (i.e. L-platers and P-platers) and drivers of public vehicles.	
Alcohol	9	58	As a road safety initiative, ACT Policing will continue breath testing of motorists in the ACT. This will be undertaken via random breath testing, targeted campaigns, and specific intelligence-led targeting of drink drivers.	Harm Reduction	Reduction in the proportion of persons who self-report to driving while suspecting they are over the prescribed alcohol limit. Number of drivers breath tested per annum. Number of drivers per annum detected over the recommended BAC. Number of repeat offenders detected per annum.	ACT Policing
Alcohol	11	59	Implement recommendations arising from the review of drink driving laws in the ACT.	Harm Reduction	Changes implemented.	TaMS
Education	49	77	Expand and improve the quality of drug related community education campaigns and programs offered to target groups.	Harm Reduction	Community Education programs developed, implemented and evaluated for (and in partnership with): <ul style="list-style-type: none"> the general population, and targeted populations including young people; the gay, lesbian, bi-sexual, sex and gender diverse communities; people for whom English is a second language; multi-cultural communities; and people experiencing, or at risk of experiencing alcohol and other drug and mental health problems currently, 	ACT Health

					<p>...using targeted approaches including...</p> <p>...in relation to....</p> <ul style="list-style-type: none"> consequences and dangers of poly-drug use (illicit and licit drugs including alcohol and dangers such as loss of inhibitions, unsafe sex, dangerous driving and violence) 	
Research and Surveillance	62	85	Advocate for research that may determine whether there may be delays experienced by people with hepatitis C in efficiently metabolising alcohol due to decreased hepatic function.	Harm Reduction	<p>Research completed.</p> <p>Findings from research inform road safety messages for people with hepatitis C.</p>	ACT Health

Victoria's Alcohol Action Plan 2008-2013: Restoring the balance also highlights that Aboriginal and Torres Strait Islander people

experience significantly higher rates of alcohol-related harm such as alcohol cardiomyopathy (disease of the heart muscle), alcohol gastritis and alcoholic liver cirrhosis, traumatic injuries, road crashes, suicide and violent death. In addition, public drinking by Aboriginal and Torres Strait Islander people is a factor that contributes to the greater likelihood of arrest or detention for public drunkenness and alcohol-related violence than that experienced by non- Aboriginal and Torres Strait Islander Australians

(Appendix 3)

Road Safety

In 2008 the ACT Government announced a review of the *Road Transport (Alcohol and Drugs) Act 1977*, which sets the law relating to alcohol and other drug driving.

A discussion paper outlining key issues covered by the review was developed. The paper focussed on:

- drugs and driving
- improving detection of drink driving
- interventions to prevent drink driving
- blood alcohol concentration limits
- penalties for drink driving
- alcohol interlocks, and
- granting restricted licences to drink drivers.

Amendments to the Road Transport (Alcohol and Drugs) Act 1977, covering the drink-driving reforms are expected to be introduced into the Legislative Assembly in mid 2010.

(Appendix 5)

Attachment 2: ATODA Submission on the exposure draft of the Road Transport (Drug Driving) Bill 2010

This submission is from the Alcohol Tobacco and Other Drug Association ACT (ATODA), the peak body for the alcohol, tobacco and other drug (ATOD) sector in the ACT. We thank the ACT Government for the opportunity to comment on the exposure draft of the *Road Transport (Drug Driving) Bill 2010* (the Bill).

ATODA strongly support the ACT Government’s commitment to evidence based drug policies, as stated in the *ACT Alcohol Tobacco and Other Drug Strategy 2010 – 2014*.

The ACT Government has stated that the purpose of implementing roadside drug testing should be about road safety:

*“I needed to be certain that **the testing was about road safety** and not about catching drug users and punishing them for using drugs rather than endangering other road users. As a Minister, I will do whatever I can **to improve road safety** but I am not going to be involved in punishing ACT drug users for their addiction.”*

- Mr John Hargreaves, Minister for Territory and Municipal Services (8 April 2008)

ATODA has significant concerns with the Bill because the evidence states that roadside drug testing does not improve road safety.

1. The evidence states that the Bill will not achieve its road safety goals

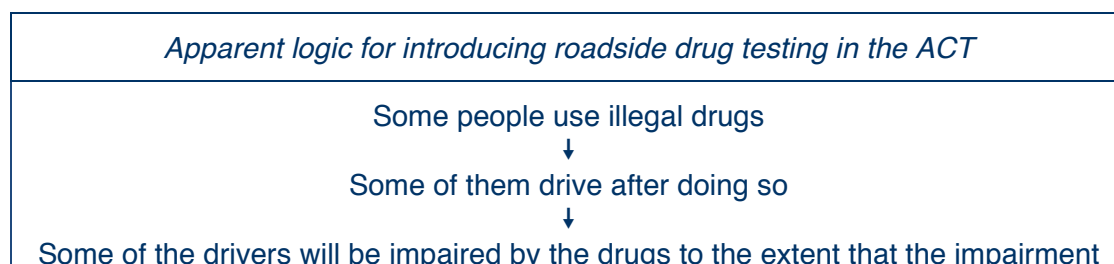
The ACT Government has stated that the purpose of this legislative initiative is to make the roads safer for everyone.

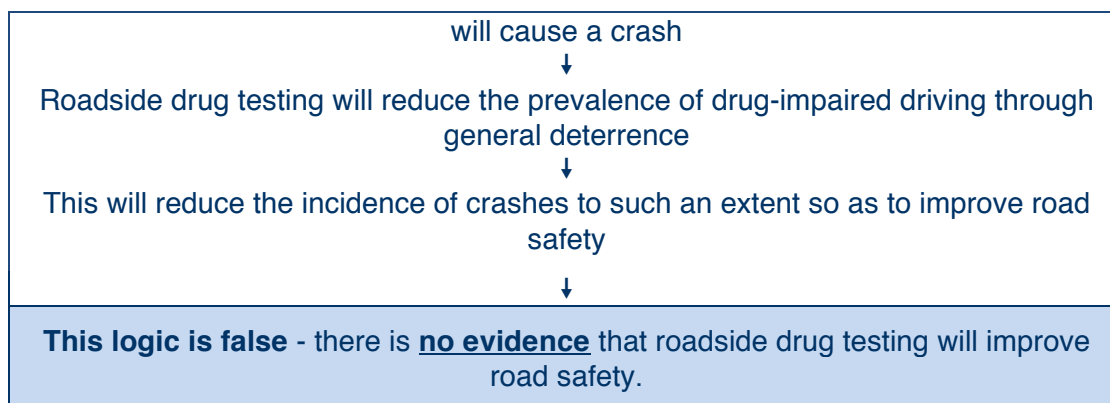
This implies that its objective is to reduce the incidence of traffic fatalities, crashes and injuries. It is not intended to be an extension of legislation that criminalises the use of certain psychoactive substances.

The approach to this legislation is flawed as there is no Australian or international evidence that adopting roadside drug testing has any impact on the incidence of traffic fatalities, crashes and injuries.

This applies both to targeted roadside drug testing (the approach used in other jurisdictions) and to random roadside drug testing (an approach that has not been attempted anywhere in the world).

The apparent logic (described below) to justify introducing roadside drug testing in the ACT is false as there is not evidence to support it.





2. Human rights implications – drug driving is not the same as drink driving

The core issue is the need to balance the right to life (which can be enhanced through effective road safety legislation and its enforcement) and human rights.

These human rights include the right to liberty, the right to legal advice and the right not to be required to self-incriminate.

This is where the core human rights issue of proportionality comes into play.

The courts have held that mandatory roadside blood alcohol concentration testing, based upon *per se* legislation, is acceptable on the grounds that the relationships between elevated levels of blood alcohol concentration and road crash risk are very clear.

However, since there is no corresponding evidence relating to most of the drugs and medicines covered in the Bill, the initiative fails the tests of proportionality.

This is not to deny that some of the drugs covered by the legislation have the potential to impair driving.

The issue is that we have no convincing body of epidemiological evidence about what level of intoxication, in what kind of individuals, in what circumstances, create what types of changes in the risk of a road traffic crash.

3. Drugs or medicines in the body don't equate to elevated risk of road traffic incidences

The Bill appears to be based on the assumption that any measurable level of the targeted drugs and medicines in the body can be equated with an elevated risk of road traffic crash.

This is false and brings into questions the whole approach to the legislation.

On one hand the Canberra community is confronted with significant impositions on people's rights to liberty, etc. – and on the other hand a set of false assumptions about why these rights can be infringed upon.

4. Comments and concerns regarding specific provisions of the Bill

4.1 Concerns regarding custody and arrest

At a number of places in the Bill police are authorised to take a person into custody for testing for the presence of drugs or medicines in the body.

The Bill does not appear to place any limitations on the length of time for which people can be held in custody. If there is no provision that a person must be released from custody as soon as the testing is completed, there is a risk that police powers are open to abuse under road traffic legislation.

Similarly, s. 47 talks about police 'arresting' a person for an offence but this seems to be the first use of the term 'arrest'.

Difference between 'arresting' a person and 'taking the person into custody' for the purposes of oral fluid or blood testing is unclear. Does arresting mean that the police have further powers in certain circumstances? For example, holding people in custody even when this is not necessary for the purposes of blood or oral fluid testing. This requires clarification.

4.2 Concentrations of medicines

S. 22 (3) (c) introduces a provision that police officers may ask an analyst to work out the concentration of medicine in a blood sample. It is totally unclear, from the context, what the purpose of this may be. There is no justification provided.

Explanation and justification need to be provided or the provisions need to be removed.

If the intention is that information on the concentration of substances can be used for prosecuting offences under the Act (e.g. s. 31 regarding 'the person's ability to drive safely is impaired by the effect of the medicine on the person') then this needs to be clarified.

On the basis of current pharmacological knowledge, it is very challenging to demonstrate that a particular concentration of medicine in a particular individual at a particular time produces any quantifiable level of driving impairment.

It is not clear why there is a provision for assessing the concentration of medicines in body fluids but not assessing the targeted illicit drugs.

This comes back to an underlying flaw of the legislation – the absence of knowledge about links between concentrations of substances in bodily fluids and elevated road safety risks.

4.3 Concerns regarding police powers

The title of the Bill, and in a number of places in its body, refer to people being 'affected' by drugs. It is not clear what is meant by 'affected' and the word is not found in the Bill's dictionary. This needs to be addressed.

S. 19 appears to provide that a police officer only has to form a belief that the person 'may be affected' by a controlled drug or medicine in order for the police officer to have power to order a blood test.

There is a significant body of research evidence demonstrating that police have very limited capacity to identify whether or not a person is affected by a drug or medicine.

These provisions are concerning could constitute a slippery-slope towards providing police with powers that could be readily abused.

4.4 The reverse onus of proof

ATODA is very concerned about the reverse onus of proof provisions within the Bill.

For example, within the draft Bill the details what a prosecutor would need to present to court to get a conviction on the offence of medicine-induced impaired driving could not be identified. The pharmacological evidence of the presence of a drug or medicine in the body is, of itself, insufficient to prove the offence - and the lack of knowledge about the relationship between concentrations of medicine and impairment adds to the difficulty.

In terms of how the Act is likely to be applied, it appears that all the prosecutor needs to do to get a conviction is advise the court that a police officer 'believed' a driver to be impaired, and that medicines were found in the body.

But defendants have to prove that they were not impaired. This is an unacceptable balance of onus of proof.

ATODA suggests the Bill should include provisions where the prosecutor should have to:

- (1) give evidence to the court as to the basis of the police officer's 'belief' that the person was impaired by medicine, and
- (2) prove beyond reasonable doubt that the person was impaired by the detected medicine.

Doing so would provide a fairer degree of balance between prosecution and defence and introduce a higher degree of justice in to what is already a flawed piece of policy and legislation.

4.5 The use of samples for research and evaluation

ATODA supports specifying limitations on the use of the oral fluid and blood samples, particularly prohibiting their use to prosecute drug offences (a problem with the Tasmanian legislation) and for contributing to DNA databases.

However, ATODA suggests that the drafting of s. 32 is too restrictive in that the body fluid data cannot be used for research purposes "if identifying information about the tested person can be ascertained from the sample".

This is because, to have sound criminological, epidemiological and evaluation research into the impacts of the drug driving legislation and its implementation, it will be crucial to have available information that links the identity of the person tested and the results of the body fluid tests.

This will be essential, for example, to study repeat offending.

The ethical, privacy and confidentiality issues involved are dealt with satisfactorily under the provisions of the ACT *Epidemiological Studies (Confidentiality) Act 1992*, the

Commonwealth *Privacy Act*, and the NHMRC's *National Statement On Ethical Conduct In Human Research*.

It will be highly problematic to seek to override these established legislative and procedural approaches to dealing with the issues by means of the blanket prohibition envisaged in s. 32.

5. Recent developments that could make the Bill high risk - 1 in 5 false positives

We urgently draw your attention to the recent drug driving false positives in Western Australia. Here is an excerpt of a news article from 21 May 2010:

“One in five drivers who this year tested positive to drugs in police roadside analysis was later exonerated, according to figures that show the accuracy of drug-driver testing has fallen dramatically each year since its launch.

The WA Law Society called yesterday for the immediate suspension of drug-driver testing after figures obtained by The West Australian revealed that of the 141 confirmed positive roadside drug tests to May 21 this year, 28 were found to be negative once analysed by a laboratory.

Although a review of WA's drug-driving regime in February last year by Adelaide University's Centre for Automotive Research recommended that police closely monitor the accuracy of their roadside analysis, the rate of false positives has increased from one in nine in 2008 to one in seven last year and one in five this year. Police gave no explanation why testing was becoming more unreliable, saying only that they would continue to monitor the technology.

Law Society president Hylton Quail said he was shocked by the increasing unreliability of roadside testing. He said it should be suspended until police improved its accuracy.”

Source: O'Connell, R 2010, 'Drug-driver testing "inaccurate"', *The West Australian*, 29 May, <http://au.news.yahoo.com/thewest/a/-/breaking/7311225/drug-driver-testing-inaccurate/>

If the inconsistencies experienced in Western Australia occurred in the ACT, the negative implications for the Canberra community could be significant. It could also effect community support for the legislation and risk of a loss of community confidence in the legitimacy of law enforcement.

ATODA therefore urges the ACT Government to re-consider drug driving legislation in the ACT in light of the evidence, the limitations of the technology, the human rights implications and the recent false positives in Western Australia.

Again, we thank the ACT Government for the opportunity to comment on the Bill and look forward to working with you to develop strategies to promote health and improve road safety in the ACT.

This submission is an adapted excerpt of the work of David McDonald, Visiting Fellow, National Centre for Epidemiology and Population Health, Australian National University & Director, Social Research and Evaluation, including:

- *Submission on the exposure draft of the Road Transport (Drug Driving) Bill 2010 and related regulations* (June 2010)

- McDonald, D 2009, 'The policy context of roadside drug testing, *Journal of the Australasian College of Road Safety*, vol. 20, no. 1, pp. 37-43.
 - *Policy Content of Drug Driving Countermeasures* - Presentation from the drug driving forum hosted by the University of Canberra on Friday 6 June 2008.
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