

## **Component 2 case study 1: Project STOP**

### **Aims of Project STOP**

Project STOP aims to reduce diversion of pseudoephedrine-based medications into illicit drug manufacture by:

- enhancing pharmacists' ability to identify suspicious requests for medications containing pseudoephedrine, and determine whether customers seeking to purchase pseudoephedrine products were legitimate or illegitimate users
- providing intelligence to police and health agencies about 'pseudo runners' and 'rogue pharmacies'
- complementing related measures under the National Precursor Strategy.

Project STOP delivered an online and real-time recording system that allowed pharmacists to record identification of purchasers of pharmaceutical products that contained pseudoephedrine. It helps control of access to pseudoephedrine-based products that might be used for illicit purposes, while recognising legitimate therapeutic needs for such products.

### **The policy context of Project STOP**

In 2004, reports from law enforcement agencies estimated that around 90% of pseudoephedrine used in illicit laboratories was sourced from community pharmacies, linked to a more than six-fold increase in clandestine laboratory detections in the previous ten years.

Building on the achievements of the PGA's national awareness raising program 'Pseudo Watch', the Queensland Branch of the Pharmacy Guild (PGAQ) independently initiated and fully funded a more sophisticated method of controlling the sale of pseudoephedrine sourced from community pharmacies, titled Project STOP. The Guild implemented Project STOP in Queensland with an investment of about \$500,000 for support staff and development of a web-enabled database. The Project was the subject of a joint launch by the PGAQ and the Queensland Police Service (QPS) in November 2005. Health and law enforcement partnered to disseminate Project STOP information as part of their core business.

The *National Strategy to Prevent the Diversion of Precursor Chemicals into Illicit Drug Manufacture* (the National Precursor Strategy) was adopted as an initiative under the NIDS. The National Precursor Strategy was developed and implemented by the federal Attorney-General's Department. The Australian Government committed \$5.4 million over five years to the National Precursor Strategy from 2003-2008. In 2007, the Commonwealth Government provided the National Precursor Strategy with recurrent annual funding of approximately \$1.1 million.

A Precursor Working Group was established in September 2002 with members from law enforcement, health, and industry. From the outset, it focused on the diversion of pseudoephedrine and other precursor chemicals not only from illegitimate sources, but also from legitimate outlets including pharmacies. It has overseen a variety of projects to reduce the availability of key precursors and related equipment under four broad outcome areas, one of which was: National regulatory approaches to control access to chemicals and equipment while recognising the legitimate needs of business and the public. In 2007, Project STOP was included as one of four initiatives to be implemented under this outcome area.

The national implementation of Project STOP was funded through the federal Attorney-General's Department. It was rolled out nationally through partnerships among federal, State and Territory police and health authorities, community pharmacists.

### **Purpose of the case study**

This case study examines the nature and sustainability of Project STOP's inputs, processes, activities, and its intermediate outcomes. It describes how partnerships have been fostered and operated to reduce the supply of precursor chemicals to the manufacture of illicit drugs, in this case, pseudoephedrine.

### Proposition tested by the case study

The starting proposition is that Project STOP uses partnerships in an effective way to reduce the supply of pseudoephedrine into illicit drug manufacture, and illustrates the congruence between the NDS and the National Precursor Strategy.

The Project STOP case study focuses specifically on the partnership between the Federal, State and Territory police, health authorities, community pharmacists.

### Method

Documents, literature reviews on drug treatment models and resource allocation, and informant interviews were analysed using qualitative research methods to test the proposition. A set of research questions helped collect this information.

#### Research questions for Project STOP

- 1 What partnership processes have been used to develop Project STOP?
- 2 What partnership processes have been used to implement Project STOP?
- 3 How have these partnerships been established and fostered overtime?
- 4 How have the Project STOP partnerships contributed to the Project STOP outcomes?
- 5 What factors, other than Project STOP partnerships, have contributed to achieving the Project STOP outcomes?
- 6 To what extent is the National Precursor Strategy informed by and congruent with the NDS?
- 7 To what extent is the development and implementation of Project STOP informed by evidence regarding collaborative partnerships and supply reduction strategies?
- 8 To what extent is there consistency in the allocation of resources to programs to reduce the supply of precursor chemicals into illicit drug manufacture, under the NDS and the National Precursor Strategy?
- 9 Are there activities or programs to reduce the supply of pseudoephedrine into illicit drug manufacture, which have occurred outside the NDS or the National Precursor Strategy? To what extent have they enhanced or diminished the aims or outcomes of Project STOP?
- 10 What other factors (at the system, organisation, personnel and community level) influenced the capacity of Project STOP to deliver effective partnerships?

### Data collection and collation

Sources reviewed for this case study included NDS and the National Precursor Strategy documents, Project STOP progress reports 1–4, media releases from the PGA, Attorney-General’s Department, and Ministers, web-based materials, speech and interview transcripts, conference programs and papers, selected data reports, and the available data on Project STOP funding, activities, coverage, performance and outcomes. Literature and data on methamphetamine use in Australia and the diversion of pseudoephedrine to the manufacture of methamphetamines were also reviewed.

A set of discussion topics derived from the research questions facilitated informant interviews.<sup>4</sup> Eighteen informants said they were knowledgeable about Project STOP. They included members of the development and working groups of the National Precursor Strategy and Project STOP, and people who were involved in developing and implementing Project STOP and related initiatives at State and Territory levels.

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<sup>4</sup> See Appendix E for the Case Study interview protocol

## **Context**

### **Methamphetamine use in Australia**

The 2007 National Drug Strategy Household Survey (NDSHS) suggests that methamphetamine use in Australia is relatively high in comparison with other illicit drugs, with 6.3% of the population having used this drug on at least one occasion (AIHW 2007b). It is estimated that 73,000 Australians are dependent users of methamphetamines (McKetin *et al* 2005). Methamphetamines produce anxiety, panic attacks, paranoia and depression in users. Methamphetamine use is also associated with harms to the community through crime and violence (ANCD 2007).

Although these statistics are cause for national concern given the social and personal harms its use causes, the self-reported prevalence of recent use of the drug fell from 3.2% in 2004 to 2.3% in 2007. This is statistically significant. Among all illicit drugs, the lifetime prevalence rate for methamphetamine was behind that of other illicit substances such as cannabis (33.5%), ecstasy (8.9%) and hallucinogens (6.7%).

### **Diversion of pseudoephedrine to the manufacture of methamphetamines**

Pseudoephedrine is one of the active ingredients in common cold and flu medications. It is also the precursor chemical most often used by criminals to manufacture methamphetamines (ACC 2007; McKetin & McLaren 2004). Clandestine laboratories produce methamphetamines, and pose risks to the community through increased risk of fires, explosions, chemical burns, toxic fumes and environmental damage.

Since 1997-98, Queensland has recorded the highest number of clandestine laboratory detections in Australia. The Australian Crime Commission (ACC 2008) reported a 23% reduction in detections in Queensland, while the number of laboratories detected nationally increased markedly.

## **National implementation of Project STOP**

### **Dissemination of the Queensland results of Project STOP**

The PGAQ presented the results of Project STOP in Queensland at the National Chemical Diversion Conference in December 2005. The presentation described the design, implementation and results of Project STOP in Queensland. It described how Project STOP had used its web-based capacity to provide police with intelligence to detect, track and follow-up individuals making suspicious pseudoephedrine purchases. It also contributed to the quality assurance of professional dispensing of medications, meeting pharmacists' own professional standards of practice. It identified and implemented processes for building on existing partnerships, information and communication technology, and a supportive legislative environment.

The connectivity needed for a system of rapid and secure information-sharing between pharmacies, and between pharmacies and law enforcement bodies, had been made possible by PGA's website, which enabled links between [epothacary.com.au](http://epothacary.com.au) and the Australian Government's Broadband for Health initiative. As a result of Broadband for Health, 78% of Australian pharmacies took up the offer of a business grade broadband connection.

### **Project STOP processes**

Project STOP allows pharmacists to record three distinct types of sales: a sale, a non-sale, or a sale under duress. An additional feature of this system was that it detected instances where a pharmacist or assistant logged on but exited without completing the protocol, providing indications of possible professional malpractice. The system tracked previous purchases by the same individual, thus providing pharmacists with information to decide whether to dispense products containing pseudoephedrine. There was a nominated threshold of pseudoephedrine sales within a single 24 hour period. Once this threshold was exceeded, a

text message was sent to a nominated police representative for appropriate follow-up and action. This threshold is considered confidential, and for this reason it was not provided to this evaluation.

There was a high level of uptake by community pharmacists in Queensland in the first year of operation. By October 2006, the PGAQ had provided Project STOP to more than 900 Queensland pharmacies, free of charge and regardless of whether they were Guild members. The QPS reported a 25% reduction in the detection of clandestine laboratories in the first year of Project STOP in Queensland, and a further reduction of 20% in the following year.

On the basis of this presentation about Project STOP in Queensland, the federal Attorney-General's Department and the Precursor Working Group discussed the concept and the feasibility of implementing Project STOP nationally as part of the National Precursor Strategy.

The PGA developed a proposal for national implementation, including the aims of the program and target audiences, project scope, budget and implementation timeline, a list of the key stakeholders, and other information associated with the various inputs, processes and outputs related to the pharmacy aims of the program. The submission highlighted the success of the initiative in Queensland, the infrastructure and technology that was already established, specific key performance indicators (KPIs), and noted that PGA, as a national body, actively supported the national implementation of Project STOP.

### **Complementary regulation**

In early 2006, the Therapeutic Goods Administration (TGA) rescheduled products containing pseudoephedrine from schedule 2 to schedule 3 products, thus classifying them a non-prescription medicine that may only be supplied by a pharmacist and prohibiting them from being advertised in pharmacies. Preparations that contained more than 720 milligrams of pseudoephedrine were rescheduled to schedule 4, requiring a prescription (TGA 2006).

### **Funding**

The PGA received a funding under the National Precursor Strategy of \$380,000 to implement Project STOP nationally over 2 years, commencing in March 2007. This funding covered the costs of instruction kits to be sent to all pharmacies, two positions on a Project STOP help desk, upgrades of the global positioning mapping system, and server and hosting charges.

### **Governance structure**

In March 2007 the Attorney-General's Department contracted the PGA to deliver Project STOP and provide quarterly progress reports against KPIs, including the number of pharmacists who registered, the national uptake percentage, the number of registered pharmacists who continued to use Project STOP, and the number of transactions entered into the system.

### **Development and dissemination of user agreements and pharmacy instruction kits**

The federal Minister for Health and the PGA's representatives in each State and Territory were contacted to inform them of the importance of Project STOP and plans to implement it across Australia. The PGA led the development of user agreements and pharmacy instruction kits through an iterative process. In June 2007, the pharmacy instruction kits received final approval.

The kits included a Project STOP guide, counter card, window decal, an implementation checklist, patient information leaflets, a pharmacy registration card, and a copy of the PGA pharmacist user agreement. Later, the PGA negotiated tailored user agreements with State and Territory representatives in order to accommodate any local issues (such as privacy regulations).

Project STOP began nationally in August 2007 with dissemination of the pharmacy kits to all pharmacies in Australia. After the first 12 weeks, pharmacy registrations began to plateau in

all States and Territories. This prompted the PGA to send faxes to all unregistered pharmacists stating that pseudoephedrine ‘runners’ were in their area, and suggesting that they register to use Project STOP.

The partnership between the PGA and NSW Police was used to identify and target problematic areas in New South Wales. Pharmacies in problematic areas were contacted by the PGA to discuss their reasons for not participating in the national initiative. Help desk staff provided initial assistance over the phone to pharmacies interested in registering, to monitor the targeted pharmacies over a two-week period to ensure registration and participation, and then to make follow up calls to thank pharmacies for their registration and support against pseudoephedrine diversion. These uptake initiatives were aimed to maximise registration and close any gaps in the system in New South Wales. The same strategy was later applied in the Australian Capital Territory.

By March 2008, additional uptake activities had been introduced across Australia. The Victorian Branch of the PGA employed a telemarketer to contact all unregistered pharmacies in Victoria, while the Northern Territory Branch of the PGA included presentations on Project STOP in briefings of its members. The South Australian Branch of the PGA identified clusters of registered pharmacies in close proximity to encourage their registrations. Registrations were promoted in New South Wales by visits to pharmacies from the NSW Drug Squad.

The Queensland Drug Squad continues to have quarterly meetings with the PGAQ, where Project STOP is reviewed, emerging issues are discussed (that is, increases in pharmacy break-ins after the inception of Project STOP), and there is collaborative problem-solving to address these issues (for instance, circulating pharmacy security tip sheets).

Law enforcement, health and PGA representatives partnered to promote Project STOP at the national level through the Precursor Working Group. They provided industry specific presentations and promotional material on the diversion of precursors and Project STOP results. These presentations highlighted the level of evidence about the harms associated with amphetamine use, that is, increased anxiety, panic attacks, paranoia and depression, community harms such as amphetamine fuelled violent crime and the increased risk to the community of fires, explosions, chemical burns and toxic fume inhalation and environmental damage from clandestine laboratories.

The presentations also described how pseudoephedrine was diverted and used to manufacture methamphetamines. They also promoted Project STOP’s potential to reduce the supply from community pharmacies and significantly reduce the operation of clandestine laboratories. To achieve this goal, it was deemed necessary that Project STOP command a high level of reach, penetration and coverage across Australia, as police intelligence had suggested that ‘pseudo runners’ often cross State and Territory borders during runs.

National implementation of Project STOP was facilitated by the long standing joint approaches and partnerships that had been fostered at a national level between police and peak industry bodies over many years, in order to reduce the diversion of precursor chemicals to illicit drug manufacture. When amphetamines came to attention in Australia, police departments established Police Chemical Diversion Desks (CDD) in each State and Territory to communicate with pharmacy, chemical and plastics industries. According to informants, day to day communication occurs between PGA, pharmacists and the officers from the CDD. As part of this process, the CDD may supply data to PGA and pharmacists on the number of clandestine laboratories detected and seized, as well as the number of arrests resulting from Project STOP.

## **Legislation**

At the time of national implementation, Queensland’s *Drugs and Poisons Act* was clear that the law provided for pharmacists require photo identification at the point of sale.

The PGA and the federal Attorney-General's Department made considerable changes to the design of Project STOP to meet the conditions required under National Privacy Principle 8, which applies to the ability of individuals to transact anonymously, and to clarify its application to Project STOP.

Informants said inconsistency in legislation among the jurisdictions affected take up rates. Jurisdictions that have mandatory reporting of licenses have much higher levels of pharmacies signing up to Project STOP.

### **Partnerships**

In interviews we were advised that the federal Attorney-General's Department and the PGA's representatives worked in a responsive and collaborative manner to lead the project in government and in the field. There were strong policy and program links at the State and Territory level through the Precursor Working Group. Some thought the two key partnerships for Project STOP had been between the PGAQ and the QPS initially, and later between the QPS, the PGA and the Attorney-General's Department.

Informants believed that partnerships among the chemical industry, community pharmacies, health and law enforcement agencies were a key factor affecting the coverage of the program. A central factor affecting the sustainability of partnerships and the success of the program was dissemination of outcomes. Strong policy and program links at the State and Territory level were established through the Precursor Working Group. They were further developed and fostered as a result of Project STOP, and have contributed to Australia's capacity to reduce diversion of precursor chemicals such as pseudoephedrine into illicit drug manufacture.

Informants highlighted examples of successful local level efforts to sustain partnership capacity around Project STOP and related community pharmacy, police and health sector activities. The pharmacy industry (pharmacists, the PGA, and business owners) and the Police Chemical Diversion Desk (CDD) in each State or Territory work in partnership to highlight the types of chemicals that are currently being diverted, and encourage pharmacists to take actions to reduce diversion from community pharmacies.

The Project STOP database has the capacity to disseminate information to pharmacists about the success of the initiative, but Queensland is the only State making use of this information channel. Information and general statistics from the QPS is provided to the PGA. The PGA is responsible for posting them in its quarterly newsletters and media releases on the system. This information serves to provide pharmacists with feedback and assurance that their efforts are effective in reducing pseudoephedrine diversion from community pharmacies. The CDD also supplies data on the number of clandestine laboratories detected and seized, as well as the number of arrests that have resulted from Project STOP. (These data were not made available to this evaluation.)

Informants agreed that while the local level communication between police and health authorities had been effective, many pharmacists were still unaware of Project STOP. In addition, they commented that Project STOP had not been covered in the mainstream media. The PGA undertook a nationwide awareness raising campaign taking out advertisements in periodicals and placing signs at the point of sale, not only for the pharmacists but also for the customers who were not experienced in providing identification for their purchases. Informants believed that buy-in should extend beyond the pharmacy level to consumers to ensure a better understanding of Project STOP and its rationale among pharmacy customers, thus increasing their willingness to provide identification when purchasing pseudoephedrine-based medication.

In summary, informants shared a strong perception that the success of the program relies on the relationship between the PGA and law enforcement nationally, and between pharmacists and police at the local level. Pharmacist buy-in was crucial for the success of Project STOP as a voluntary initiative. They believed that without sufficient buy-in, the project would not be

sustainable in the future. They highlighted the importance of disseminating the positive law enforcement outcomes of Project STOP.

### Capacity to measure program outputs

The PGA collects and reports on data to meet the KPIs of Project STOP, including the number of pharmacists who register, the national uptake percentage, the number of registered pharmacists who continue to use the Project STOP, and the number of transactions entered into the system. Because registration of all pharmacies is a goal of the program, pharmacy registration is considered to be a key measure of the success of the national program.

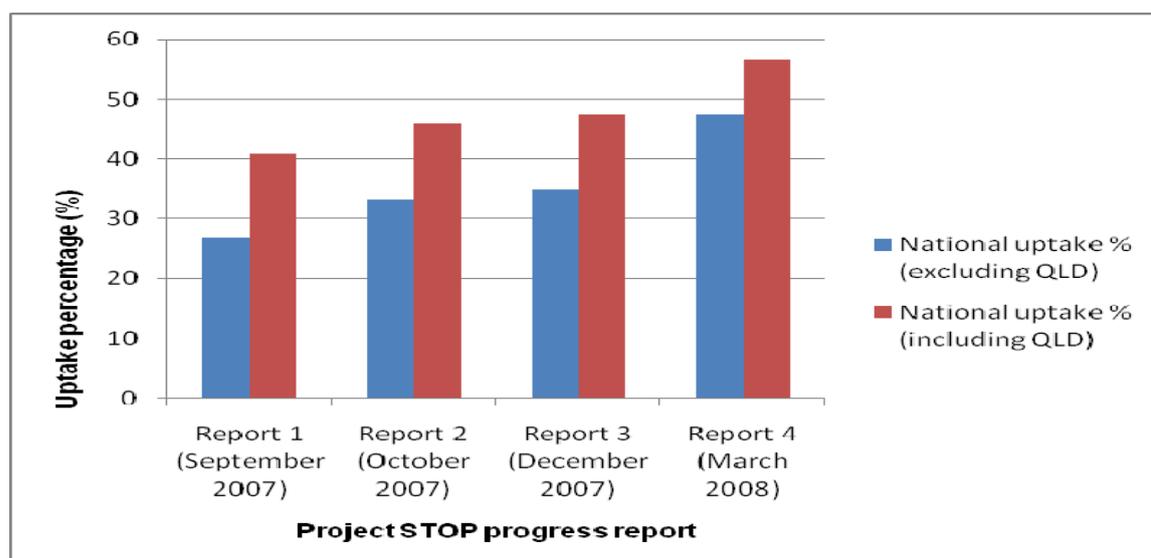
Table 2 presents the number of pharmacies registered, national uptake rate percentage and the number of transactions processed through Project STOP. By September 2007, about 980 Queensland pharmacies were registered for Project STOP. While there was an initial increase in all pharmacy registrations during the first month of the national implementation (265 registrations), there were only 71 additional pharmacy registrations across Australia between October and December 2007.

**Table 2: Pharmacy registrations, national uptake percentages and transactions across reporting periods**

Key Performance Indicator	Report 1 (Sept 2007)	Report 2 (Oct 2007)	Report 3 (Dec 2007)	Report 4 (Mar 2008)
Pharmacies registered (excluding QLD)	1,143	1,402	1,467	1,838
Pharmacies registered (including QLD)	2,043	2,308	2,379	2,771
National take up % (excluding QLD)	26.94%	33.2%	34.85%	47.35%
National take up % (including QLD)	40.78%	45.88%	47.29%	56.5%
Transactions processed to date	534,245	640,533	689,996	914,259

This table also shows that both pharmacy registrations and the number of transactions processed through Project STOP continued to increase to March 2008.

National uptake data is also displayed graphically in Figure 1:



**Figure 1: National uptake percentage for Project STOP across all reporting periods**

Pharmacy registration data excluding Queensland figures show that registrations in the other States and Territories increased from 1,143 to 1,838 in the first seven months of national implementation. Between January and March 2008 (when strategies to increase uptake were under way) pharmacy registrations increased by 391, taking the national total to 2,771.

During 2007, national uptake rates increased from 40.8% in September to 45.9% in October and 47.3% in December. The latest figures from March 2008 suggest that 56.5% of all Australian pharmacies were registered for Project STOP. Uptake percentages (excluding Queensland) suggest that 26.9% of pharmacies outside of Queensland registered for Project STOP in the first month, increasing to 34.9% by December 2007. Data from progress report 4 show that 47.4% of all pharmacies excluding Queensland were registered to use Project STOP by March 2008.

State and Territory specific information on pharmacy registrations, number of pharmacy instruction kits sent, and the national uptake percentage are shown in Table 3. As of March this year, the ACT, NT and Queensland showed the highest uptake rates, all above 90%. NSW and Victoria - the States with the highest number of pharmacy outlets - demonstrated the lowest uptake rates across Australia at 39.6% and 37.9% respectively.

**Table 3: Pharmacy registrations, instructions kits sent and uptake as a function of jurisdiction**

State or Territory	Registered	Kits sent	% Uptake
Australian Capital Territory	57	61	93.44%
Northern Territory	25	27	92.59%
Queensland	933	1,021	91.38%
Tasmania	100	135	74.07%
Western Australia	369	516	71.51%
South Australia	221	402	54.98%
New South Wales	639	1,613	39.62%
Victoria	427	1,128	37.85%
<b>Total</b>	<b>2,771</b>	<b>4,903</b>	<b>56.52%</b>

The latest progress report also gave a snapshot measure of database usage, based on the proportion of registered pharmacies logged into the system when the latest figures were being generated. The number of pharmacies registered, snapshot usage data, and the national uptake percentage of Project STOP are presented in Table 4.

**Table 4: Pharmacy registrations, snapshot usage data<sup>5</sup>, and registered pharmacies logged in**

State or Territory	Registered	Usage snapshot	% Logged in
Australian Capital Territory	57	52	91.23%
Northern Territory	25	20	80.00%
Queensland	933	666	71.38%
Tasmania	100	74	74.00%
Western Australia	369	262	71.00%
South Australia	221	145	65.61%
New South Wales	639	299	46.79%
Victoria	427	187	43.79%
<b>Total</b>	<b>2,771</b>	<b>1,689</b>	<b>60.95%</b>

These snapshot data are used as a proxy for usage but may under- or over-estimate usage. These data indicate that only 61% of all registered pharmacies were logged into Project STOP at the time the latest figures were being generated.

Only aggregate summary output data was available to the evaluation team to assess the performance of Project STOP. Recently efforts have been made to improve the range and accuracy of the information in the progress report to March 2008.

<sup>5</sup> Snapshot usage data: the proportion of registered pharmacies logged onto the system when the latest figures were generated

### **Capacity to measure outcomes**

Informants believed the significant reduction in clandestine laboratories detected in Queensland after Project STOP began meant that a national focus on the community pharmacy component of the pseudoephedrine supply chain would contribute to reductions in methamphetamine supply, use and related harms:

Pharmacists were helped to judge whether the customer wishing to purchase pseudoephedrine products was a legitimate or illegitimate purchaser. Intelligence on 'pseudo runners' was provided to law enforcement

When Project STOP was first introduced in Queensland, there was a large reduction in the number of clandestine laboratory detections compared to other States and Territories (IDDR 2007). The intelligence provided by Project STOP assisted police in arresting more than 30 individuals. Law enforcement saw the movement of pseudoephedrine 'runners' (persons who travel from pharmacy to pharmacy buying pseudoephedrine products for the illicit trade) across jurisdictions doing runs for pseudoephedrine. This suggested that Project STOP was having a considerable effect on the supply and manufacture of methamphetamine in Queensland. However, it is difficult to assess the separate contributions of Project STOP and rescheduling to the reduction in clandestine laboratories detected. Informants believed that both the rescheduling of products containing pseudoephedrine and Project STOP contributed to the reduction.

It was suggested that, in addition to uptake and transaction data, the performance of the program should be informed by law enforcement data on a number of outcomes, such as number of arrests, charges and notices to appear, number of laboratories detected and shut down, availability, price and purity of their illegal methamphetamines, and the number of pharmacies displaying promotional signs to the public about Project STOP.

Some informants said that, in the absence of information about what proportion of illicit amphetamines sold in Australia are domestically produced and what proportion are imported, it was not possible to draw conclusions about the effect of detection and closure of domestic clandestine laboratories on the supply of and demand for illicit amphetamines in Australia. Some believed that Project STOP was endorsed and implemented nationally before any worthwhile data were available on expected outcomes.

Most informants believed that Project STOP had reduced the supply of pharmacy pseudoephedrine to illicit drug manufacture, increased the detection and seizure of clandestine laboratories manufacturing amphetamines, increased arrests associated with diversion of pharmacy pseudoephedrine products to illicit drug manufacture and decreased the number of clandestine laboratory operations.

In the first year of national implementation, some pharmacists were reluctant to request individual customer identification in the absence of supportive State and Territory privacy clauses in State and Territory drugs and poisons regulations.

Experience in the first year of national implementation also showed that the dissemination efforts of police and pharmacy partners would be needed to ensure sustained uptake and usage. The success of the national implementation required a high degree of sustained uptake and usage and targeted capacity building investment over two years to capitalise on existing national, State and Territory partnership capacity. Dissemination of local level law enforcement outcomes was a crucial element in sustaining usage.

### **Alignment with NDS principles and objectives**

As we have seen above, the National Precursor Strategy contributes to the supply reduction aspect of the NDS. Project STOP also aligns with several of the stated objectives of the current NDS, in particular to reduce the supply of and use of illicit drugs in the community, but also to reduce the risk of criminal drug offences, and build new partnerships to fulfil the goals of the NDS.

The Australian Government initiated and funded the National Precursor Strategy to contribute to the supply reduction aspect of the National Illicit Drug Strategy (NIDS) by preventing legitimately provided pharmaceuticals being used to make illicit synthetic drugs in clandestine drug laboratories. Project STOP is one of the National Precursor Strategy funded initiatives designed to enhance national regulatory approaches to control access to chemicals and equipment while allowing the legitimate use of these drugs by the public. The National Precursor Strategy was not referred to in MCDS communiqués, but the IGCD noted its support for the National Precursor Strategy in its 2005-2006 Annual Report (IGCD 2006).

While the link to the objectives and outcomes of the NDS was not explicit in the Project STOP documentation, informants linked Project STOP to the reduction of supply and the prevention and minimisation of drug-related harms. They believed that even though Project STOP was developed at state level, its program decisions and approaches aligned with the broad objectives of the NDS.

While all informants were aware that Project STOP was the result of collaboration among the law enforcement, health and pharmacy sectors in all jurisdictions, they did not know how much evidence was used in developing Project STOP. Rather, the work to initiate Project STOP in Queensland and monitor its results was a pilot phase to inform national implementation.

Some informants thought Project STOP was a highly effective contribution to reduced manufacture and supply of amphetamines and thus to reducing the harms caused by their use. Others simply saw the Project as an element of more effective policing, since decreased availability of pseudoephedrine led to a reduction in the number of clandestine laboratories.

### **Evaluation**

Project STOP was established as a capacity building project - an investment in upgrading communication technology and developing resources that remain beyond the life of the funding - with funding for two years. The program design identified a number of inputs, processes and outputs, and implied a number of intermediate outcomes. There was a reasonable basis to assume that the program would contribute to reducing drug supply and drug-related harm, and this logic was implicit in the program design.

The program design does not explicitly link processes, inputs and outputs to outcomes. In addition to difficulties accessing law enforcement data, the lack of an explicit program logic also diminishes capacity to evaluate the program. The prospective use of instruments such as program logic to inform program design builds in a basis for evaluation from the outset, and identifies future implementation challenges and opportunities.

Partnerships, registration kits, and a range of local communication strategies were used to engage pharmacies actively before and after registration. Individual pharmacies cannot know what seizures have resulted from their own participation in Project STOP, but the progress reports submitted to the Attorney-General's Department report the numbers of pharmacies registered and the number of transactions processed quarterly state by state. These accumulated results could be communicated explicitly to pharmacies to highlight the results of their efforts and to encourage their partnership. Such communication is a well-established factor in successful monitoring of performance and continuing local implementation.

Data on uptake were collected and used to monitor performance with a view to reviewing the program results in the second year of the program. This process aligns with the use of action learning approaches to support innovative program development.

The impact and outcomes of Project STOP are yet to be evaluated. A comprehensive evaluation of Project STOP, assessing the impact of the program on drug law enforcement outcomes and demand for treatment, has recently received funding from the NDLERF and the Drug Policy Modelling Program (DPMP). This evaluation, led by Professor Lorraine Mazerolle, is due for completion by 2011. It will compare the policy, implementation, and outcomes of Project STOP across two jurisdictions (Queensland and Victoria). The evaluation

will look at the organisational structures within police agencies and how partnerships have been formed and operate, the responses from pharmacists and impacts on them, as well as the other local level impacts including pseudo runners targeting community pharmacies not participating in Project STOP.

Some informants were of the view that the evaluation of Project STOP will be limited by the lack of data available on law enforcement outcomes. Informants were unsure if the outcomes of Project STOP could be linked to any measurable effects on methamphetamine availability at street level.

## **Summary and observations**

Numerous factors affect methamphetamine production and use in Australia. Reducing the diversion of pseudoephedrine from pharmacies is one of those factors, but drugs are also imported, there are different methods for manufacturing amphetamines, and pseudoephedrine can be diverted from other points in the supply chain. The objective of Project STOP was to reduce the diversion of pseudoephedrine from pharmacies as one part of a comprehensive set of precursor measures, including the introduction of phenylephrine into the pharmaceutical market. It is not clear whether the proponents of Project STOP think its contribution to limiting the availability of precursor chemicals in Australia should be specified.

Rather, the Project STOP case study has focussed on the partnership among the Federal, State and Territory police, health authorities, community pharmacists and the pharmaceutical and chemicals industries to reduce the supply of pseudoephedrine to the manufacture of illicit drugs.

Project STOP in Queensland was seen as a pilot or trial phase, and stakeholders anticipated it would produce similar results nationally. It was incorporated into the National Precursor strategy and national implementation was funded for a two year period. National implementation aimed for a high degree of sustained uptake and usage and targeted capacity building investment over two years to capitalise on existing national, and State and Territory partnership capacity.

The case study found that successful partnerships were the key to Project STOP's innovative design and implementation. These partnerships supported a high level of uptake and use of Project STOP's resources and processes. This in turn resulted in a large volume of referrals from the health sector to the law enforcement sector to support their common goal of reducing the role of pharmacy pseudoephedrine in the illegal manufacture of methamphetamines.

Project STOP was developed collaboratively on the basis of Queensland's experience of high levels of uptake of Project STOP. This reflected the concerted efforts of partners in health, pharmacy and law enforcement across sectors. Its implementation processes and stated outcomes aligned with the objectives of the National Precursor Strategy and the NDS.

Design, implementation and key partnerships appear to have supported a high level of uptake and use of Project STOP's resources and processes. This, in turn, has resulted in a high level of referral of matters from the health sector to the law enforcement sector to support their common goal of reducing the role of pseudoephedrine in illegal manufacture of amphetamines. Those that have taken up Project STOP have done so with enthusiasm and there has been cross-fertilisation between the private and public sectors and the health and law enforcement sectors. Strong informant views and some evidence indicate that the programs impact would be strengthened by geographic coverage.

The sustainability of Project STOP relies on the buy-in achieved through its partnerships, legislation which allows pharmacists to require identification, and pharmacists' persistence in securing identification in accordance with law. It also relies in part on its capacity to report on program outcomes.

As an innovative intervention, Project STOP is to be commended for the work its participants have done to increase the ability to report on pharmacist uptake and use, and to solve problems arising in the early stages of implementation (privacy legislation, dissemination of outcomes). Its successes would have been enhanced if more explicit evaluation had been built in from the outset.

Efforts should continue to support States and Territories to address legislative barriers to recording identifying information at the point of sale.

In the next phase of Project STOP, those involved with Project STOP may take steps to:

- consciously acknowledge that they have built an action learning approach to innovative program development,
- draw on the lessons to date and develop a clear program design that ensures that the program is sustainable and can be evaluated, and
- cooperate fully, particularly by providing access to comprehensive unit record data for the Commonwealth and DPMP funded evaluation of Project STOP.

## **Component 2 case study 2: Non-Government Organisation Treatment Grants Program**

The *Non-Government Organisation Treatments Grants Program* (NGOTGP) has been operating since 1997. As one element of funding to the drug treatment service system, NGOTGP complements State and Territory funding to NGO drug treatment services and other sources of Commonwealth funding to these services.

The NGOTGP currently provides funding to 197 NGOs to operate a range of AOD treatment services. The funding aims to strengthen the capacity of NGOs to achieve improved service outcomes and to increase the number of treatment places available.

Between 1997 and the end of the 2007-08 financial year the Commonwealth has allocated approximately \$291,188 million in funding to the program. As part of the 2007-2008 Budget, the Commonwealth Government committed additional funding of \$79.5 million, in addition to its ongoing commitment to NGOTGP of \$48.9 million, to expand the NGOTGP over the next four years to better support families and youth.

### **Purpose of the case study**

The purpose of this case study is to explore issues in Commonwealth Government funding to treatment services, and analyse any changes arising from NGOTGP funding in terms of the number of treatment places available, improved access to quality treatment, and contribution to the intended long-term outcome of reduced drug use and related harms.

### **The proposition tested by the case study**

Funding programs designed and implemented in accordance with the best evidence contribute to achieving intended outcomes for clients, families and communities. The starting proposition for this case study is that NGOTGP funding and the Commonwealth's processes for its allocation have increased availability and access to drug treatment.

For the purposes of this study, we have considered the program logic behind the NGOTGP, the efficiency and effectiveness of aspects of implementing the NGOTGP funding processes in Rounds 2 and 3 (which span 2004-2009, the period of the current NDS), and how these processes and activities link to the NGOTGP outputs and intended intermediate outcomes, including:

*Inputs* - policies, funding models and mechanisms, resources and qualified staff

*Processes* - resource allocation processes, including call for and assessment of applications, allocation of funds, monitoring and reporting on progress and evaluation

*Outputs* - increased funding of a range of evidence-based drug treatment services

*Intermediate outcomes* – increased availability and access to quality drug treatment services

*Long term outcomes* - reduced drug use and related harms

The case study describes the Commonwealth's rationale and processes for implementing the NGOTGP funding, including the funding allocation model, its assessment and allocation processes, performance and accountability processes and activities, as well as the extent to which direct funding by the Commonwealth to agencies has enhanced the capacity of NGOs to provide quality treatment.

It also sheds light on questions of congruence between policy and program implementation, federal, State and Territory Governments' investment in core drug treatment services, complementary initiatives designed to build capacity in the AOD treatment services sector nationally, and the extent to which the NDS has stimulated actions on the ground.

## Method

Documents, reviews of literature on drug treatment models and resource allocation, and informant interviews were analysed to test the proposition. A set of research questions was formulated to guide the collection of data, informant interviews, and analyses of the data:

### Research questions

1. What were the strengths and benefits of the NGOTGP funding allocation processes? What were the limitations of the NGOTGP funding allocation processes?
2. To what extent were there clear evidence-based rationales which informed the Commonwealth's NGOTGP funding allocations and processes (eg application and assessment processes, criteria for assessment performance and accountability)?
3. What processes have been used to allocate the NGOTGP funds?
4. How well have different processes for allocating NGOTGP funding supported the achievement of the NGOTGP's intended outcomes?
5. To what extent was the implementation of the NGOTGP informed by evidence and knowledge of local constraints and opportunities for the effectiveness and efficiency of the investment?
6. To what extent is the NGOTGP funding adequate (eg sufficient, timely) to support implementation of treatment programs and achieve the intended outcomes?
7. What information sources are available to quantify improved access to treatment, and what do they reveal?
8. What other factors (at the system, organisation, personnel and community level) influenced the capacity of the NGOTGP to increase the number of treatment places available and improve access to quality treatment?

## Data collection and collation

### Documentation of policy, funding model and NGOTGP resource allocation processes

Documents reviewed included the current NDS Framework 2004-2009, IGCD Annual Reports to MCDS 2005 and 2006, web-based materials, and documents supplied by the DoHA's Diversion and Treatment Section of the Drug Strategy Branch. Commonwealth documentation included the administration guidelines for the NGOTGP 2004 and 2005, requests for tender for the evaluation of NGOTGP, state reference group guidelines and deed of conflict and confidentiality, application guidelines and forms, standard funding agreements, the National Minimum Data Set for Alcohol and Other Drugs Treatment Service (AODTS-NMDS) requirements for grant holders, State/Territory project report assessments, and the key performance indicators for funding Round 3 grants 2008-2011.

### Performance reports

DoHA State and Territory NGOTGP project officers provided us with progress reports from organisations that received NGOTGP funding in their jurisdiction under Round 2 grants.<sup>6</sup> The reports were the main source of secondary data available to document the performance of individual services in relation to the funding provided under the NGOTGP. The reports included project schedules, final reports for the period 2003-2006, and annual reports for 2006-2007. We reviewed 130 reports that provided information on the performance of the NGOTGP for one complete cycle of funding.

### Literature reviews

The literature on the AOD burden of the disease and injury is summarised in Volume 1 of this report.<sup>7</sup> Literature on evidence-based models of care and interventions, resource allocation in the AOD treatment sector, and the social determinants of drug-related harm were also reviewed to inform analysis of the outcomes of national initiatives in Component 2.<sup>8</sup>

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<sup>6</sup> NGOTGP project officers in each State and Territory provided progress reports, with the exception of the ACT office. The SA NGOTGP office provided only project schedules and 2006-07 annual reports but no final reports.

<sup>7</sup> Summaries of the literature and data on drug trends may be found in Volume 1, Chapter 3

<sup>8</sup> See Page 89 below for summaries of these reviews

## Informant interviews

A set of discussion topics derived from the research questions was used to facilitate interviews.<sup>9</sup> With advice from DoHA and the PWG, informants were drawn from members of the IGCD, ANCD, key NGOs, NGO Peak Bodies, NGOTGP funding and governance committees, and DoHA officers responsible for developing and implementing the NGOTGP nationally and at jurisdictional levels. Additional State and Territory Government informants were included on the advice of the Commonwealth officers responsible for implementing the NGOTGP in each State and Territory. 25 informants commented on the NGOTGP case study.

## Analysis of data

Analysis of information gathered through the document, literature and data reviews and informant interviews were synthesised using the research questions to generate findings about the Commonwealth's rationale and processes for implementing the NGOTGP funding, its assessment and allocation processes, performance and accountability, as well as the extent to which direct funding by the Commonwealth to agencies enhanced the capacity of NGOs to improve access to quality treatment.

## Research, policy, funding and service system context

Alcohol, tobacco and illicit drug use were in the top 14 risk factors in 2003 in their contribution to the burden of disease and injury in Australia, expressed in disability-adjusted life years (DALYs). Tobacco, alcohol and illegal drugs comprised 12.1% of the total burden. Tobacco accounted for 65% of the drug-related burden of disease and injury, and alcohol and illicit drugs accounted for 19% and 16% respectively (Begg *et al* 2007).<sup>10</sup>

Improved access to quality drug treatment is one of eight priority areas of the NDS. It is integral to its program of effort to reduce drug related harms. Research and evaluation have demonstrated that the treatment of substance abuse problems is effective - certainly as effective as treatments provided for other chronic health conditions.<sup>11</sup> Evidence supports the effectiveness of the following illicit drug treatment modalities:

- Pharmacotherapy maintenance for opioid dependence, particularly by methadone, buprenorphine and combined buprenorphine/naloxone
- Conventional detoxification from psychostimulants and cannabis dependence
- Rapid detoxification under sedation or anaesthesia for heroin users
- Psychosocial therapies, which add to the effectiveness of methadone maintenance treatment for people dependent on opioids, are effective among some people dependent on psychostimulants including amphetamines and cocaine, and can be effective in the treatment of cannabis dependence and relapse prevention
- Residential rehabilitation and therapeutic communities are important components of the treatment mix, with at least three months residence and active program participation required to achieve change
- Twelve-step (self-help) approaches such as Narcotics Anonymous may be effective in preventing relapse, but participation needs to be voluntary and cannot be considered to be treatment when used in isolation.

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<sup>9</sup> See Appendix E for the case study interview protocol

<sup>10</sup> See Vol 1 Chapter 3 for data on drug related morbidity and mortality

<sup>11</sup> See Page 98 below for a literature review on the effectiveness and cost-effectiveness of AOD interventions

## **Nature and extent of NGOTGP funding**

The NGOTGP provides funding to establish, expand, upgrade and operate non-government services. The funding aims to strengthen the capacity of NGOs to achieve improved service outcomes and to increase the number of places available.

Since the program's inception in 1997, the Commonwealth Government has invested approximately \$291 million through the NGOTGP to fund NGOs to establish and operate new treatment services for illicit drug users and/or expand or upgrade their existing treatment services. This has been done in three funding rounds:

- Round 1 (1998-2002): \$58 million was allocated to 138 NGOs (two instalments in 1998)
- Round 2 (2003-2008): more than \$99.4 million was allocated to 177 NGOs (2 instalments in 2003 and 2006)
- Round 3 (2008-2011): funding of \$134.4 million was allocated to 197 NGOs, including 48 new services<sup>12</sup>

## **Scope of funding under the NGOTGP**

Organisations seeking funding under the NGOTGP had to be community-based, non-government and not-for-profit in nature, and had to have their own incorporated management structures that oversaw the operation of their treatment service. Potential grant holders also had to operate their service independently of any Commonwealth or State/Territory Government Departments and instrumentalities, although they could receive financial assistance from these sources to provide services required by Government. Applications for NGOTGP funding were not accepted from individuals, unincorporated organisations, government agencies, universities, commercial or profit organisations, or agencies whose core business was research.

The drug treatment services eligible for funding under the NGOTGP include counselling, outreach support, peer support, home detoxification, medicated and non-medicated detoxification, therapeutic communities and in- or out-patient rehabilitation. NGOTGP Round 3 particularly emphasised filling gaps in drug treatment services across geographic areas and target groups such as women, youth, and families with children, people with comorbidity, psychostimulant users and Aboriginal and Torres Strait Islanders.

NGOTGP funding Rounds 2 and 3 extended the quantum of funding, and increased the number of organisations providing treatment. These funding rounds continued and enhanced funding to services already funded under the NGOTGP, and also allocated resources to new services.

Progress reports and informant data indicated that the increased NGOTGP funding strengthened drug treatment service capacity by complementing State and Territory Government and local funding, broadening the scope of illicit drug treatment services, and filling some service delivery gaps. For example, it provided more residential rehabilitation beds, outreach, assessment, information and education, counselling, withdrawal management (detoxification), support and case management (care planning), and follow-up (aftercare).

## **Resource allocation model**

Research and practice make clear that the complexity of drug-related harms requires (1) a whole-of-system approach to providing drug services (2) effective and efficient delivery of evidence-based interventions (3) a planned allocation of resources to those most in need and (4) access to a comprehensive continuum of drug treatment, health and social care.

The NGOTGP resource allocation model reflects knowledge of the aetiology of drug-related harm, the social determinants of problematic drug use and the extent and nature of needs. These factors have informed decisions about the allocation of resources to NGO drug treatment services.

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<sup>12</sup> Figures supplied by DoHA

Funding allocations for the NGOTGP were guided by several key principles of treatment reflected in the selection criteria and assessment processes for Rounds 2 and 3. The intention of the NGOTGP was to fund services that offer evidence-based treatment interventions and use models of good practice, reduce illicit drug use, criminal behaviour and the risk of infectious disease, and improve physiological, psychological and social functioning and wellbeing.

A growing body of evidence for the social determinants of drug-related harm is receiving increased attention - that is, social exclusion as a result of such socio-economic disadvantage as poverty, homelessness, unemployment, poor education level, lack of social support, membership of minority groups (Indigenous and certain ethnic groups), and living environments (Marmot & Wilkinson 2006; Spooner & Hetherington 2004)

Any formula for determining the allocation of resources should take into account the size of the population, the relative level of need across different regions, and the relative cost of providing services to different regions. While the allocation of funds to regions should be based on need, the allocation of funds within regions should be output-based - that is, providers within the region are funded on the basis of what they achieve or are expected to achieve (for example, a specific number of consumers treated within a given year).

There has been a general shift in Australia away from contracts specifying the outcomes that funded services should deliver, towards contracts specifying the activities agencies have been funded to perform. The application form requires the applicant to provide the evidence of the treatment modality, but this may be problematic if there is no sound evidence for these activities. There are many examples of agencies using interventions of low cost-effectiveness (eg long term residential, 12 step (self-help) only programs) or interventions of no known efficacy.

NGOTGP Rounds 2 and 3 funding was allocated across the States and Territories using a funding model based on a formula that incorporates population estimates (eg *per capita* split) and the Commonwealth Grants Commission community health factor weighting.

The community health factor weighting takes into account a range of socio-economic indicators for resource allocation, such as scale-effected expenditure, community health and isolation. In addition, other aspects of equitable national resource allocation are considered, such as access to AOD treatment services for people living in rural and remote areas, Aboriginal and Torres Strait Islander communities, people from diverse cultural and linguistic backgrounds, and young people.

## **NGOTGP resource allocation processes**

The NGOTGP resource allocation model is implemented by processes including a call for applications, assessment of applications by State and National Reference Groups, allocation of funds, monitoring, and reporting on progress and evaluation, and providing final reports.

In the 2008-2011 funding round, funding criteria and allocation processes were revised to provide a greater focus on NGO capacity to deliver programs that were more evidence-informed, collaboratively planned and integrated. The assessment criteria required NGOs submitting for grants in the 2008-2011 round to show evidence of need, and of their capacity to provide quality evidence-based interventions to meet these needs. SRGs involved State and Territory and NGO peak bodies and representatives to provide evidence and specific knowledge about regional and local community needs, constraints and opportunities, service mix and coverage.

### **Call for applications**

The application form asked potential grant holders to provide a project plan and describe:

- the treatment service
- the evidence-base for the development and/or delivery of treatment

- organisational capability and organisational stakeholder relationships
- the relevance of treatment service to local State or Territory government strategic plans and service delivery guidelines and standards
- organisational capacity to plan and report
- detailed budget for the funding period
- the governance of the service.

Informants involved in the assessment processes said they relied on applications to provide service level data about reach and penetration, geographical coverage and high needs groups. The detailed application form required time and resources if organisations were to address the selection criteria adequately. Informants said the requirements to demonstrate capacity to deliver services, knowledge of client needs, and capacity to provide evidence-based treatment modalities were appropriate and accountable. It is important that correct procedures are followed to ensure probity and fairness and that the funds are expended in an efficient, effective and ethical manner; but application of these principles should also take account of the compliance burden for some smaller organisations.

### **Assessment of applications**

The Diversion and Treatment Section of the Drug Strategy Branch of DoHA (Central Office) is responsible for managing the NGOTGP funding allocation processes, providing the Minister with recommendations for funding, and developing and implementing the program processes at the national level.

These tasks includes developing NGOTGP policies, program guidelines, the national evaluation strategy, national consultation with program stakeholders such as MCDS, IGCD, ANCD, ADCA, liaison with the Minister's offices about NGOTGP program development and implementation, and effective communication between Central Office and the State/Territory offices of DoHA.

The *National Reference Group (NRG)* was responsible for reviewing all shortlisted grant applications to ensure that there was an equitable spread of resources nationally, and to identify any gaps in service provision. In so doing, the NRG considered the availability of services in rural and regional areas, the accessibility of services to target groups, and the extent to which the NGOTGP had improved the capacity of NGOs to treat specific groups affected by illicit drug problems (eg families of users and youth). In certain circumstances, the NRG also contacted the independent referees supplied by grant applicants as a means of collecting further information on the organisation's ability to provide the treatment services listed on its application.

The NRG consists of a senior officer from Central Office as chair, representatives from ANCD, OATSIH, the 'Strengthening Families Program' of the Department of FAHCSIA, and other experts as required.

DoHA State and Territory project officers address project management at a local level. They are responsible for liaison with funded NGOs, and interacting with Central Office project officers and other Government Departments. Their major responsibility is liaison with NGOs to prepare and negotiate funding agreements, develop and maintain effective relationships, understand the aims and objectives of funded projects, monitor and evaluate projects, and help grant recipients render invoices for payments and provide progress reports. The expectation has been that State and Territory project officers would visit funded NGOs on a regular basis to gain insight into their operations, speak with stakeholders, and attend functions arranged by services where possible.

All the State Reference Groups (SRGs) - the assessment panels - involve State or Territory representatives, and in some jurisdictions representatives of NGO peak bodies.

SRGs assess eligible applications against the selection criteria and provide completed score card assessments to Central Office, where a shortlist and prioritisation report is prepared for

the consideration by the NRG. The NRG considers SRG assessments and provides final advice to the federal Minister for Health and Ageing on equitable distribution of funds and a list of projects recommended for funding under the NGOTGP.

The DoHA State or Territory NGOTGP project officers advise unsuccessful applicants, and work with the successful applicants to enter into contractual arrangements with DoHA for NGOTGP funding. Each funding agreement contains a detailed and specific project schedule for the particular project, comprising the project plan, aims and objectives, timeframe and completion dates, budget and payment schedule, and the timeframes for reporting requirements as fund holders.

The collaborative nature of the assessment process has been enhanced by sustained relationships between DoHA NGOTGP State and Territory project officers, State and Territory Government representatives and NGO peaks or representatives. The NGOTGP program staff in DoHA have communicated regularly with State and Territory colleagues by six monthly informal meetings where both agencies discuss issues and share relevant information, make joint visits to services funded by both agencies, exchange views on services of concern, and partnering to support initiatives for people with mental health and AOD comorbidity, and initiatives for Aboriginal and Torres Strait Islander peoples with AOD issues.

There were few data on unmet need (such as numbers turned away or waiting list data). The documentation recorded that competitive grant rounds were consistently oversubscribed: 169 applications from over 270 applications received funding in Round 2, and 197 applications from 277 applications in Round 3 resulted in offers of funding. This oversubscription may serve as a proxy measure of unmet treatment need for illicit drug users in the Australian community, and confirm informants' perceptions that significant unmet need exists. On the other hand, an application for funding does not necessarily mean that the applicant can attract people into treatment. Applications may also have been unsuccessful because the SRG/NEG determined there was no need for the types of services applied for.

Some progress reports provided comparisons of referral and admission statistics as proxy data for unmet need. Waiting lists and areas of unmet need were included in several progress reports: they included prison parole programs, residential rehabilitation beds, outreach services to clients at various locations (eg schools in urban and rural areas, juvenile detention centres, prisons, and home visits), but a majority of reports lacked quantitative data.

While the allocation processes call for evidence of existing client need, informants said that organisations with well-established organisational capacity and scale were more likely to succeed than smaller organisations in competitive tendering processes. Larger, longer-established organisations had better infrastructure to compete for funding than smaller organisations with few staff. Smaller organisations also had less infrastructure to deliver new services, recruit and retain appropriately skilled and qualified workforce, and meet requirements for performance reporting, data collection and review.

The Commonwealth provided more NGOTGP funding to more organisations in both Rounds 2 and 3. In Round 2, funding was allocated in two stages: Stage 1 offered organisations currently receiving NGOTGP grants an opportunity to submit applications for continuation of funding into the new grant period 2003-2006. Stage 2 was open to organisations seeking funds in addition to their existing grant, and to organisations seeking funding for new drug treatment services. In addition, unsuccessful applications from stage one could be reconsidered.

Following an open and competitive application process, Round 3 funding agreements began in mid-June 2008, when NGOTGP funding of \$134.4 million was provided to 197 organisations over the next three years (2008-09 to 2010-11). In Round 3 improvements were made to the processes for allocation of funds: funding was allocated for three or more years,

allowing NGOs sufficient time to perform, report and document results in their submissions for the next funding round. There was a greater collaboration in the SRGs.

Overshadowing these improvements were issues of timeliness of allocation of funds, and delays in informing organisations of funding in 2008. The call for applications closed in December 2007. After a lengthy approval process, the announcement of Round 3 grants in June 2008 coincided with expiry of contracts from Round 2. Because AOD NGOs were unsure of continued funding, they were unable to commit to staff salaries at the end of the financial year. This reduced their capacity to retain staff and necessitated the recruitment and training of new staff after the funding was announced.

DoHA has met with key NGO stakeholders to discuss the processes for Round 3, and is in the process of establishing a working group including NGO representation to examine processes for future funding rounds.

### **Reporting and performance monitoring processes**

DoHA State/Territory project officers negotiated performance indicators on an organisation by organisation basis at the time of negotiating funding agreements. Service reports served as agency or service level compliance reports which documented the services delivered, provided information on barriers to delivering contracted activities, and described efforts to address these barriers, thus accounting for the expenditure of funds against the objectives of the projects.

In addition, some States and Territories collaborated with their Commonwealth counterparts to identify indicators of performance and data collection mechanisms to resource, implement and monitor the performance of local systems of treatment and care.

Project performance has been monitored through (1) liaison between the funded NGO and the State/Territory NGOTGP officers and (2) assessment by these officers of funded NGOs' regular progress reports. This monitoring approach encourages feedback between the parties, and allowed program variations to be identified and corrected early. It ensures that safe practices are being adhered to, and enhances both client outcomes and the quality of project reporting. Informants said the effectiveness of these activities has been greatly enhanced by adequate handover from old to new staff, and by site visits.

Funding agreements between DoHA and the funded NGOs have required NGOs to six monthly financial reports, annual progress reports, a final report addressing performance over the funding period, and AODTS-NMDS reports. Funded NGOs receive their payments from the relevant State or Territory Office Financial Management Unit on a quarterly basis in advance, on receipt and acceptance of a correctly rendered invoice and indication by State or Territory project officers that the submitted progress reports are satisfactory.

Each funded NGO has received a *pro forma* to help them prepare the core components of the six monthly and annual progress reports. NGOs have been required to:

- evaluate and report on the progress of their project or service against the main objectives outlined in the funding agreement project schedule
- provide evidence of how the service has met client needs
- identify any problems experienced throughout the reporting period and detail the means by which these issues were addressed
- provide supporting evidence of any project material produced during the reporting period (eg written materials, training packages, videos, audiotapes, including copies of publications and papers presented at conferences)
- provide a financial statement that lists the purpose and manner in which the NGOTGP funding has been expended by the service.

The principal method DoHA has chosen for measuring the effectiveness, efficiency and appropriateness of the NGOTGP has been analysis of the AODTS-NMDS data provided to

AIHW by the funded NGOs. These data are provided annually by funded NGOs as part of their service reporting requirements.<sup>13</sup> The two main elements of the AODTS-NMDS are establishment level data (eg geographical location of treatment service), and client level data (eg referral source, age, sex, principal drug of concern, and main type of treatment provided). It is compulsory for all NGOTGP grant holders (dually funded and directly funded NGOs), although a small number of projects have held special exemptions from this collection process (eg some Aboriginal and Torres Strait Islander services that reported directly to OATSIH; and correctional institutions). Nevertheless, it remains difficult for NGOs to attribute or even apportion part of a service to an individual in an organisation that receives funding from multiple sources, including but not exclusively NGOTGP.

A final report is required of funded NGOs within three months of the project's conclusion. It is to provide a summary of the project over the entire funding period containing:

- An executive summary outlining the nature and scope of the funded project
- The range of activities undertaken
- Evidence of the project's success in reaching the intended target group
- Evidence of the achievement of the objectives and outcomes of the project
- A detailed description of specific outcomes linked to the activities undertaken
- The annual AODTS-NMDS data report
- A financial statement and a copy of a qualified accountant's report
- Auxiliary materials that have been produced for the project during the funding period
- How the report and outcomes of the project were to be disseminated to stakeholders
- Limitations or problems encountered in service delivery throughout the funding period

Review of 2003-2006 final reports from 130 services indicated that capacity for reporting and consistency of the information provided varied among organisations. Some had difficulty aligning evidence (protocols, activities, resources) with statements of objectives. Others had difficulty aggregating their reports over time. Some organisations' 2003-2006 final reports included information on one year of operation, while others provided information over three years.

Some jurisdictions have used a reporting template that includes an executive summary (project summary, key achievements, key challenges, forward plan), a statistical report against performance indicators presented quantitatively over each funding year to allow comparisons, and sections for comments on the objectives or qualitative information regarding the services performance, service demand, referrals, and brief narratives reflecting client outcomes.

The AODTS-NMDS data were consistent with State and Territory Government funded services data requirements as a minimum. The method of collecting data has varied across the country, although a common feature across jurisdictions has been a requirement for agencies to collect and provide treatment service data consistent with AODTS-NMDS specifications. Data from agencies that received NGOTGP funding were reported to the AIHW in a variety of ways. Some data were reported from the agencies through the DoHA's Central Office to the AIHW. Other data were reported from NGOTGP funded agencies through the respective State or Territory health department to the AIHW. These different mechanisms were the result of agreements between the States and Territories and the DoHA.

In some jurisdictions, services were asked by their respective State or Territory health departments to collect additional items for planning and performance monitoring. Some agencies designed their own data collection forms which incorporated AODTS-NMDS requirements but expanded on them to report against their priority areas. Some service reports called for a more integrated electronic data management system to improve the efficiency of NGOTGP data collection and reporting. Some jurisdictions collaborated on contracts and

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<sup>13</sup> There was a problem obtaining NGOTGP specific reports from the AODTS-NMDS data because of difficulties identifying agencies or programs or both, as described in detail in the section on AODTS-NMDS below

performance indicators but there were inconsistencies in the reporting requirements of different funding bodies (eg number of closed treatment episodes in the AODTS-NMDS versus number of clients in other data collections), and separate reporting was across three or four funding streams. In some jurisdictions, reporting of State or Territory funding and Commonwealth funding had been integrated, thus creating efficiencies and the prospect of more consistent data collection.

Informants recognised that the emphasis on compliance in the service report data limited their usefulness for performance monitoring and evaluation, other than at the agency level. National key performance indicators were developed for NGOTGP Round 3 (2008-2011) in order to build greater consistency across services into program reporting.

### **AODTS-NMDS**

The AIHW describes the AODTS-NMDS as a highly valued data collection which ‘...was implemented to help monitor and evaluate key objectives of the National Drug Strategic Framework 1998-99 to 2003-04, and help to plan, manage and improve the quality of AOD treatment services in Australia. The AODTS-NMDS continues to support key treatment-related objectives of the NDS 2004-2009, particularly trend data are becoming available’ (AIHW 2007a).

AODTS-NMDS is an administrative by-product that collates data collected for the purposes of administering or providing an alcohol and other drug treatment service. It includes data on referral sources, principal drug of concern and method of use, types of services accessed, and their reach and penetration aggregated across all program/funding inputs. The collection consists of de-identified unit record data for treatment agencies and closed treatment episodes.

The main purpose for collecting ongoing AODTS-NMDS data at the individual agency level is to provide useful drug and alcohol treatment information that is appropriate for monitoring and evaluating the type, usage and availability of current treatment interventions used in Australia. NMDS data collections also potentially contribute to agencies’ work in assessing and planning service delivery, as well as providing data that can be used in preparing future grant applications. The AIHW is responsible for collating the data received from DoHA and each of the States and Territories, and for preparing the national data set for analysis and aggregated reporting at national, State and Territory levels.

AODTS-NMDS publications provided a comprehensive picture of drug treatment service provision across the government and non-government sector and national, State and Territory levels. Its usefulness was limited, however, by the fact that there was no NGOTGP-specific analysis as a component of the over-all AODTS-NMDS to use for monitoring and evaluating NGOTGP performance. DoHA advised that such analyses would be of departmental and national interest, but that it is not possible to separate NGOTGP-funded treatment episodes from other treatment episodes at the service delivery agency level.

For the purposes of this case study, the evaluators, Drug Strategy Branch officers and AIHW explored the feasibility of AIHW producing AODTS-NMDS reports on the reach and penetration of the NGOTGP funded treatment episodes aggregated at the State, Territory and national levels. The aim was to assess the extent to which access to treatment had improved as a result of increased funding during the period 2003-2008. Data from agencies funded through the NGOTGP constituted a small component of the total data reported by jurisdictions annually to the AIHW. Data reported by the agencies through DoHA’s Central Office to the AIHW could be identified as treatment episodes funded through the NGOTGP. Once aggregated at a state or territory level, however, there is no indication of the funding source. This makes it difficult to separate NGOTGP-funded treatment episodes from those provided through complementary funding streams. Indeed, in many cases it is probably not possible for treatment agency workers to identify which treatment episodes are NGOTGP-funded, and which are not. This is further compounded by the often complex nature of drug and alcohol treatment. These data would be useful to support performance monitoring, review and evaluation and inform future iterations of the NGOTGP.

Discussions with the AIHW revealed that, in order to extract the NGOTGP data from the national collection, it may be possible to develop a data element that indicates whether a treatment service is fully, partially or not NGOTGP funded (though this would still be only a proxy measure for NGOTGP services). We encourage AIHW and other stakeholders to explore the feasibility of introducing this modification to the data sets with a view to using the resulting data for performance monitoring and evaluation.

### **Increased availability of treatment and increased access to quality treatment**

Over the life of the NGOTGP, more funding has been provided to more organisations. Increased funding over the life of the program is a proxy measure of increased outputs, but data to quantify the increase in NGOTGP funded treatment places or episodes is not yet available.

Informants said that NGOTGP funding increased the number and type of services available and improved the reach and penetration of drug treatment services. The NGOTGP had funded a range of services for which the evidence base was clear. Funding under NGOTGP and IDDI had increased the range of illicit drug treatment services and filled some service delivery gaps, such as additional residential rehabilitation beds, outreach, assessment, information and education, counselling, withdrawal management (detoxification), support and case management (care planning) and follow-up (aftercare).

The call for Round 3 applications focussed on providing services at different stages of treatment, including outreach and referral services, detoxification, residential and outpatient rehabilitation, aftercare and counselling, and services specifically targeted at families with children and youth. This funding round allocated resources to a prison-based service using the therapeutic community model. Recent NGOTGP funding rounds have allocated resources to a wider range of services, moving towards a continuum of evidence-based services through a better balance of investment in the spectrum of drug treatments.

Evidence of the effectiveness of drug treatment services justifies support for an integrated continuum of drug treatment services that includes voluntary and involuntary addiction treatment, withdrawal services (detoxification, rehabilitation, therapeutic communities), relapse prevention, counselling, care planning and management, and aftercare/community liaison.<sup>14</sup>

### **Evaluation of NGOTGP**

The amount of funding allowed agencies to implement programs in line with best evidence. It contributed to a growing knowledge base about the impact of different sub-populations and contexts on the achievement of the desired outcomes for clients, families and communities.

If decisions about what type of programs to fund and where to fund them continue to be based on a thorough knowledge of the evidence for effectiveness, then performance monitoring and evaluation should focus on ensuring the integrity of a program's implementation, its intermediate outcomes including access, reach and penetration, and how it has met identified needs.

Evaluation should consider the contribution of a program and the broader contextual factors affecting its success or failure. A majority of the 2003-2006 final reports described system factors that affected their capacity to deliver the objectives of the funded projects. To varying degrees, information in the service reports illustrated ways in which the NGOTGP had strengthened agencies' capacity to address the challenges they faced in program activities, referrals, coordination and networking, community involvement, collaborative links and partnerships with other AOD agencies, workforce, infrastructure and resources

Criteria for reporting were revised in Round 3 contracts to collect more consistent information through the service reports. In addition 2008-2011 funding agreements required recipients to

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<sup>14</sup> See Page 91 below for literature on AOD models of care

sign a 'data collection advice form' that gave DoHA permission to obtain NMDS data from the State or Territory Government or from AIHW, irrespective of the processes used for collection. It is hoped this initiative will allow DoHA to obtain AODTS-NMDS data that will contribute to performance monitoring and future evaluations.

Requests for tender to evaluate the NGOTGP were advertised in 2005 and 2007, but on each occasion the tender process did not proceed. DoHA indicated that more consistent reporting performance data will be collected in future to support evaluation. An agency level evaluation of the NGOTGP in Tasmania was due to report in September 2008, but was not available within the timeframe for this case study.

## **Effectiveness of the NGOTGP**

This case study assesses the effectiveness, strengths and weaknesses of the NGOTGP as a high level program to increase capacity. It is not an assessment of the effectiveness of individual fund recipients' performance or the treatment modalities they employ.

The National Health and Hospitals Reform Commission statement of principles of governance (NHHRC 2008) provide a valid benchmark for performance in the AOD sector. The principles speak to the key issues of equity, shared responsibility, comprehensiveness, recognition of the broader environmental influences that shape our health, monitoring and planning, transparency, accountability and reporting, the need for a culture of quality improvement, public participation, and delineation of roles and responsibilities of the Commonwealth and state and territory governments, and the private and non-government sectors. Over the life of the program, the NGOTGP (and the broader AOD sector) has progressively improved in each of these areas.

### **Resource allocation model and processes**

Funding should be based on a planned allocation of resources to those most in need. The concept of evidence-informed resource allocation and its practice was well documented, and senior informants understood it as a desirable approach. The formula used for determining the allocation of NGOTGP resources takes into account the size of the population and socioeconomic indicators, cross cultural factors, community health and isolation. The resource allocation model and the resource allocation processes were also guided by several key principles of treatment that are reflective of the needs of the broader AOD treatment sector, that is treatment should be evidence-based and use models of good practice, reduce illicit drug use, criminal behaviour, the risk of infectious disease, and improve physiological, psychological and social functioning and wellbeing.

Resource allocation processes seem to align with best practice. They have been appropriate and inclusive of jurisdictions. Some stakeholders in the NGO sector wanted to have more NGO involvement in decision making, but this is difficult owing to potential conflicts of interest, given the small size of the sector and the make-up of the peak organisations' governing bodies. It would be appropriate to consult with the NGO sector about the principles to guide decision-making and resource allocation, but then entrust decision-making to the government on behalf of the community.

Processes for allocating NGOTGP funds conform to evidence, governance and accountability standards, but program and contextual factors - variations in state and territory level collaborative planning and performance monitoring, timeliness of resource allocation processes, workforce skills and shortages, output and outcome data collection mechanisms, and performance monitoring and ongoing review – remain limitations on the capacity to implement treatment activities as planned.

### **Intended outcomes**

The program logic for the NGOTGP is sound, and if implemented as intended the processes and activities funded through the NGOTGP should achieve the intended outcomes.

Assessment of the extent of the success of the NGOTGP, including the extent to which resources have been allocated to those most in need, has been limited by the lack of NGOTGP specific data describing unmet need, access, reach and penetration of the program.

Widely accepted evidence indicates that AOD services need to address a comprehensive continuum of drug treatment health and social care. Working in an integrated manner with AOD and mental health sectors but also with the primary and community care sectors remains a challenge, but some States and Territories have been working with DoHA state and territory officers to improve the integration of care through government, private and NGO providers via co-location, coordinated referral pathways and shared care arrangements to meet the clinical and non-clinical needs of their clients.

Informants said that the NGOTGP funding increased the number and type of services available and improved the reach and penetration of drug treatment services. Based on data on inputs, processes, informant information, and progress reports, we assume that NGOs with existing NGOTGP funding have continued to operate and extra NGOTGP funds have enabled considerable expansion. However, as national, State and Territory NGOTGP-specific AODTS-NMDS data were not available, it was not possible to quantify increased access to drug treatment or expanded reach and penetration as a result of increased funding during Round 2 and between Rounds 2 and 3. Nevertheless, increased NGOTGP funding to more NGOs over the three rounds, together with increased treatment episodes, offer a reasonable proxy measure for improved service access, reach and penetration.

Although most services have treatment plans which record interventions undertaken by clients, and some have the client closure forms that record client's satisfaction with the program, there were no quantitative data on client outcomes in terms of changes in substance use, psychosocial issues, or other personal circumstances. The client data in the final reports and in the NMDS focused on episodes of care and activities.

## **Other funding sources**

Providing drug and alcohol services is predominantly the responsibility of State and Territory governments. The NGOTGP is only a small part of the total drug and alcohol treatment services provided through NGO, public and private settings in Australia, and supplements these services. It complements State and Territory funding. It operates alongside other sources of Commonwealth funding to NGO drug treatment services, for example:

- In 2008-09 Amphetamine-type Stimulants Grants Program (ATSGP) funds were provided for two years to NGOs for infrastructure upgrades, better information and educational resources, and to engage staff with particular expertise in the treatment of ATS users. The funds were part of a package of measures under the NIDS
- In 2007-08, additional resourcing were provided for drug and alcohol treatment and rehabilitation services in regional and remote areas under COAG's National Framework on Indigenous Family Violence and Child Protection
- The *Improved Services for People with Drug and Alcohol Problems and Mental Illness* initiative aims to build the capacity of non-government drug and alcohol treatment services to effectively address and treat coinciding mental illness of the Council of Australian Governments' (COAG) *National Action Plan on Mental Health 2006-2001*. The initiative is providing about \$20 million a year to 2011-12 to help non-government drug and alcohol treatment organisations build their capacity to treat concurrent mental illness and substance abuse effectively. Grants of up to \$500,000 over three years were available to individual non-government alcohol and other drug treatment services to carry out service improvement activities to build their organisation's capacity to respond to comorbid clients. 122 non-government alcohol and drug treatment services are being funded a total of \$44.8 million over three years under the capacity building grants component of this initiative, to support workforce training, partnerships with local health services, and policies and procedures for identification and management of comorbid clients.

- A second component of the initiative is the *Cross Sectoral Support and Strategic Partnership* (CSSSP) project. The CSSSP project funds AOD non-government peak bodies (or equivalent state-based support organisations) to help services build partnerships with other health sectors, identify workforce development and training opportunities, and to undertake service improvement activities.
- Since 1999, COAG has funded additional treatment places under the IDDI in order to increase the capacity of NGO treatment programs to cater for non-voluntary clients.

### **Broader system issues**

Sectors responsible for activities that address broader system issues and social determinants also contribute to the success of AOD-specific investment. Coordination of effort across governance and implementation structures remains a significant challenge which is not specific to the AOD field. Both the progress reports and the informants indicated that, in this broader context:

- the pressures faced by AOD NGO providers were common across jurisdictions
- in some jurisdictions, the State or Territory Government continued to be the main funder of NGOs' core AOD business
- AOD NGO provider development in the sector varied across jurisdictions
- there was a persisting need to continue funding complementary initiatives to build an appropriately skilled and qualified staff, and the organisational capacity to deliver the full range of effective and cost-effective service types
- NGOTGP funds recipients also received grants from two or three other funding streams managed by DoHA or FaHCSIA
- the complementary funding provided through the range of Commonwealth programs was critical to the sustainability of AOD NGOs

The Australian Government's NGOTGP began direct funding to NGOs with a first funding instalment of \$2 million to 54 projects, announced in August 1998. Many NGOTGP-funded organisations have also received State or Territory funding. Informants commented that the capacity for integrated planning approaches to service delivery at State and Territory level depended on how closely DoHA officers in the States and Territories worked collaboratively with their State and Territory government counterparts. Some States and Territories had worked with DoHA state officers on ways to improve the integration of care through government and NGO provider co-location, coordinated referral pathways and shared care arrangements to meet both the clinical and non-clinical needs of their clients.

Collaboration is critical to coordination and consistency in efforts to enlist government jurisdictions, public administration and services, and the significant capabilities of the private and not-for profit sectors. To meet demand, treatment services need to work in an integrated manner not only in AOD and mental health, but also with primary and community care. This remains a challenge, but is critical to effective delivery of an evidence-based continuum of care.<sup>15</sup>

### **Workforce**

Efforts have been made by States, Territories, the Commonwealth, the funded agencies and the AOD NGO peak bodies to increase the capacity of the NGO AOD sector to recruit appropriately skilled and qualified staff.

Effective resource allocation depends on investment in organisational and workforce capacity (ANCD 2005). In service delivery, workforce is a major factor affecting return on investment. Workforce modelling studies in other areas of the health system (such as mental health or aged care) have provided the AOD sector with analyses to inform investment in the short, medium and longer term, in this critical area of capacity and sustainability.

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<sup>15</sup> See Page 91 below for literature on AOD models of care

Informants said that AOD service providers – both Government AOD services and NGO AOD services - had been unable to deliver planned services because of staff shortages and skills gaps in the sector. Matters that posed major problems included a shortage of qualified AOD workers, GP prescribers and AOD specialist clinicians, a lack of minimum competency standards, limited capacity to replace workers released to participate in training, and the limited availability of supervision, mentoring and career progression.

Staff turnover and vacancies reduced their capacity to deliver the number of treatment episodes expected in a funding or reporting period, to create effective referral networks and coordination of services, or to offer culturally appropriate and gender specific services.

Some States and Territories have developed their own AOD workforce strategies. These strategies relied on partnerships and collaborations across sectors. There could be a greater role for peak bodies in some jurisdictions to work with government to strengthen this aspect of the sector.

Informants spoke of the need for competitive pay and conditions, incentives and benefits to be offered by State and Territory governments, NGOs, and private providers in order to recruit and retain appropriately skilled and qualified staff. The fee-for-service basis for funding treatment services allowed NGOs to bid for grants using a funding formula that included pay levels benchmarked to the pay levels in the government sector, but there was limited funding for quality improvement, HR services, or other infrastructure management or governance needed for delivering high quality services. NGOTGP provided sufficient funding to NGOs to pay salaries at levels equivalent to the government sector.

Accreditation of services required employment of appropriately trained and qualified staff. Training and education programs at the Certificate III and IV levels were the focus of the AOD sector workforce development in recent years. The current imbalance in the AOD workforce, where there is still a short supply of tertiary trained clinicians, suggests that return on investment in the NGOTGP would be enhanced if the next iteration of the NDS gave particular attention to a comprehensive workforce development strategy that increased the NGO sector's capacity to attract and retain the services of skilled clinicians.

## **Summary and observations**

This case study set out to test the proposition that the NGOTGP funding and the Commonwealth's processes for its allocation have improved access to AOD treatment. The study has done so by:

- examining congruence between policy and program implementation, federal, State and Territory Governments' programs of effort, and the extent to which the NDS has prompted actions on the ground
- examining the extent and nature of the NGOTGP funding Rounds 2 and 3 which covered the period of the current NDS (2004-2009)
- describing the processes used to implement the NGOTGP across the nation to improve access to quality treatment services and to reduce drug use and related harms
- highlighting issues associated with Commonwealth Government funding to treatment services and analysing any changes arising from this funding in terms of the number of treatment places available, improved access to quality treatment and its contribution to the intended long-term outcome of reducing drug use and drug-related harms

NGOTGP funding is one element of a broader drug treatment service system. It has complemented State and Territory government funding and other sources of Commonwealth funding to NGO drug treatment services by strengthening drug treatment service capacity, broadening the scope of illicit drug treatment services, and filling some service delivery gaps and gaps in an evidence-based continuum of care (eg additional residential rehabilitation beds, increased counselling, outreach, care planning and follow-up).

## **Evidence-based resource allocation**

The collaborative processes for implementing the NGOTGP funding, in particular its allocation, application and assessment processes, have increased the congruence between policy and program implementation, federal, State and Territory governments' programs of effort and succeeded in enhancing the capacity of NGOs to provide access to quality treatment.

While the scope of the funding is broad, it is specifically for illicit drug problems. Treatment services that treated only alcohol abuse and dependence or provided pharmacotherapy programs (methadone, buprenorphine) have been ineligible for NGOTGP funding. Responsibility for treating people whose primary problem is alcohol, and delivery of pharmacotherapy programs, remain largely with State and Territory government services.

As NGOTGP funding has been one element of drug treatment service system funding, collaborative planning, assessment of applications for NGOTGP funding and subsequent performance monitoring and review have been critical in ensuring a needs-based and equitable allocation of resources. Through collaborative assessment of submissions, the opportunity has existed for state and territory quality frameworks, system gaps, planning priorities and population needs data to be incorporated into resource allocation decisions. The extent to which this collaboration was made operational has varied between jurisdictions.

Commonwealth, State/Territory and NGO representatives have offered expert advice about needs, quality, and the performance of NGOs applying for NGOTGP funds. The extent to which officers practically engaged with services has varied from jurisdiction to jurisdiction.

The needs of target populations, sub-populations and gaps in the service delivery system capacity have been progressively addressed through the NGOTGP, planning and funding allocations. However limited data were available to quantify the improvements in access, reach and penetration of treatment programs. Limited data were available to quantify unmet need at the service level.

## **Resource allocation processes**

NGOTGP funded a range of services for which the evidence base is clear. It has improved its processes for collaboration with States and Territories in meeting regional population needs. Assessment criteria and processes including collaboration with the States and Territories and NGO peak bodies have delivered information about the availability of services in rural and regional areas, the accessibility of services to target groups, and the capacity of NGOs to treat specific groups affected by illicit drug problems. NGOTGP has increased the range of illicit drug treatment services and filled some service delivery gaps (additional residential rehabilitation beds outreach, assessment, information and education, counselling, withdrawal management, support and case management and follow-up).

## **Data to support quality processes**

Further work is needed on better methods for data collection, reporting on and monitoring of performance. The quality, usefulness and accessibility of AODTS-NMDS data for monitoring program performance in access, reach and penetration are limited. It would be of national interest to introduce a data element to the AODTS-NMDS that captured information about funding source.

Overall, there has been limited capacity to collect data, report on program performance, and use these results to review and improve service and system level performance. The data available from progress reports and AODTS-NMDS were limited to processes and outputs (activities). In order to inform a national evaluation and monitoring framework, there is a need to identify relevant data indicators and ensure that data are collected on measures that are able to assess program outcomes and impacts. Greater understanding of the performance of the NGOTGP and related programs in access, reach and penetration could be achieved by identifying a minimum set of common performance indicators across all treatment program

funding streams, and streamlining, clarifying and improving the consistency of data collection mechanisms and tools.

There are also inefficiencies in multiple reporting requirements for complementary AOD NGO treatment funding to the same service.

### **Evaluation**

Historically, there has been limited opportunity to build evaluation into program implementation in NGOTGP. The program's documentation identified and described its inputs, processes, outputs (activities) and a number of intermediate outcomes. Data collection has focussed on activities rather than on the outcomes of treatment. Evaluation should consider the impact of other health and social factors on the outcomes of treatment (including individual and family progress on broader social outcomes such as relationships employment and/or accommodation).

## Component 2 case study 3: Tobacco legislation covering exposure to environmental tobacco smoke, and tobacco products' health warnings

This case study deals with the development and implementation of various Commonwealth, State and Territory laws covering non-smokers' exposure to environmental tobacco smoke, or health warnings on tobacco products. These varied legislative instruments mandate very different types of intervention to address different kinds of problems. In broad terms, the health warnings are mandated by Commonwealth legislation, and controls on environmental tobacco smoke by State and Territory legislation. The case study illustrates input into policy making by the research community, NGOs and government officials through the use of policy instruments such as advocacy, negotiation and legislative reform to prevent harm from tobacco.

### Purpose of the case study

The purpose of this case study is to add to understanding about how one of the NDS sub-strategies, the National Tobacco Strategy 2004-2009 (NTS), contributes to achieving desirable outcomes for society by facilitating development and implementation of legislation that aims to promote public health and well-being.

Under the NTS, the Commonwealth, States and Territories committed to the further use of regulation 'to reduce the use of, exposure to, and harm associated with tobacco' (NTS iii). Each Australian jurisdiction undertook to develop or update an action plan that included further efforts to use regulation:

'To minimise commercial conduct that currently contributes to ill-informed, non-voluntary and unnecessarily harmful and costly use of tobacco products and exposure to tobacco toxins with an aim to:

- **Eliminate** remaining forms of tobacco **promotion** (including through the pack itself), and find ways to reduce and offset the impact of **positive portrayals of smoking in films** and other forms of popular entertainment
- Dramatically **reduce the visibility** of tobacco products and their accessibility to young people
- Recommend measures to make tobacco products **less affordable**
- **Eliminate** remaining exposure to **environmental tobacco smoke** among workers, clients and patrons in many blue collar workplaces and public places including very high rates of exposure in pubs and clubs; and **minimise exposure** among clients **in** some publicly-funded (**residential**) **mental health treatment and correctional facilities**
- Devise and find finance for **a system** that **provides accurate and timely advice** that will help consumers more fully understand the risks and consequences associated with smoking
- Develop a **regulatory system** for tobacco and tobacco replacement products that, **if** it is **feasible**, allows us **to reduce the overall harm** associated with dependence on tobacco and nicotine
- Set in place an **overarching legislative framework** that ensures that the costs of addressing tobacco-related harm are borne by those who manufacture or sell tobacco, rather than by other Australian taxpayers.' (42-3)

'Each Australian jurisdiction is able to develop or update an action plan describing efforts to meet each of these challenges'. (v)

In this case study we examined the influence of the NTS on legislation concerning two of the regulatory interventions – the package labelling of tobacco products, and restrictions on smoking in various environments. We also assessed differences in implementation across jurisdictions to inform the extent to which there is synergy and consistency in efforts among the States and Territories.

## Method

This is a single case study with one unit of analysis, namely the influence of the NTS on legislation relating to the package labelling of tobacco products and minimising exposure to environmental tobacco smoke. Two data collection strategies were employed: document analysis and informant interviews. A set of research questions was formulated to guide the collection and collation of data, informant interviews, and analyses of the data:

### Research Questions

1. What is the extent and nature of development and implementation of tobacco legislation across jurisdictions?
2. To what extent is the development and implementation of tobacco legislation congruent with the NDS Framework and the NTS?
3. How have the NDS and the NTS influenced/contributed to the development and implementation of tobacco legislation in each jurisdiction?
4. What determines significant variation (if any) in implementation between and/or within States and Territories?
5. To what extent is the national program of tobacco legislation covering packaging and restrictions on smoking environments informed by evidence?
6. In what ways, and to what extent, has tobacco legislation contributed to achieving outcomes identified in the NDS Framework and the NTS?
7. What factors, other than tobacco legislation, have contributed to achieving these outcomes?
8. Are there activities or programs, which have occurred outside the NDS Framework or the NTS, which have enhanced or diminished the achievement of the aims of tobacco legislation?
9. What other factors (at the system, organisation, personnel and community level) influenced the capacity of the national program of tobacco legislation to deliver the intended outcomes?

The documents reviewed included research literature, Chapman's influential 2007 book, *Public Health Advocacy and Tobacco Control: Making Smoking History*; Commonwealth, State and Territory legislation, policy documents and implementation reports, including the NTS web site <http://www.health.gov.au/internet/main/Publishing.nsf/Content/phd-pub-tobacco-tobccstrat2-cnt.htm>; key on-line data bases such as the Tobacco Control Supersite <http://tobacco.health.usyd.edu.au>. Technical Paper no. 2 of the National Preventative Health Task Force's Tobacco Working Group (2008), *Tobacco Control in Australia: Making Smoking History*, was another key source.

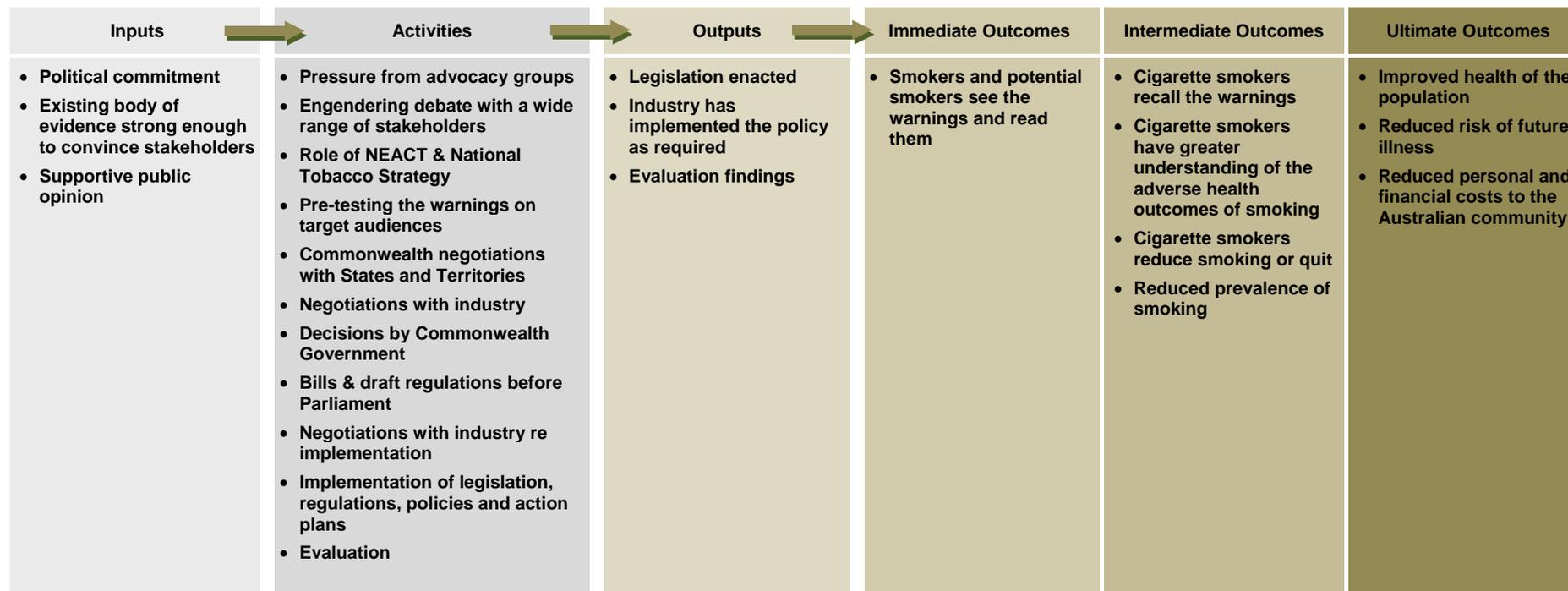
Interviews were conducted with 28 informants who included senior public servants, leaders of advocacy bodies (NGOs and professional associations) and tobacco researchers. The data were analysed using qualitative research methods to identify themes.

### Program logic model

Based on the document review, we developed models of the logic of the two legislative interventions under review, namely introducing restrictions on smoking in various environments (reducing environmental tobacco smoke), and the labelling of tobacco packaging with graphic health warnings. Both these logic models draw attention to the importance of political commitment, research evidence that convinces key stakeholders, and supportive public opinion. Activity leading to the passage of legislation mandating smoking bans or requiring graphic health warnings on tobacco packets have occurred in various sectors. Beneficial outcomes are obtained immediately from reducing environmental tobacco smoke exposure. The effects of mandating graphic health warnings on tobacco packaging require a longer time to see any effects.

## Program Logic Model: The labelling of tobacco packaging with graphic health warnings

Overarching objective: To make further use of regulation to minimise commercial conduct that results in ill-informed, non-voluntary and unnecessarily harmful and costly use of (and exposure to) tobacco products (*National Tobacco Strategy*, (iv))



Context: A broad movement towards more healthy lifestyles. Community opposition to tobacco use. Tobacco industry now characterised as a problem. Other tobacco control initiatives that may interact positively with this one. Concerns in the retail sector that graphic warnings could reduce sales.

**Program Logic Model: The introduction of restrictions on smoking in various environments (reducing environmental tobacco smoke)**

**Overarching objective: To make further use of regulation to minimise commercial conduct that results in ill-informed, non-voluntary and unnecessarily harmful and costly use of (and exposure to) tobacco products (National Tobacco Strategy, p. iv)**

Inputs	Activities	Outputs	Immediate Outcomes	Intermediate Outcomes	Ultimate Outcomes
<ul style="list-style-type: none"> <li>• Political commitment</li> <li>• Existing body of evidence strong enough to convince stakeholders</li> <li>• Supportive public opinion</li> <li>• Funds for personnel &amp; enforcement</li> </ul>	<ul style="list-style-type: none"> <li>• Pressure from advocacy groups</li> <li>• Engendering debate with a wide range of stakeholders</li> <li>• Role of NEACT &amp; National Tobacco Strategy</li> <li>• S/T authorities negotiations with industry groups</li> <li>• Decisions by S/T and local govt</li> <li>• Bills &amp; draft regulations before legislatures</li> <li>• Negotiations with industry re implementation</li> <li>• Implementation of legislation, regulations, policies and action plans</li> <li>• Evaluation</li> </ul>	<ul style="list-style-type: none"> <li>• Legislation enacted</li> <li>• Agreement with industry groups as to implementation steps incl. timetable</li> <li>• Industry has implemented the policy as required: designated S/F areas, building modifications, signage</li> <li>• Enforcement processes decided and implemented</li> <li>• Evaluation findings</li> </ul>	<ul style="list-style-type: none"> <li>• Smokers and potential smokers know of the restrictions</li> <li>• Smoking is eliminated in designated areas</li> <li>• Reduced environmental smoke</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced smoking prevalence</li> <li>• Lower levels of smoking in continuing smokers</li> <li>• Non-smokers and staff of the affected premises ingest less environmental smoke</li> </ul>	<ul style="list-style-type: none"> <li>• Improved health of the population</li> <li>• Reduced risk of future illness</li> <li>• Reduced personal and financial costs to the Australian community</li> <li>• Improved amenity for non-smokers</li> </ul>

**Context: A broad movement towards more healthy lifestyles. Community opposition to tobacco use in general and in enclosed premises particularly. Political power of the hospitality industry and their tobacco industry associates. False but widespread perception that smoking bans adversely affect hospitality industry profitability. Other tobacco control initiatives that may interact positively with this one.**

## Findings

The findings derived from this case study focus on the ways the NTS has been a factor in producing NDS program outcomes in the area of tobacco control that are likely to improve the health of the Australian population, and the extent to which it has done so.

## Context

### The epidemiology of smoking and its consequences

The first important contextual issue is *the epidemiology of smoking and its consequences*. The position has been nicely summarised by the Tobacco Working Group of the National Preventative Health Task Force (2008):

Smoking continues to be Australia's largest preventable cause of death and disease. Over three million people—just under 18% of Australians aged 14 years and over—still smoke at least weekly...About half of the smokers who continue to smoke for a prolonged period will die early, half of them in middle age...when children and grandchildren depend on them, and while they are in the most productive years of their working lives...Tobacco use caused 15,511 deaths in 2003,...and cost the Australian community around \$31.5 billion in 2004–2005...Smoking is responsible for 12% of the total burden of disease and 20% of deaths in Indigenous Australians (1).

The Tobacco Working Group explained that:

The Australian death toll caused by smoking will pass the million mark within the next decade. The social costs of tobacco exceeded \$31 billion in 2005,...but it is impossible to put a value on the grief suffered by the hundreds of thousands of families who have lost a child, a spouse or a parent in what should have been the most productive and rewarding years of their life.

Projections based on current patterns of uptake and quitting suggest that on our current course, prevalence of daily smoking will still be over 14% in 2020 and will remain close to 10% well past the year 2070 (v).

### The body of research evidence

The second important contextual factor is a *body of research evidence* that: demonstrates the adverse impacts on health of environmental tobacco smoke (United States Public Health Service, Office of the Surgeon General 2006); shows that bans on smoking in enclosed commercial venues such as pubs and clubs do not adversely affect the profitability of those businesses (Scollo *et al* 2003); and graphic health warnings, including on the tobacco product packaging, are effective in reducing smoking prevalence (White *et al* 2008). As pointed out by our informants from all sectors—research, advocacy and public service—the tobacco field is a domain of public health that has a sounder evidence base for action than most.

The third important contextual factor is the attention paid to tobacco in the NDS Framework document and, more particularly, the acceptance by all Australian governments of the NTS. The work of the National Preventative Health Task Force is likely to be instrumental in increasing the momentum of action to 'make smoking history' in Australia.

Internationally, perhaps the most important step forward in recent decades has been adoption of the WHO Framework Convention on Tobacco Control (<http://www.who.int/tobacco/framework/en/>) which came into force on 27 February 2005 after Australia ratified it on 27 October 2004. This Convention is the first global public health treaty reflecting the global impact, now and into the future, of tobacco in both the more developed and less developed nations. The Treaty's provisions include those that are the subject of this case study: reducing exposure to environmental tobacco smoke and requiring tobacco products to carry health warnings describing the harmful effects of tobacco use. Australia played a significant role in the development of the Convention and the negotiations which led to its adoption, and it was one of the first contracting parties to the Convention.

## Cultural shifts

A critical contextual factor has been the cultural shift in Australia favouring reductions in the availability and use of tobacco products. Over the years there has been some debate as to whether this reflects a general trend towards greater awareness of health issues and willingness of people to engage in health promoting activities, the direct effects of tobacco control policies, or some combination of the two. The research evidence suggests that health promotion interventions have been the key drivers, influencing and being influenced by other issues in culture and society (Chapman 2007).

## Development and implementation of tobacco legislation across Australia

### Graphic health warnings on tobacco products

Australia is well advanced, and has been one of the world leaders, in requiring graphic health warnings to be displayed on tobacco packaging. The history of health warnings in this country goes back over 30 years, with warnings introduced in 1973 when tobacco packaging was required to show the warning 'Smoking is a health hazard'. In 1994 cigarette packets were required to include six health warnings in black text on a white background.

The current health warnings on tobacco products are mandated by Commonwealth legislation, specifically the *Trade Practices Act 1974*. The detailed requirements of the current graphic health warnings are found in the Trade Practices (Consumer Product Information Standards) (Tobacco) Regulations 2004 (Cwlth). They came into full effect on 1 March 2006. According to the Department of Health and Ageing the key features of the health warnings system for most cigarette packs and loose tobacco (roll-your-own) and pipe tobacco packaging are as follows:

- 14 health warnings comprising graphic images, warning messages, explanatory messages
- A rotation system to optimise consumer learning and awareness of the health effects of smoking. Two sets of 7 health warnings (Set A and Set B) are alternated every 12 months
- Each set of 7 warnings appearing on, or as near as possible to, an equal number of each type of product for each 12 month period
- A 4-month transition period occurring between November and February (inclusive) each year to allow the phase-out of the previous set and the introduction of the next set of health warnings
- Health warnings covering 30% of the front and 90% of the back of most cigarette packs, with graphics appearing on both the front and back of packs
- Health warnings covering 30% of the front and 50% of the back of most loose tobacco and pipe tobacco pouches, with graphics appearing on both the front and back of packs
- The national Quitline number and Quitnow website address are included on the back of packs to provide a contact for smokers for assistance with quitting
- An information message on the health effects of chemicals in tobacco smoke appears on the side of the cigarette pack. The information message covers one full side of cigarette packets and 25% of one side of cigarette cartons
- Adhesive labels are not permitted for flip-top, soft pack cigarettes and cartons, but are permitted for pipe and tobacco pouches

<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-drugs-tobacco-warnings.htm>

The key features of the system of health warnings displayed on most cigar packaging are as follows:

- 5 cigar-specific health warnings comprising graphic images, warning messages and explanatory messages
- The 5 cigar-specific health warnings must appear on, or as near as possible to, an equal number of each type of product for each 24 month period
- Health warnings must occupy 25% of the front and 33% of the back of most cigar packages
- Adhesive labels displaying the cigar warnings are permitted for all cigar products
- An information message is not required on cigar packaging.

DoHA advises that mandatory graphic health warnings have three goals: (1) to increase consumer knowledge of the health effects of smoking, (2) to encourage the cessation of smoking and (3) to discourage uptake of smoking and relapse among quitters.

The 2004 regulations were introduced after an extensive period of market research and consultation with stakeholders.

Although it is only two years since these health warnings began appearing on tobacco product packaging, the Tobacco Working Group of the National Preventative Health Task Force has expressed the view that ‘Australia is now well behind when it comes to the potency of warnings’, and has proposed a number of actions to improve the effectiveness of the health warnings’ (2008, 22). The Department of Health and Ageing has commissioned an evaluation of the current set of graphic health warnings to determine their effectiveness, especially their impacts on smoking behaviour, attitudes, knowledge and intentions. The study is currently under way. It is likely that its findings will help guide the future directions for Australia’s graphic health warning system.

### **Reducing exposure to environmental tobacco smoke**

Australia has implemented smoking bans in most enclosed public places and in some places where non-smokers may be exposed to environmental tobacco smoke.

Legislative initiatives to limit people’s exposure to environmental tobacco smoke (or second-hand smoke or passive smoking) are, in the main, matters for the States and Territories. The Commonwealth’s role is to provide policy leadership where appropriate and to legislate in areas for which it has responsibility such as prohibiting smoking on domestic air flights and international flights operating out of Australia (mandated under the *Air Navigation Act 1920* and the *Air Navigation Regulations*) and in airport buildings operated by the Federal Airports Corporation (mandated under the *Federal Airports Corporation Act 1986* and the *Federal Airports (Amendment) By-laws Act 1986*). The *Interstate Road Transport Act 1985* and the *Interstate Road Transport Regulations* prohibit smoking on interstate buses, and there is a similar ban on interstate trains. Bans on smoking in Commonwealth buildings were for some years a matter alone. Subsequently, all States and Territories legislated regarding smoking in public places and workplaces.

There are substantial differences between the various states and territories in their legislation on smoking bans and in the implementation timetables. During the current phase of the NDS each State and Territory has acted to further limit exposure to environmental tobacco smoke. The Northern Territory stands out as being substantially slower than the States and the ACT in introducing these provisions, but it has recently announced that it plans to do so in the future. Smoking in vehicles containing children is prohibited in Tasmania and South Australia, and some other States and the ACT have indicated that they plan to introduce similar legislative provisions.

The Tobacco Working Group of the National Preventative Health Task Force (2008, 16) has pointed out that the uncoordinated introduction of smoking bans has led to the emergence of ‘...several loopholes and inadequacies...in some aspects of operation and enforcement’, as evidenced by a 2008 study by NSW Health demonstrating unacceptably high levels of tobacco smoke in pubs which should be free of these toxins. No jurisdiction bans smoking in prisons although some are planning to review their policies when the results become available of the trial of banning smoking in indoor areas of the Greenough Regional Prison in WA (<http://www.mediastatements.wa.gov.au/Lists/Statements/DispForm.aspx?ID=130069>). Prohibiting smoking in the home in the presence of children is not currently prominent on the policy agenda of any Australian jurisdiction because of the challenges in enforcing such a ban.

### **Influence of the NDS and the NTS on the development and implementation of tobacco legislation in each jurisdiction**

The NTS 2004-2009 was endorsed by the MCDS in November 2004 and so has been in operation for most of the current phase of the NDS. The States and Territories are invited in the Strategy to develop action plans to implement legislative reform in those areas that fall within their constitutional responsibilities.

The implementation of graphic health warnings is relatively straightforward: the Drug Strategy Branch of DoHA has policy responsibility for the health warnings, while compliance with the regulations is administered by the Australian Competition and Consumer Commission. The Drug Strategy Branch operates within the framework of the NDS and the NTS. The NTS 2004-2009 did not influence the introduction of these measures because graphic health warnings were introduced before the commencement of the current phase of the NDS and NTS and the research and policy analysis activity that led to the policy began five years before the current NTS. The current version of the NTS (pp. 23-4) acknowledges decisions already made on the regulation of tobacco packaging and identifies some emerging issues, but does not spell out a fully-developed implementation pathway towards more effective graphic health warnings.

A far more complex relationship exists between the national policy settings on tobacco and the development and implementation of tobacco control legislation within those jurisdictions. This is because most of the authority to limit exposure to environmental tobacco smoke is the responsibility of the States and Territories.

The first point is that nearly all informants agreed that the NTS was an excellent document. It was evidence-based, realistic and provided a clear framework for action by the States and Territories. It was developed collaboratively between highly committed public servants, advocacy representatives and members of the research community. The only caveat was that some observers thought it only included initiatives that governments were willing to implement; that is, it documented existing policy rather than pointing to new policies that could be considered. This was not the general view, however. It also has not reflected the fact that many new initiatives have been developed since the adoption of the NTS in 2004 that are consistent with the strategy.

In most jurisdictions people in government, advocacy organisations, and researchers were very much aware of the NTS and referred to it in their work. In contrast (and this is one of the areas where the tobacco field differs from other drugs) most of our informants were not familiar with the NDS Framework and did not see it as relevant to their work on tobacco. This is not surprising since IGCD/MCDS has given little attention to tobacco control during the current phase of the NDS.

Senior informants from both large and small Australian jurisdictions have characterised the NTS as ‘an enabling strategy’. What they mean by this is that their own State and Territory strategies and tobacco action plans largely reflect the contents of the NTS. It has provided a blueprint that they have been able to use within their own jurisdictions with minimal modification to local circumstances.

The small jurisdictions, with limited resources for research and policy analysis, have used the contents of the NTS without having to develop, from the ground up, arguments for the policies that it advocates. The fact that the Strategy is supported by high quality research-based documents has been a powerful positive influence for people engaged in policy activity. We heard of a number of instances where senior public servants, seeking to convince their colleagues and Ministers in other portfolios about the importance of new tobacco control initiatives, have only needed to refer to the NTS and the fact that it has been endorsed by MCDS to have its provisions accepted by their colleagues. This has been valuable in achieving progress across the country and a degree of congruence between the tobacco strategies and action plans of the various States and territories.

Some people in NGOs reported using the NTS as the framework for their advocacy work. In negotiations with decision-makers they point to its contents as the standard and called for their jurisdictions to implement the provisions of the Strategy.

There were differences of opinion among our senior informants about whether the agenda setting role of the NTS was sufficient, or if something else was required to optimise the national effort in tobacco control. Some argued that the States and Territories were operating independently in the tobacco control area with very little support and guidance from the Commonwealth, IGCD and MCDS. They pointed out that, although there is a high-level National Strategy, there is no detailed national action plan on tobacco specifying what actions will be taken, by whom, in what timeframe and using what resources, and no specific Commonwealth funding to the States and Territories for tobacco control. (Commonwealth officers have pointed out, however, that the State and Territory Governments are at liberty to use funds provided under the Public Health Outcomes Funding Agreements on tobacco control activities.) A review of the NTS will begin in 2008-09. Some argued that, over the years, the Australian Health Ministers' Conference (AHMC) and the Australian Health Ministers' Advisory Council (AHMAC) had given more attention to tobacco than MCDS and IGCD whose focus has been more on illicit drugs and alcohol. In other words, while they thought that the contents of the Strategy were fine, they believed there was insufficient national action to implement it.

This was a minority view, with the bulk of our senior informants feeling that the State and Territory initiatives, operating within the framework of the Strategy, were sufficient to achieve the desired ends. Some informants expressed concern that the Commonwealth had not used its taxation powers to discourage smoking by increasing the cost of tobacco or funding large-scale mass anti-smoking media campaigns, both initiatives for which there is strong evidence for efficacy and effectiveness.

We conclude that the NTS has been a powerful enabler of legislative reforms in the states to minimise non-smokers' exposure to environmental tobacco smoke.

### **Similarities and differences in tobacco legislation within and between States and Territories**

Clearly there are differences among the various States and Territories in the ways they have implemented the broad national agreements about tobacco control in protecting non-smokers from environmental tobacco smoke. Most of our informants do not consider this a problem because of the good progress that has been made in all jurisdictions except the Northern Territory during the current phase of the NDS. The Northern Territory has also announced that it will soon move decisively in the area of smoking bans. We have seen a process of policy 'leapfrogging' in which one jurisdiction will introduce an initiative, such as South Australia's ban on smoking in cars with children, and then other jurisdictions will introduce the same legislation soon after. This process has been characterised as one of 'catch-up', with competition between the jurisdictions in response to advocacy groups' pointing to other jurisdictions as models for what their own should be doing.

The annual AMA/ACOSH National Tobacco Scoreboard, including its ‘Dirty Ashtray Award’ ([http://www.acosh.org/news/legislation\\_australia.html](http://www.acosh.org/news/legislation_australia.html)), was cited by informants as being highly influential in government. The ‘carrot and stick’ approach that it uses—highlighting both excellence in public tobacco policy and tardiness in introducing evidence-informed policies—has been highly effective.

We heard no support for uniform legislation, harmonising legislation or introducing tobacco control initiatives simultaneously in all jurisdictions. Attempts to do this in other sectors have generally introduced huge delays because of the challenges in agreeing to a single legislative model for all settings. Most informants thought it better to allow the various jurisdictions to develop their own approaches in ways that reflected local circumstances, and allowed Ministers to make announcements in their own timeframes within their own jurisdictions.

### **The role of evidence in informing the national program of tobacco legislation covering packaging and restrictions on smoking environments**

Tobacco control is one of the areas in public health for which there is a very sound evidence base. The research evidence is both broad and deep. New high-quality, policy relevant research is published continually.

Importantly for policymakers, well respected economic evaluations have been conducted in this area and are frequently cited (eg Applied Economics 2003, Hurley & Matthews 2008, Shearer & Shanahan 2006). These constitute compelling evidence in a political environment where value for money is an important consideration.

One senior informant correctly described research evidence as the ‘bedrock’ of policy in tobacco control. Australia has produced some of the world’s leading tobacco policy researchers. Some of them have strategically and very effectively combined research with public health advocacy to produce outstanding public health benefits.

The utilisation of the research evidence on tobacco has been both direct and via the ‘enlightenment’ route, to use Weiss’ (1979) terminology. An example of direct use has been the evidence presented by Wakefield *et al* (2008) on point-of-purchase cigarette displays as cues to purchasing cigarettes in people not intending to do so. This study has been used by policy officers in proposing that their governments ban point-of-purchase promotions. The return on investments research (eg Applied Economics 2003) has had a major influence through the ‘enlightenment’ route, in that the current general understanding (if not always reflected in action) is that public health campaigns are an effective policy instrument for governments to reduce tobacco-related harm in a highly cost-effective way.

Policy analysts and informants in NGOs in the small jurisdictions that have limited research resources have benefited from the packaging of the evidence and the dissemination activities engaged in by the larger, more prominent, interstate NGOs and State governments.

Some initiatives have been implemented in the absence of convincing research evidence. This is inevitable in the case of innovative strategies but it highlights the need to systematically monitor and evaluate such policies.

There remain a number of areas in which there is insufficient evidence to clearly guide policies. Two prominent examples are ways to reduce smoking prevalence among Indigenous people and low SES communities. Other population groups with high prevalence of smoking, but which have received insufficient attention to date, are people with mental illness, users of illicit drugs and people dependent on alcohol. Innovations which are currently being evaluated include training midwives in major public birthing hospitals in brief interventions for pregnant women who smoke, and smoking cessation guidelines to assist general practitioners to provide brief interventions .

In summary, tobacco control is one of the areas in public health where we can clearly identify what works in what circumstances, and much of this evidence has come in part from top-

quality Australian research. The mutually respectful relationships that exist between public servants, the research community and tobacco control advocates means that the evidence has been disseminated and used well in creating healthy public policies in Australia.

### **The contribution of tobacco control legislation contributed to achieving the outcomes identified in the NDS and the NTS**

Senior informants were unanimous that smoke-free environments legislation in all six States and the ACT has been instrumental in achieving the objectives of the NDS and the NTS. This has reduced exposure to second-hand smoke among non-smokers, prevented the uptake of smoking and encouraged and assisted smokers to quit by providing an environment that de-normalises smoking in the community.

In 2008 the Northern Territory Government was awarded the 'Dirty Ashtray Award' for the third time running by the Australian Medical Association and the Australian Council on Tobacco and Health. The President of the AMA stated that 'The Northern Territory's record on tobacco control is an embarrassment for a nation that is otherwise making good progress' (<http://www.ama.com.au/web.nsf/doc/WEEN-7F65DR>). The NT Government has announced plans to legislate effectively in this area. When it does so, the NT will join the others in using tobacco control legislation to help achieve the public health outcomes identified in the NDS and the NTS.

### **The contribution of activities or programs outside the NDS and the NTS to the achievement of the aims of the tobacco legislation**

In Australia more generally, many factors influence policy on tobacco and its implementation. Some of these are positive, facilitating the development and implementation of sound policies, while others operate in the opposite direction.

Pressures to thwart sound public health policy on tobacco come primarily from the tobacco and other industry groups. These include the hospitality industry, especially the owners and operators of pubs and clubs and gambling venues. Overall, the restaurant industry has been supportive of curbs on environmental tobacco smoke, in contrast to significant sectors of the pubs and clubs industries. Representatives of tobacco retailers have effectively applied pressure on governments to delay curbs on their promotion of tobacco products and to restrict the number of retailer licenses. The gambling and advertising industries are also key players.

The tobacco industry has a long history of influencing political and public opinion. It is highly resourced and is very skilful in protecting its sales and the profitability of its member companies. Examples include campaigns emphasising the 'rights' of smokers to 'choose' to smoke. Chapman (2007) has clarified the flaws in this argument when dealing with nicotine-dependent people whose ability to choose is severely compromised. The industry plays on public concerns about excessive government involvement in how people live and the choices that they make: concerns about 'the nanny state'. The industry also makes substantial political donations. It also sponsors youth anti-smoking campaigns to demonstrate that it is "socially responsible". This is a hypocritical initiative because they know that the product they manufacture and sell kills half of long-term smokers, half of whom will die in middle age. They therefore need to recruit more young people to smoking in order to maintain the profitability of their industry.

Support for healthy public policies on tobacco is widespread in the Australian community as evidenced by responses to the 2007 and earlier NDS Household Surveys. We have a community that is well informed about the health problems caused by tobacco use and supports public policy initiatives required to deal with this. This reflects the long history in Australia of research, advocacy and public communication around tobacco and health.

The work of advocacy groups, alone and in collaboration with governments, has been a crucial factor. Political leadership continues to be important, with senior informants referring

to individual State and Territory ministers who are particularly committed to tobacco control and who have shown strong leadership in this area. They point out that the introduction of some initiatives (such as prohibiting smoking in cars when children are present) are easy because they enjoy widespread community support and limited opposition from other stakeholders. In contrast, it is far more difficult for political leaders to convince their colleagues to introduce more important and far-reaching interventions such as prohibiting point-of-sale promotions, introducing significant price increases through taxation, requiring plain packaging, more strongly regulating the retail tobacco industry, etc.

At the present time an important contextual factor is the renewed commitment of the Commonwealth Government to act more decisively in preventive health and adopt public health policies for which there is good evidence of a positive return on investment. Healthy public policies on tobacco meet these criteria for priority in policy activity.

## **Observations**

The NTS, but in this case not the NDS as a whole, has provided a useful enabling framework for healthy public policies on tobacco. Some senior informants believed that the NTS had not driven the positive developments in tobacco control seen in Australia during the current phase of the NDS, but nonetheless had facilitated them.

The Commonwealth legislative initiative to introduce graphic health warnings in 2006 was strongly supported by all informants and seen to be an important part of the policy mix. The public health community is looking forward to the results of the current evaluation of the health warnings. It is also looking to new initiatives on tobacco for which the evidence base has developed since the NTS was adopted in 2004 (eg bans on point of sale advertising).

The legislative initiatives of the States and Territories, and the Commonwealth in its limited jurisdiction, on environmental tobacco smoke, have been seen as valuable. These initiatives have been implemented in a manner consistent with the NTS and are seen as important components of initiatives to achieve the high level goals of the NDS and the NTS. The fact that they have been implemented in different ways in different jurisdictions at different times is not seen as a serious issue so long as there are no significant lags in implementation. In this context, the Northern Territory has been far behind other jurisdictions in legislating to reduce non-smokers' exposure to environmental tobacco smoke.

Tobacco control is one of the areas in public health that has a sound evidence base including evidence as to cost effectiveness. The mutually respectful, collaborative activities of advocacy bodies, researchers and government officers has been a feature of the tobacco control field that has been important in countering the powerful commercial interests that work against healthy public policy on tobacco.