
A framework for action on alcohol, tobacco, illegal and other drugs

Consultation Draft
December 2010

Ministerial Council on Drug Strategy
Introduction and invitation for submissions

The Ministerial Council on Drug Strategy is releasing this draft of the *National Drug Strategy 2010-2015* for consultation with stakeholders and the community.

The draft has been developed following a period of initial consultation involving:

1. The release of a consultation paper in December 2009
2. A public submission process which closed at the end of February 2010
3. Roundtables with stakeholders in April 2010

Submissions are sought on this consultation draft of the Strategy by **8pm (AEDT), Friday 10 December 2010.** Submissions can be made via the internet at [www.nationaldrugstrategy.gov.au](http://www.nationaldrugstrategy.gov.au) or can be mailed to:

   National Drug Strategy 2010-2015 Consultations
   MDP 701
   GPO Box 9848
   CANBERRA ACT 2601

Council of Australian Government (COAG) reforms

Readers should note that COAG reforms currently under consideration may impact on the finalisation of aspects of the Strategy. In April 2010:

- COAG agreed to reform its Ministerial Council structure by March 2011, which may affect the future governance of the National Drug Strategy.

- As part of the National Health and Hospitals Network Agreement, the Commonwealth, States and Territories (with the exception of Western Australia) committed to undertaking further work to consider the following services, either for transfer to the Commonwealth or for strong national reform efforts with current roles and responsibilities, with a recommendation to be put to COAG in December 2010:
  
  i. community health promotion and population health programs including preventive health, in order to determine how to maximise the value of the new National Health and Hospitals Network and National Preventive Health Agency; and

  ii. drug and alcohol treatment services.
Table of Contents

Table of Contents .......................................................................................................................3

Executive Summary ...................................................................................................................4

1. About the National Drug Strategy .........................................................................................5

2. The Pillars ...........................................................................................................................15
   Pillar 1: Supply reduction .............................................................................................15
   Pillar 2: Demand reduction ..........................................................................................19
   Pillar 3: Harm reduction ...............................................................................................25

3. Supporting Approaches .......................................................................................................29
   Workforce ....................................................................................................................29
   Evidence base ...............................................................................................................31
   Performance measures .................................................................................................33
   Governance ..................................................................................................................36

Appendix A ..............................................................................................................................38
Executive Summary

The aim of the National Drug Strategy 2010-2015 is to build safe and healthy communities by minimising alcohol, tobacco, illegal and other drug related health, social and economic harms among individuals, families and communities.

The harms to individuals, families, communities and Australian society as a whole from alcohol, tobacco, illegal and other drugs are well known. For example, the cost to Australian society of alcohol, tobacco, illegal and other drug misuse in the financial year 2004-05 was estimated at $56.1 billion, including costs to the health and hospitals system, lost workplace productivity, road accidents and crime.

The overarching approach of harm minimisation, which has guided the National Drug Strategy since its inception in 1985, will continue through 2010-2015. This encompasses the three pillars of:

- **supply reduction** to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs.

- **demand reduction** to prevent the uptake and/or delay the onset of use of alcohol, tobacco, illegal and other drugs; reduce the misuse of alcohol, tobacco, illegal and other drugs in the community; and support people to recover from dependence and reintegrate with the community.

- **harm reduction** to reduce the adverse health, social and economic consequences of the misuse of drugs.

The three pillars are applicable across all drug types but in different ways for example, depending on whether the drugs being misused are legal or illegal. The approaches in the three pillars need to be sensitive to age and stage of life, disadvantaged populations, and settings of use and intervention.

In the National Drug Strategy 2010-2015, the three pillars are underpinned by strong commitments to:

- building workforce capacity;

- evidence-based and evidence-informed practice, innovation and evaluation;

- performance measuring; and

- building partnerships across sectors.


Part 2 details specific objectives and suggested actions under each pillar.

Part 3 discusses the supporting approaches of workforce, evidence, performance monitoring and governance.
1. About the National Drug Strategy

The National Drug Strategy provides a national framework for action to minimise the harms to individuals, families and communities from alcohol, tobacco, illegal and other drugs.

At the heart of the framework are the three pillars of supply reduction, demand reduction and harm reduction, which are applied together to minimise harm.

The 2010-15 framework builds on longstanding partnerships between the health, law enforcement and education sectors and seeks to engage all levels and parts of government, the non government sector and the community.

Australia has had a coordinated national policy for addressing alcohol, tobacco, illegal and other drugs since 1985 when the National Campaign Against Drug Abuse was developed. In 1993, it was renamed the National Drug Strategy. This 2010–2015 iteration is the sixth time the Strategy has been updated to ensure it remains current and relevant to the contemporary Australian environment.

Mission: To build safe and healthy communities by minimising alcohol, tobacco, illegal and other drug related health, social and economic harms among individuals, families and communities.

Throughout this Strategy, terms are used as follows:

**Drug**
The term ‘drug’ includes alcohol, tobacco, illegal (also known as ‘illicit’) drugs, pharmaceuticals and other substances that alter brain function, resulting in changes in perception, mood, consciousness, cognition and behaviour.

**Illegal drug**
A drug that is prohibited from manufacture, sale or possession. For example: cannabis, cocaine, heroin and amphetamine type stimulants (ecstasy, methamphetamines).

**Pharmaceuticals**
A drug that is available from a pharmacy, over-the-counter or by prescription, which may be subject to misuse. For example: opioid-based pain relief medications, opioid substitution therapies, benzodiazepines, codeine, and steroids.

**Other drugs**
Other psychoactive substances potentially used in a harmful way. For example: kava; or inhalants such as petrol, paint or glue.
The harms from drug misuse

The harms to individuals, families, communities and Australian society as a whole from alcohol, tobacco, illegal and other drugs are well known.

- The cost to Australian society of alcohol, tobacco, illegal and other drug misuse in the financial year 2004-05 was estimated at $56.1 billion, including costs to the health and hospitals system, lost workplace productivity, road accidents and crime. Of this, tobacco accounted for $31.5 billion (56.2%), alcohol accounted for $15.3 billion (27.3%) and illegal drugs $8.2 billion (14.6%).

- The excessive consumption of alcohol is a major cause of health and social harms. Short episodes of heavy alcohol consumption are a major cause of road and other accidents, domestic and public violence, and crime. Long-term heavy drinking is a major risk factor for chronic disease, including liver disease, brain damage and contributes to family breakdown and broader social dysfunction. Drinking during pregnancy can cause birth defects and disability, and there is increasing evidence that early onset of drinking during childhood and the teenage years can interrupt the normal development of the brain.

- Tobacco smoking is one of the top risk factors for chronic disease including many types of cancer, respiratory and heart disease.

- Illegal drugs not only have dangerous health impacts but they are a significant contributor to crime. They are a major activity and income source for organised crime groups. Like alcohol, illegal drugs can contribute to road accidents and violent incidents, and to family breakdown and social dysfunction. Unsafe injecting drug use is also a major driver of blood-borne virus infections like hepatitis C and HIV/AIDS.

- Other drugs and substances that are legally available can cause serious harm. The abuse of inhalants, like petrol, paint and glue, can cause brain damage and death. The misuse of pharmaceutical drugs can have serious health impacts and their trafficking contributes to illegal drug-related crime.

- Alcohol, tobacco, illegal and other drug misuse can contribute to and reinforce social disadvantage experienced by individuals, families and communities. Family breakdown and job loss is associated with drug misuse. Children living in households where parents misuse drugs are more likely to develop behavioural and emotional problems, tend to perform more poorly in school and are more likely to be the victims of child maltreatment. Children with parents who drink heavily, smoke or take drugs are also more likely to do so themselves – leading to intergenerational patterns of misuse and harms.
Harm Minimisation

Since its inception in 1985, harm minimisation has been the overarching approach of the National Drug Strategy. This encompasses the three pillars of supply reduction, demand reduction and harm reduction being applied together in a balanced way.

- **Supply reduction** means strategies and actions which prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs.

- **Demand reduction** means strategies and actions which prevent the uptake and/or delay the onset of use of alcohol, tobacco, illegal and other drugs; reduce the misuse of alcohol, tobacco, illegal and other drugs in the community; and support people to recover from dependence and reintegrate with the community.

- **Harm reduction** means strategies and actions that aim primarily to reduce the adverse health, social and economic consequences of the misuse of drugs.

The *National Drug Strategy 2010–2015* seeks to build upon this multi-faceted approach which is recognised internationally as playing a critical role in Australia’s success in addressing drug misuse.

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**Figure 1 - Harm minimisation approach**
Figure 1 illustrates the approach that will be taken to implement the harm minimisation framework under the *National Drug Strategy 2010-15*:

- The three pillars are applicable across all drug types but in different ways. For example, supply reduction in relation to legal drugs refers to regulation of supply but for illegal drugs means disruption of supply. This is covered in more detail against each pillar.

- The approaches within the three pillars need to be sensitive to age and stage of life, disadvantaged populations, and settings of use and intervention. For example, people with mental illness need specialised approaches to treatment as they are more likely to have co-occurring drug and alcohol problems. People may be more vulnerable to experimenting with drugs at key transition points like moving from school to work. The workplace, schools, licensed premises and communities need to be considered as settings for possible interventions. Using the potential of new media, such as the internet, to deliver interventions also needs to be considered. These are explained in more detail below and against each pillar.

- The three pillars will be underpinned by commitments: to partnerships across sectors; to building the evidence base, evidence informed practice and innovation; to monitor performance against the Strategy and its objectives, and to developing a skilled workforce that can deliver on the Strategy. These supporting approaches are covered in part 3 of the Strategy.

A number of sub-strategies sit under the umbrella of the *National Drug Strategy 2010-2015*. These sub-strategies provide direction and context for specific issues, while maintaining the consistent and coordinated approach to addressing drug misuse, as set out in this National Strategy. In particular, the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan* was developed to provide national direction on drug misuse issues that concern Aboriginal and Torres Strait Islander peoples. There are also national strategies and frameworks in other sectors that are relevant to the work of the National Drug Strategy 2010-2015. These sub-strategies and relevant national strategies are listed at Appendix A.

**Age and stage of life**

It has long been recognised that people are at greater risk of harm from drugs at points of life transition, for example: transitioning from primary to high school; from high school to tertiary education or the workforce; when leaving home; and when retiring.

- Drinking alcohol in adolescence can be harmful to young people’s physical and psychosocial development. Alcohol-related damage to the brain can be responsible for memory problems, inability to learn, problems with verbal skills, alcohol dependence and depression.

- The Australian Secondary School Students Alcohol and Drug Survey has consistently shown over time that fewer students are smoking overall. However, the secondary school years remain a key risk period for the uptake of smoking, with higher rates in each age group from 12 years onwards through adolescence.
• The adolescent drive to take risks and the need for coping mechanisms during adolescence can be key influences on the uptake of illegal drugs by teenagers.

The National Drug Strategy 2010-15 will also recognise the challenge of long-term drug misuse among adults and the new challenges that an ageing population may pose.

• Daily cannabis use is most common amongst 40-49 year olds. This age group is nearly twice as likely as 14-19 year olds to report daily use. This is despite an overall decline in the proportion of the population reporting recent use of cannabis.

• The proportion of Australians aged 65 years or older is expected to increase from 12.1% currently to 24.2% by 2051. Older people face particular issues with drug misuse including interactions with prescribed medications, under-recognition and treatment of alcohol and drug problems, unintentional injury and social isolation. Alcohol can increase the risk of falls, motor vehicle accidents and suicide in older people.

Disadvantaged populations

Drug misuse can have a particularly significant impact among disadvantaged groups and lead to intergenerational patterns of disadvantage. For example:

• There is strong evidence of an association between social determinants – such as unemployment, homelessness, poverty, and family breakdown – and drug misuse. Socio-economic status has been associated with drug-related harms such as foetal alcohol syndrome, alcohol and drug disorders, hospital admissions due to diagnoses related to alcoholism, lung cancer, drug overdoses and alcohol-related assault. In the 2007 National Drug Strategy Household Survey the highest prevalence of recent illegal drug use was reported by unemployed people – some 23.3% compared with 13.4% of the general population. Alcohol and drug misuse among homeless people is common – one study estimated the overall 12 month prevalence of alcohol misuse for homeless people in Sydney at 41% and the prevalence of drug misuse at 36%. Family factors – including poor parent-child relationships, family disorganisation, chaos and stress, and excessive family conflict and marital discord with verbal, physical or sexual abuse – also have a strong association with drug misuse.

• Smoking is the number one cause of chronic disease among Aboriginal and Torres Strait Islander people. In 2003, smoking was responsible for one-fifth of deaths and accounted for 12% of the total burden of disease among Aboriginal and Torres Strait Islander people. In 2004-05, 55% of Aboriginal and Torres Strait Islander peoples aged 18 years and over reported drinking at short-term risky/high risk levels on at least one occasion in the previous 12 months.

• Despite a sustained decline in the prevalence of smoking among people in major cities, the decline has been slower among people living in regional and remote areas. Men in regional and remote areas were significantly more likely than those in major cities to report risky or high-risk alcohol consumption.

• 35% of people who misuse drugs also have a co-occurring mental illness. Although people with mental illness benefit from drug and alcohol treatment, they continue to have poorer physical and mental health and poorer social functioning following treatment than other people.
• People in prison have underlying high rates of drug misuse. In 2009, 81% of prison entrants were current smokers and 74% smoked daily, 52% of prison entrants reported drinking alcohol at levels that placed them at risk of alcohol-related harm and 71% of prison entrants had used illicit drugs in the 12 months prior to their current incarceration. Injecting drug use and the associated risk of blood-borne virus infection is a particular issue for prison populations. Among prison entrants, 35% tested positive for hepatitis C.

• Some culturally and linguistically diverse (CALD) populations have higher rates of, or are at higher risk of drug misuse. For example, new migrant populations from countries where alcohol is not commonly used may be at greater risk when they come into contact with Australia’s more liberal drinking culture. Some types of drugs specific to cultural groups, such as kava and khat, can also be problematic in the Australian setting.

• People from disadvantaged groups may also experience more difficulty in accessing drug treatment and in achieving successful outcomes from that treatment unless it is appropriate for their particular needs. Those who are most at risk are people with multiple and complex needs – which may involve a combination of drug misuse, mental illness or disability, family breakdown, unemployment, homelessness and/or having spent time in prison.

Under the National Drug Strategy 2010-15, socially inclusive strategies and actions are needed that recognise the particular vulnerabilities and needs of these disadvantaged groups.

Settings

Settings-based approaches are also a key feature of the National Drug Strategy 2010-2015.

More emphasis will be placed on schools, workplaces, licensed premises and communities as settings for possible preventive interventions on alcohol, tobacco, illegal and other drugs.

More attention is needed to address drug misuse among prison populations, the challenges of the prison environment for supply reduction but also the opportunities for demand reduction through education and treatment, and for harm reduction approaches. Attention is also needed to help prevent drug misuse from continuing or recurring when people leave prison.

The internet as a key emerging medium for prevention and treatment approaches and as a potentially effective tool for reaching new or hard to reach settings will also receive more of a focus (also see challenges below).

Partnerships

Since its inception, the National Drug Strategy has been underpinned by strong partnerships, particularly across the health, law enforcement and education sectors, between the government and non-government sectors, and among policy-makers, service providers and experts.

For 2010-2015, the health-law enforcement-education partnership will remain at the heart of the strategy. However, this partnership will be extended to other sectors as appropriate, particularly to help tackle the more complex causes and harms from drug misuse in the present environment (see also Part 6 Governance).
In relation to alcohol, partnerships will continue to be needed with liquor licensing authorities, local governments including town planners and transport authorities and local communities themselves to help reduce potential harms.

Strong partnerships – and integrated service approaches – with social welfare, income support and job services, homelessness services, mental health care providers and correctional services will be needed if people with multiple and complex needs are to be assisted to stabilise their lives, reintegrate with the community and recover from drug and alcohol problems.

Closer integration with child and family services will be needed to more effectively recognise and manage the impacts of drug misuse on families and children.

Ongoing partnerships with Aboriginal and Torres Strait Islander communities will be needed to help reduce the causes, prevalence and harms of alcohol, tobacco, illegal and other drug misuse among Aboriginal and Torres Strait Islander people.

Finally, Australia needs to engage in international partnerships to maximise the effectiveness of law enforcement efforts, to learn and share best practice supply, harm and demand reduction approaches and to help enhance our regional neighbours’ efforts to respond to the problem of drug misuse. Under the National Drug Strategy 2010-2015, Australia will continue to actively engage in multilateral fora for international cooperation on drug-related issues, including the World Health Organization, the United Nations Office on Drugs & Crime, the Conference of the Parties to the World Health Organization Framework Convention on Tobacco Control and the United Nations Commission on Narcotic Drugs. The Australian Federal Police and the Australian Customs and Border Protection Service will continue to cooperate with their international counterparts on drug investigations. Australian health and law enforcement agencies and non-government organisations will also continue to engage with developing countries, particularly in the Asia-Pacific region, to provide assistance on drug issues where such assistance is needed.

Successes of the National Drug Strategy

Since the inception of the National Campaign Against Drug Abuse in 1985, Australia has had major successes in reducing the prevalence of, and harms from, drug misuse.

- Far fewer Australians are smoking and being exposed to second-hand smoke as a result of comprehensive public health approaches, including bans on advertising, bans on smoking in enclosed public spaces and significant investments in public education and media campaigns. The daily smoking rate among Australians aged 14 years and over has fallen from 30.5% in 1988 to 16.6% in 2007.

- Far fewer people are using illegal drugs. The 2007 National Drug Strategy Household Survey shows the proportion of people reporting recent use of illegal drugs fell from 22% in 1998 to 13.4% in 2007. The recent use of cannabis – the most commonly used illegal drug – fell from 17.9% in 1998 to 9.1% in 2007.

- Law enforcement agencies have continued to be effective in detecting and seizing illegal drugs to disrupt supply. The number of illegal drug seizures increased by almost 70% between 1999-2000 and 2008-09, and the collective weight of seizures increased by about 116%.
• The *heroin* shortage that began in 2000 has been sustained, with heroin use remaining at low levels since that time. Harms associated with injecting drug use have also been reduced. It is estimated that over the decade 2000-2009, needle and syringe programs, which ensure the safe supply and safe disposal of syringes to injecting drug users, have directly averted over 32,000 new HIV infections and nearly 97,000 Hepatitis C infections.

• Since its introduction in September 2005, non-sniffable Opal fuel has contributed to a 70% reduction in *petrol sniffing* across 20 regional and remote communities in Western Australia, South Australia, the Northern Territory and Queensland.

• Early intervention and *diversion programs*, which help prevent young people apprehended for drug misuse from getting caught up in the criminal justice cycle and divert them to treatment interventions, have become an established and successful part of the harm minimisation approach.

• *Drink driving* has become largely unacceptable within the general Australian population. A substantial reduction in alcohol-related road deaths was achieved between the early 1980s and the early 1990s through mass breath testing of drivers, lower and nationally consistent driver blood alcohol content limits, zero limits for special driver groups, a well-thought-out system of penalties and mass public education and media campaigns.

• Far more is known about what works in the *treatment* of drug and alcohol dependence, including through brief interventions, detoxification, pharmacological and psychosocial treatment approaches.

**Challenges for 2010-15**

Many challenges still remain. The following have been identified as priorities for 2010-2015:

• Risky drinking, drinking to intoxication and *alcohol*-related violence and accidents continue to cause significant harms in the community. An estimated 813,072 Australians aged 15 years and older were hospitalised for alcohol-attributable injury and disease over the 10–year period 1995-96 to 2004-05, and rates of alcohol-attributable hospitalisations increased in all States and Territories. Alcohol remains a leading cause of Australian road deaths, particularly among young people.

• *Smoking* rates continue to be unacceptably high in the general population – 16.6% smoked daily in 2007 – and particularly among Aboriginal and Torres Strait Islander people, of whom around 45% smoked daily in 2008. COAG has agreed in the National Healthcare Agreement 2008 to targets of reducing the prevalence of smoking among the Australian population to 10% by 2018 and to halving the smoking rate among Aboriginal and Torres Strait Islander people.

• New *illegal drug trends* and associated harms continue to emerge. At the time of writing in 2010, these included:
- increasing harms from cannabis. The number of older users presenting to hospital with dependence and other cannabis related problems increased markedly between 2002 and 2007 and nearly doubled among users aged 30-39. Hospital presentations for cannabis-induced psychosis were highest among users aged 20-29. The number of hospital outpatient treatment episodes for cannabis problems increased by 30%. Cannabis continues to be the most popular drug of choice by police detainees; 48% tested positive for cannabis in 2008. Cannabis cultivation continues to be an activity of interest for organised crime.

- increasing use of ecstasy and domestic production of amphetamine type stimulants (ATS). Self-reported recent use of ecstasy increased from 2.4% in 1998 to 3.5% in 2007 with particularly concerning increases among young women. ATS arrests more than doubled between 1999-2000 and 2008-09. Manifestations of extreme behaviour in ATS users, including violence, increases risks for police, ambulance, and hospital emergency department workers, as well as users and the community. Organised crime involvement in the manufacture and trafficking of ATS is also of concern.

- an expansion of the cocaine market is reflected in recent increases in cocaine arrests, seizures and reported use. Two distinct user groups have been identified, the first comprising employed, well-educated and socially integrated individuals and the second injecting drug users.

- while rates of heroin and other injecting drug use have stabilised at relatively low levels, harms from ongoing heroin and other injecting drug use persist, particularly in relation to blood-borne virus infections and overdose.

- new ‘analogue’ drugs – derivatives or substances similar in chemical structure to illegal drugs – are emerging, particularly in sales over the internet. Many of these substances have not yet been captured under the schedules to drug laws which govern whether drugs are legal or illegal to use and/or supply. Analogues are being marketed to users as ‘legal highs’ which may lead to false perceptions that they are safe and legal. The challenge will be to adequately capture these analogues in drug schedules and to educate law enforcement agencies and the public about their illegality and the harms from their use.

The harms from drug misuse are potentially amplified by the increasing pattern of poly-drug use, defined as the concurrent use of more than one drug. Alcohol is the drug most commonly used in this way and is increasingly mixed with energy drinks and illegal drugs with unpredictable effects. Mixing of drugs can multiply the effects of each drug, increase adverse reactions and increase the unpredictability of the reactions. Polydrug use involving cannabis and injecting drugs can, for example, increase the risk of overdose, severe paranoia and other mental health problems, and increased heart rate, blood pressure and body temperature.

- Pharmaceutical drug misuse. The most commonly misused pharmaceuticals include opioids, benzodiazepines, codeine, the stimulants methylphenidate (Ritalin) and dexamphetamine, and performance-enhancing drugs such as steroids. Diversion and misuse of opioid drugs is widespread and prevalent where heroin is not readily available. Misuse is also prevalent among poly-drug users.
• The internet poses both challenges and opportunities for the National Drug Strategy. It is an efficient channel for information on illegal drug manufacture and use. But it also provides opportunities for providing information, and potentially treatment, to audiences who may not be reached through other media.

• planning and quality frameworks for treatment services need to incorporate evidence into successful drug treatments.
2. The Pillars

This part of the National Drug Strategy sets out the objectives of, and actions against, each of the three pillars of the Australian harm minimisation approach: supply reduction; demand reduction; and harm reduction.

The objectives and actions listed under each pillar are not intended to be exhaustive but to provide a rounded explanation of what is involved.

The approach and the actions specified take into consideration differences across: drug type; disadvantaged populations; age/stage of life; and settings.

Pillar 1: Supply reduction

Supply reduction strategies are directed toward enforcing the prohibition of illegal drugs and regulating and enforcing access to legal drugs, including alcohol, tobacco, pharmaceuticals and other drugs. In the case of illegal drugs, supply reduction activities, including both border and domestic policing, extend to controlling the availability of precursor chemicals and equipment used in the manufacture of drugs. It also extends to compliance with Australia’s obligations under international drug control treaties.

Reducing the supply of drugs requires the collaborative participation of all levels of government including law enforcement and the health sector (public and private), industry and regulatory authorities.

It also requires engagement of the Australian community in seeking their support for these strategies. The message must be clear that the supply and misuse of illegal drugs and the illegal supply and misuse of tobacco, alcohol, pharmaceuticals and other legal drugs is not acceptable.

For alcohol, tobacco, pharmaceuticals and other legal drugs, government and non-government authorities need to collaborate in regulating access to these drugs based on community norms and standards, and the health and other harms arising from inappropriate access. For alcohol, this means that liquor licensing, planning authorities, licensed venues and retailers need to be involved – as do parents in reducing the supply of alcohol to minors. For tobacco, the involvement of retailers is essential. For pharmaceutical drugs, doctors and pharmacists need to be consulted and involved in supply reduction strategies to reduce pharmaceutical misuse. Retailers of other drugs (for example, inhalants) are an essential part of regulation and enforcement of supply.

For illegal drugs, law enforcement strategies are needed which target all parts and levels of the supply chain from actions aimed at preventing importation across the border to those that target the point of supply to consumers. The increasing prevalence in the use of the internet to facilitate the global supply of illegal drugs – particularly those marked as ‘party pills’ and ‘legal highs’ – also needs to be considered within these strategies. Communities – not only in metropolitan areas but also in rural and remote areas and Aboriginal and Torres Strait Islander communities – have a strong role to play in not tolerating illegal drug supply and helping law enforcement to combat it.
There is a strong connection between the supply of illegal drugs and the illegal supply of legal drugs because of the financial proceeds that arise from such activities. Therefore the disruption of organised crime and money laundering is an important component of any drug supply reduction strategy. The disruption and dismantling of organised crime is a high priority for governments as reflected in the Commonwealth’s Organised Crime Strategic Framework.

**Objective 1: Reduce the supply of illegal drugs (both current and emerging)**

Reducing the supply of illegal drugs requires activity at Australia’s borders to prevent and disrupt importations of illegal drugs and their precursors and within Australia to prevent cultivation, manufacture and distribution of illegal drugs. Legislative frameworks exist and require constant enforcement to ensure a reduction in the supply of illegal drugs is achieved. These frameworks need to be supported by demand reduction strategies which engage the health sector and community and serve to raise awareness of the harms and consequences arising from illegal drug misuse.

Noting the importance of border activities in controlling the importation of illegal drugs, Australia must continue to develop strong international partnerships and strengthen the border management capabilities of our international partners, particularly in the Asia-Pacific region. It is important too that Australia continues to participate in international law enforcement activities, such as those coordinated by United Nations Office on Drugs and Crime.

The illicit drug market is not only constrained by the international border. Information sharing and coordinated approaches are needed to stem the supply of illicit drugs at all stages of the supply chain from overseas suppliers, interception at the border (jurisdictional and international), and investigation and prosecution of domestic producers, manufacturers and suppliers.

**Actions**

- Prevent the importation of illegal drugs, and control the legitimate trade of equipment and chemicals used in their manufacture.
- Increase and improve enforcement targeting of the cultivation, manufacture and trafficking of illegal drugs, including the financial proceeds arising from these activities.
- Improve powers of detection through supportive technology (and systems), access to relevant information and workforce development.
- Strengthen collaboration between law enforcement, industry and relevant agencies to prevent the diversion of precursor chemicals into the manufacture of illegal drugs.
- Improve cooperation and collaboration between law-enforcement agencies, especially with respect to information and intelligence access and exchange.
- Develop closer relationships with international partner agencies and bodies and enhance Australia’s national approach to implementing its obligations under international drug control treaties.
• Build upon Australia’s capacity to utilise the border as a significant choke point for the supply of illegal drugs into Australia through promoting nationally consistent drug control laws, which would also limit the opportunity for organised crime to exploit legislative inconsistencies.

• Ensure the ongoing and timely review of legislation and regulation to reflect the dynamic nature of illegal drug markets and manufacture.

• Research, investigate and gather information on all aspects of drug supply markets including the identification of emerging drugs and manufacturing techniques to properly inform law enforcement responses.

• Foster research and development in technological innovation to provide investigative tools for use in the disruption of the supply markets.

Objective 2: Control and manage the supply of alcohol, tobacco, pharmaceuticals and other legal drugs

Supply reduction for alcohol, tobacco, pharmaceutical and other legal drugs involves activities targeted toward the regulation of legitimate supply and the detection and interruption of illegal markets.

By way of example, regulation of the sale of alcohol focuses on who can sell alcohol, to whom and when, for example by ensuring that alcohol is sold only to adults and only by licensed premises and liquor retailers. Regulations also control the number and type of outlets in a community, aiming to minimise the social impact of alcohol in any given community. Police, licensing inspectors and hospitality workers have a responsibility for limiting supply to intoxicated people or removing them from licenced premises. Parents, siblings, and friends are the main sources of supply of alcohol to young people and therefore have a key role to play in reducing access to alcohol by this group.

Similarly, age restrictions on tobacco sales need to be enforced and families have a responsibility to reduce access by young people. The illegal cultivation, sale and supply of tobacco and the importation and distribution of kava exceeding the permitted amount require appropriate regulation and enforcement.

An emerging and challenging issue is the misuse of pharmaceutical drugs – including opioids, stimulants and performance- and image-enhancing drugs. An effective supply reduction response will require a collaborative cross-sectoral approach that balances the need to ensure the availability of these drugs for medicinal purposes while, at the same time, restricting illegal access and diversion to illegal drug markets. Legislative and regulatory frameworks exist and require constant monitoring to ensure they support the appropriate prescribing and supply of pharmaceutical drugs. These frameworks also need to be supported by demand reduction strategies such as information and education campaigns which engage the health sector and community and serve to raise awareness of this emerging issue.

For legal substances like inhalants (petrol, paint, glue) that are readily misused, a balance also needs to be found between access for legitimate purposes and regulation of supply. This balance needs to take account of the prevalence of misuse and the harms from these substances.
**Actions**

- Improve and strengthen the regulatory framework surrounding the promotion, sale and supply of legal drugs (both from domestic and overseas sources) to prevent misuse, diversion and consequent harm.

- Increase and improve the enforcement of regulatory mechanisms concerned with the supply and availability of legal drugs that are subject to misuse and harm.

- Target the illegal importation and illegal supply and cultivation of tobacco.

- Participate in negotiations to finalise the Protocol to Eliminate the Illicit Trade in Tobacco Products under the WHO Framework Convention on Tobacco Control.

- Further foster relationships with industry, relevant agencies and the community to assist in regulating and reducing inappropriate access to legal drugs that are subject to misuse and harm.

- Improve powers of detection through supportive technology (and systems), access to relevant information, and workforce development.

- Increase training and support to those at the point of supply of pharmaceutical drugs (eg doctors, pharmacists) to reduce the inappropriate supply, misuse and diversion of these drugs into the black market.

- Increase training and support to those at the point of sale of alcohol to reduce the inappropriate supply of alcohol and in particular the supply of alcohol to young people.

- Increase the community’s understanding of the inappropriate supply and diversion of alcohol, tobacco, pharmaceutical and other legal drugs and the associated consequences through targeted public information campaigns, information sharing and social marketing.

- Research, investigate and gather information on all aspects relating to the supply of alcohol, tobacco, pharmaceutical and other legal drugs, including the impact upon individuals and the community.

- Research the effectiveness of strategies aimed at curtailing the inappropriate supply of alcohol, tobacco, pharmaceutical and other legal drugs.
Pillar 2: Demand reduction

Demand reduction includes strategies to prevent the uptake of drug use, delay the first use of drugs, and reduce and stop drug misuse. This can include the provision of information and education, for example through school based programs or public awareness campaigns. Evidence-based early intervention programs, counselling, treatment, rehabilitation, relapse prevention, aftercare and social integration can help drug users reduce or cease their drug use. The demand for drugs can also be affected by their availability and affordability; which can, depending on the drug, be influenced through supply control, regulation and taxation.

Drug misuse is influenced by a complex interaction of physical, social and economic factors. Disadvantaged populations are at heightened risk of drug misuse and its associated harms. People can also be at risk of different patterns of misuse at different ages – for example, younger people may be more at risk of short-term harms from binge drinking while older people may be more at risk from chronic alcohol misuse.

The appropriate mix of educational and social marketing approaches will also vary between drug type – whole-of-population strategies may be more appropriate for alcohol and tobacco and for those illicit drugs that are widely used, while approaches targeted to users and key at-risk groups may be more appropriate for those drugs which only a small percentage of the population uses.

Settings-based approaches will be a key feature of the National Drug Strategy 2010-15. The COAG Preventive Health National Partnerships includes a focus on prevention activities for alcohol and tobacco in communities, childcare and school settings and workplaces.

No one strategy on its own can prevent and reduce the demand for drugs. Rather, broad-based, multidisciplinary and flexible strategies are needed to meet the many and varied needs of individuals and communities.

Demand reduction requires the cooperation, collaboration and participation of a diverse range of sectors. It is important to recognise the range of sectors that can influence drug demand and develop closer linkages with them.

Objective 1: Prevent uptake and delay onset of drug misuse

In general, preventing drug misuse can be more cost-effective than treating established drug problems. Prevention efforts can help reduce personal, family and community harms, allow better use of health system resources, generate substantial economic benefits, and produce a healthier workforce.

A key step in preventing the uptake of drugs is changing population culture so that drug misuse is no longer seen as a cultural norm. This involves improving community understanding and awareness of the drugs that are being used, their effects and harms associated with their misuse, and the choice of effective interventions and treatments. For some drugs, such as tobacco, cultural acceptance has been successfully challenged, contributing to a significant reduction in use over many years. Harmful alcohol consumption, on the other hand, still remains a challenge.
There is an increased risk of harms associated with the early uptake of drugs. The earlier a person commences use, especially heavy use, the greater their risk of harm in the short and longer term (e.g., mental and physical health problems), and the greater their risk of continued drug misuse.

**Actions**

- Explore and implement strategies that contribute to the development of a population culture that promotes healthy lifestyles.
- Develop and implement strategies aimed at breaking intergenerational patterns of drug misuse.
- Recognise the diverse range of factors that influence drug misuse and connect with other national policies to work collaboratively to reduce risk factors and build protective factors.
- Continue to implement well-planned social marketing campaigns that address the dangers of drug misuse, dangers about specific drug misuse practices (e.g., injecting, risky drinking) and promote healthy lifestyles, including targeted approaches and local complementary initiatives for different population groups.
- Use the internet and other new media to sustain and strengthen the provision of credible and accurate information and target different population groups.
- Limit or prevent exposure to alcohol and tobacco advertising and promotion through a staged approach to regulation.
- Explore ways of influencing responsible media reporting/portrayal.
- Support community-based initiatives, including in indigenous communities, to change the culture of smoking, risky drinking and illegal drug misuse.
- Strengthen evidence-based approaches to school drug education.
- Consider and respond to the report of the Preventative Health Taskforce as it relates to alcohol and tobacco, and implement responses.

**Objective 2: Reduce misuse of drugs in the community**

The effects of misuse of drugs go beyond injury and illness/disease to a range of social and economic consequences. People experiencing problems with drugs can find it difficult to form or maintain relationships, may have their educational and vocational paths disrupted and their general social development hampered. To reduce the occurrence and cost of such problems interventions need to be implemented early, preferably before problems emerge. For dependent users, reducing and/or ceasing the misuse of drugs can help them to lead stable, healthy and productive lives.
Successfully reducing the misuse of alcohol and drugs requires a range of approaches across the continuum of use, from experimental to dependent use. It is important to ensure that appropriate treatment is available and accessible to those who seek it. Engaging the support of family and friends for those seeking treatment is an important part of helping people to reduce their drug use.

Brief interventions can also be very effective. Brief interventions aim to identify current or potential problems with drug misuse and motivate those at risk to change their behaviour. They can range from five minutes of brief advice to thirty minutes of brief counselling. Brief interventions are commonly delivered by general practitioners, but can also be used by other service providers, police officers, liquor licensing inspectors or family members.

In instances of dependence, it is important for people to have access to effective treatment services and where needed, provision of support to rebuild their lives and to reconnect with the community. Evidence supports the effectiveness of a range of appropriately targeted treatment approaches. However, people can find it difficult to locate and access the service that meets their needs, and people with multiple and complex needs have the added difficulty of finding a number of different, sometimes unrelated, services.

A range of appropriate, specialised services should be available to anyone with a drug problem, irrespective of personal history, complex circumstances or socioeconomic status. A ‘no wrong door’ approach should be adopted so that people are provided with, or are guided to, appropriate services regardless of where they enter the system of care.

Generalist health care and social welfare services should also notice, assess and respond to people with alcohol and other drug misuse problems. There is a range of brief interventions, for example, that can be delivered by generalist services or over the internet. These could refer people to specialised services where necessary or provide support before harms and long-term dependence occur.

**Actions**

- Sustain efforts to increase access to, and links between, a greater range of treatment and other support services.
- Sustain efforts to increase access to a greater range of culturally sensitive services.
- Improve access to screening and targeted interventions for at risk groups eg. young people, people living in rural and remote communities, pregnant women, Aboriginal and Torres Strait Islander people.
- Increase the community’s understanding of effective drug interventions through the provision of factual, credible information.
- Continue efforts in diverting people from traditional criminal justice pathways by providing information and/or referring them to assessment and treatment.
- Increase awareness, availability and appropriateness of telephone and internet counselling and information services.
• Develop planning models for treatment services that anticipate needs, and develop and implement quality frameworks for treatment services.

• Create incentives for, and encourage people who misuse or are dependent on drugs to access effective treatment and to make healthier decisions about their lives.

• Encourage family members to access and make use of support services to help improve treatment outcomes for clients.

• Explore and develop opportunities in the criminal justice system, including correctional services, to assist drug users through education, treatment and rehabilitation services.

**Objective 3: Support people to recover from dependence and reconnect with the community**

Recovering from drug dependence can be a long term process in which individuals need support and empowerment to achieve independence, self-esteem and a meaningful life in the community. Successful support for longer term recovery after treatment requires strategies that are focused on the whole of the individual and look across the life span.

While different people will have different routes to recovery, support for recovery is most effective when the individual’s needs are placed at the centre of their care and treatment. Treatment service providers can assist individuals to recover from drug dependence, help the individual access the internal resources they need (eg: resilience, coping skills, physical health); and ensure referral and linkage with a range of external services and supports (stable accommodation, education, vocational and employment support, and social connections).

Noting the above, in maintaining and strengthening the current system of treatment and other support services across jurisdictions, the following principles will be continued under the next cycle of the National Drug Strategy:

• In designing treatment services, it is important to recognise that all drug users are not homogenous. Consequently, treatment services should incorporate a fundamental principle of consumer involvement in planning and operations. In addition, treatment interventions should be tailored to the varying needs of individuals (including the potential for access to substance-specific treatment and services).

• In designing and coordinating referral pathways, it is important to recognise that trigger points for entry into treatment come from a broad range of sources which should be reflected in those pathways (including through drug and alcohol diversion programs and linkages with primary health care).

• In designing and coordinating support after treatment to help individuals rebuild their lives and reconnect with the community, it is important to recognise that individuals often become marginalised or socially isolated as a result of their drug use, losing touch with their families and friends as well as opportunities for education, vocational, employment, housing and other areas of social participation. Drug treatment alone cannot solve these problems which, if not dealt with, can place an individual at risk of relapsing to drug use and related issues. Consequently, it is important that treatment services be linked to that broader range of services able to provide these supports and the necessary relationships and processes developed to better ensure these linkages are effective.
Actions

- Develop a set of nationally agreed principles for treatment services based on the above premises to support the strengthening of the existing service system.

- Develop a new evidence based national planning model to better estimate the need and demand for drug and alcohol health services across Australia including the full spectrum of services from prevention and early intervention to the most intensive forms of care, and the spectrum of services across the life span.

- Develop a set of national clinical standards for drug and alcohol treatment services.

- Improve the linkages and coordination between primary health care and specialist drug and alcohol treatment services to enhance the capacity for all health needs to be dealt with as well as to facilitate the earlier identification of health problems and access to treatment.

- Improve the communication and flow of information between primary care and specialist providers, and between clinical and community support services to promote continuity of care and development of cooperative service models.

- Consider appropriate structures that could be developed to help engage families and other carers in treatment pathways including ensuring that information about the pathways is readily accessible and culturally relevant.

- Establish linkages with the necessary services to provide those impacted by drug use and dependence, such as family members, children and friends, with on-going support including linkages to child welfare and protection services.

- Move towards national consistency of approach toward the non government treatment services sector including in relation to contract and performance arrangements and a transparent and comparable cost structure.

- Develop a sustained and comprehensive stigma reduction strategy to improve community and service understanding and attitudes to drug dependence and the related problems of individuals.

- Improve linkages and coordination between health, education, employment, housing and other sectors to expand the capacity to effectively link individuals from treatment to supports required for them to reconnect with the community.

Objective 4: Support efforts to promote social inclusion and resilient individuals, families and communities

Socially inclusive communities and resilient individuals and families are less likely to engage in drug misuse. Resilient individuals are able to adapt to changes and negative events more easily and reduce the impacts that stressors have on their lives – and are less likely to misuse drugs.

Resilient and inclusive communities are characterised by strong social networks and work together to support individuals who may need assistance. They also promote safe and healthy lifestyles. Supportive and informed families and communities can prevent the uptake of drug
use, identify drug misuse in its early stages and help individuals to access and maintain treatment. A resilient community will support people to avoid relapse and help them reconnect with the community.

Responsibility for building resilient communities lies at all levels — from governments, to communities, non-government organisations, families and individuals.

Actions

• Support whole-of-government and whole-of-community efforts to build parenting and family capacity, creating communities that support the positive development of children. This may include evidence-based approaches to drug prevention in schools.

• Continue to implement skills training to provide individuals with coping skills to face situations that can lead to risky behaviours including drug misuse.

• Implement preventive support programs targeting life transition points – primary to high school, school to work, prison to community – to help individuals with the skills to manage the next stage of life.

• Support efforts to encourage participation of at-risk groups in community life including recreational, sporting and cultural activities.

• Provide support services to parents in recovery to ensure the needs of dependent children are met.
Pillar 3: Harm reduction

Harm reduction is as important for the National Drug Strategy as supply and demand reduction as it works to reduce the adverse health, social and economic impacts of drug misuse on communities, families and individuals.

Harm reduction recognises that an individual’s engagement in drug misuse, illegal drug supply or illegal drug manufacture generally has flow-on health, social, economic, environmental and other consequences for those around him or her including for family, workplace, neighbourhoods and the broader community.

In relation to alcohol, efforts to prevent drink driving and reduce the incidence of alcohol-related road accidents have been a key harm reduction approach over a long period. Programs and interventions to tackle risky drinking, including liquor licensing and responsible service of alcohol arrangements, education and information programs, and community-based approaches, have aimed to reduce alcohol-related public violence. Brief interventions, treatment for alcohol dependence and family support services can help reduce the incidence and impact of family conflict and violence.

In relation to tobacco, harm reduction efforts have included minimising exposure to secondhand smoke through bans on smoking in workplaces and enclosed public spaces and, in some jurisdictions, bans on smoking in cars where children are present.

In relation to injecting drug use, needle and syringe programs have been the main harm reduction approach, helping to slow the spread of blood-borne viruses like HIV and hepatitis C. Readily available needle disposal facilities and other strategies as simple as well-lit streets have helped to improve community amenity in areas where injecting drug use takes place. Some jurisdictions have experimented with other approaches, including a medically supervised injecting centre in one jurisdiction.

For illegal drugs more generally, programs to divert offenders from the criminal justice environment into treatment or other health interventions have helped to increase the chances of recovery and reduce the likelihood of individuals’ recidivism creating harms to the community. Strategies to prevent and effectively manage drug overdose have also been important harm reduction responses. In addition, some jurisdictions have implemented road-side drug testing to detect and deter drug impaired driving.

Other harm reduction approaches have included the provision of chill-out spaces, water, information and peer support, and emergency medical services at events where drug misuse may be occurring.
Objective 1: Reduce harms to community safety and amenity

A significant and sometimes overlooked harm from drug misuse is the impact it can have in reducing the extent to which people feel safe in their communities. Heavy alcohol consumption can lead to threats and assaults, vandalism, public disorder and road accidents. Illegal drug use – and injecting drug use in particular – can affect people’s perceptions of the safety of their community and the business confidence of an area. The illegal drug trade and drug misuse contributes to significant social costs through property crime and violence.

As higher-density living becomes the norm in our cities, greater attention is needed to public safety and health services, and supporting social connectedness. This also involves improving perceptions of public safety and amenity.

Rural and remote communities, and indigenous communities, are also affected by impacts on safety and amenity generated by alcohol, tobacco, illegal and other drug misuse.

Actions

- Make local communities and public places safer from alcohol-related violence and other incidents through stronger partnerships between health, law enforcement, liquor licensing, local government and planning and transport authorities.
- Investigate nationally consistent and transparent approaches on alcohol outlet density and takeaway hours.
- Consider further reforms to drink driving laws and develop effective evidence-informed responses to driving under the influence of illegal and pharmaceutical drugs.
- Provide new supports for frontline workers managing polydrug use and related aggressive behaviours in public places including for police, emergency department workers and welfare services.
- Sustain existing harm reduction efforts including needle and syringe programs and safe disposal of used injecting equipment and improve access for disadvantaged populations.
- Develop awareness in the community and the workforce of the health dangers of clandestine laboratories and the need for remediation of sites.
- Work with industry and consider regulation to reduce harms from emerging substances of concern, for example to address the potential for energy drinks to exacerbate alcohol related problems in public places.
- Implement the actions agreed by COAG in response to the Ministerial Council on Drug Strategy’s report on options to reduce binge drinking.

Objective 2: Reduce harms to families

The families of people misusing drugs – their parents, partners and children – often suffer the greatest impacts of drug misuse. Supports need to be available to families, particularly with children, to help them manage the stresses they may be experiencing and also to help engage
them in managing the individual’s drug misuse problem and in aiding recovery. Services interacting with people with drug misuse problems need to recognise the impact of drug misuse on families and help to ensure they are provided or connected with the right supports. This applies both to specialist drug and alcohol treatment services but also to policing, social welfare and other services that may be interacting with people with drug problems.

Alcohol is most commonly supplied to minors by parents and other family members. There are mixed community views on introducing teenagers to alcohol, with some support for introduction in a safe family environment. However, emerging health evidence highlights the importance of delaying introduction to alcohol as long as possible.

Drinking during pregnancy can have significant impacts on children in utero and cause a range of disorders known as the fetal alcohol spectrum disorders (FASD), including birth defects and developmental difficulties. FASD has been a particular issue in some indigenous communities. Coordinated education and information campaigns and other clinical and community-led strategies are needed to help prevent FASD, and action is needed to improve the diagnosis and clinical management of affected children and to make available appropriate supports to those children and their families.

In relation to tobacco, families and communities have an ongoing responsibility to protect children from second hand smoke and to help prevent children learning to smoke by example from parents and other respected elders. Efforts to reduce smoking among pregnant women, and prevention of the exposure of pregnant women and babies to secondhand smoke should be particular priorities.

**Actions**

- Enhance child and family sensitive practice in drug and alcohol treatment services and build links and integrated approaches with family and child welfare services.

- Review existing national frameworks addressing the causes of drug misuse, for example, domestic violence strategies, and consider related actions that could be taken under the National Drug Strategy.

- Develop initiatives to reduce the secondary supply of alcohol to minors including through community education and information campaigns advising parents of health and social harms from alcohol and potential criminal justice outcomes.

- Develop coordinated measures to prevent, diagnose and manage fetal alcohol spectrum disorders and make available appropriate supports to children and families affected.

- Continue efforts on preventive approaches to alcohol, tobacco, illegal and other drug misuse during pregnancy, including community education.

- Consider introducing health warning labels on alcohol products, including pregnancy health warnings.

- Reduce the incidence of smoking in cars, particularly with children, and in other places where children may be exposed, through regulation and other appropriate measures.
Objective 3: Reduce harms to individuals

Some of the key challenges in responding to the harms to individuals caused by substance abuse lie in making individuals aware of the harms to their health, safety and well-being from drug misuse, motivating them to seek and engage with treatment, and connecting them with appropriate treatment and other support services.

For many individuals, this requires a change of perspective and self-acknowledgement of a drug misuse problem before there is a willingness to enter treatment for example.

Injecting drug use carries additional risks and harms for the individual, requiring particularly focused approaches.

Actions

- Strengthen drug education initiatives to ensure they are appropriately targeted and evidence based in terms of patterns of substance abuse through the life span and mode of delivery.
- Enhance treatment and associated service systems to provide help at all stages of drug misuse.
- Raise awareness of the harmful impacts of drug misuse in the workplace including through resources to promote improved practice and better linkages to treatment and other supports.
- Develop and implement internet-based approaches to target individuals who do not think they have a problem and encourage them into treatment and/or other service supports.
- Continue successful illicit drug diversion programs and extend their application to alcohol and other substances where indicated.
- Sustain efforts to prevent drug overdose and other health harms through continuing substitution therapies and withdrawal treatment.
- Continue support for needle and syringe programs and encourage safe injecting practices.
3. Supporting Approaches

The three pillars of the National Drug Strategy 2010-2015 are underpinned by the development of a qualified workforce, maintaining and improving the evidence base, monitoring performance and enhancing governance.

Workforce

Commitment to workforce development

An appropriately skilled and qualified workforce is critical to achieving and sustaining effective responses to drug misuse.

The National Drug Strategy 2010-2015 is committed to addressing a range of factors impacting on the ability of the workforce to function with maximum effectiveness.

Who is the workforce?

The Australian alcohol and other drug workforce involved in prevention and minimisation of drug misuse is highly varied spanning diverse employment sectors, industries, communities and cultures. It includes anyone who comes into contact with drug misuse as part of their role, including health professionals; police, Customs and Border Protection officers, corrections workers; teachers; hospitality staff and community and welfare workers.

Exposure to people who misuse drugs and the consequences of their drug misuse varies across the workforce. Each of the following groups has unique and specific workforce needs that require comprehensive and systematic development:

- Alcohol and other drugs workers in treatment, prevention, health promotion and community services comprise multiple occupations that are engaged in a wide variety of roles. These largely fall into two groups: alcohol and other drugs specialists and alcohol and other drugs generalist workers. The mental health workforce has a close professional affiliation with the alcohol and other drug workforce, often sharing an overlapping client base.

- In their day-to-day operations, the law enforcement workforce, including police, Customs and Border Protection officers, and corrections officers regularly engage with the consequences of drug misuse.

- Ambulance workers and paramedics, police and corrections officers are faced daily with the traumatic effects of drug misuse.

- The general health workforce, including general practitioners and other primary healthcare workers, and hospital workers, have regular exposure to drug misuse and its consequences and responsibility for the appropriate prescribing of pharmaceuticals.

- Specialist groups such as Indigenous and culturally and linguistically diverse health workers deal with a range of complex community needs.
• **Pharmacists** and the pharmacy workforce often have close contact with drug misuse through their commitment to the provision of opioid substitution treatment and needle and syringe programs. They also have an important role in precursor control and prevention of pharmaceutical misuse.

• The **education sector** plays a key role in prevention and early intervention of drug misuse.

• Community and support services, including workers from the **welfare, child protection, homelessness, unemployment, income support and youth sectors** all regularly encounter people experiencing the harms associated with drug misuse.

• **Hospitality workers** encounter the harms associated with alcohol and other drug misuse on a day-to-day basis.

**What challenges face the workforce?**

The following have been identified as workforce development priorities for the next five years of the strategy:

• Minimum qualifications of workers and accreditation of services. Work has commenced in a number of jurisdictions to examine ways to ensure minimum qualifications for workers. This will include feasible options for upskilling workers and accrediting services.

• Support for the workforce in establishing and maintaining worker wellbeing.

• Build the capacity of the AOD workforce to effectively respond to current and emerging alcohol and other drugs issues including as they relate to as older populations, youth and the opportunities and challenges of new technologies.

• Build the capacity of the treatment workforce to strengthen outcomes from its work.

• Build the capacity of the general health workforce to perform brief interventions and identify drug misuse issues.

• Utilise new technologies to make workforce development more accessible.

• Enhance workers’ research literacy by facilitating research partnerships between clinicians, policy makers and researchers.

• Address specific issues of workforce supply such as the impact of the ageing workforce and the small Indigenous workforce.

**A systematic approach to workforce**

The **National Drug Strategy 2010-2015** will continue to support the development of a qualified workforce. The Intergovernmental Committee on Drugs will establish a working group drawing in workforce experts to develop a national workforce strategy to help address these challenges.
Evidence base

Commitment to evidence

A key aspect of Australia’s approach to drug misuse has been the commitment to a comprehensive evidence base. Under the National Drug Strategy 2010-2015 there is a common commitment to evidence-based and evidence-informed practice. Evidence-based practice means using approaches which have proven to be effective in the past. As an example, the continuing provision of methadone maintenance, detoxification, pharmacological therapies and cognitive behavioural therapies for drug and alcohol treatment are based on an extensive body of evidence in Australia and internationally.

Evidence-informed practice is the integration of the existing evidence with professional expertise to develop optimal approaches, including new or innovative approaches, in a given situation. The National Drug Strategy 2010-2015 includes a commitment to innovation and trialling new approaches. For example, the introduction of the Illicit Drug Diversion Initiative (IDDI) supported police-based diversion into early intervention and prevention programs before there was comprehensive evidence supporting this approach. The evident success of IDDI was a catalyst for its expansion into court-based diversion and treatment at correctional centres. IDDI demonstrates that where there is little evidence, leadership is needed to support innovation. Allowing room for the development of such creative approaches in the future will require new evidence to be collected so that the impact and quality of new interventions is well-understood.

Ongoing evaluation of approaches is also critical to the success of the National Drug Strategy 2010-2015. Evaluation ensures that existing programs and policies are appropriate, effective and efficient in the context of contemporary drug use patterns, trends and settings. For example, the long-standing needle and syringe programs have been regularly evaluated. The results have supported the expansion and evolution of the types of needle and syringe program services offered and demonstrated its ongoing efficacy, cost-effectiveness and public health value.

Generating evidence

Under the National Drug Strategy, a strong evidence base has been built over the past 25 years. This includes health, law enforcement, education, social and cultural evidence that contributes to the application of harm reduction, demand reduction and supply reduction. Three national drug research centres of excellence – the National Drug and Alcohol Research Centre, the National Drug Research Institute and the National Centre for Education and Training on Addiction – funded by the Australian Government under the National Drug Strategy provide high-quality research that contributes to evidence-informed practice by health, law enforcement and education services. The research centres undertake work in a number of key priority areas including treatment, prevention, drug misuse and young people, workforce, Aboriginal and Torres Strait Islander peoples, and emerging trends.

The National Drug Law Enforcement Research Fund is an important contributor to the evidence base for drug law enforcement practices at an operational level. Agencies that contribute to intelligence and research in this area include the Australian Institute of Criminology and the Australian Crime Commission. Most jurisdictions also have centres for criminal statistics and research that identify crime trends.

Other academic institutions contribute to the evidence base with support from the National Health and Medical Research Council, the Australian Research Council and universities.
It is also important that Australia learns from international evidence that is relevant to Australian conditions. As an example, the introduction of buprenorphine into the Australian treatment repertoire in 2005 was based upon substantial international evidence, particularly from Europe. International sources of research will continue to contribute to the National Drug Strategy 2010-2015.

**A systematic approach to research and data**

The National Drug Strategy 2010-2015 will continue to support the development of a strong evidence base including clinical, epidemiological, criminological and policy research. In areas where the evidence base requires further development, a systematic approach is necessary. In response to the recommendation of the evaluation of the National Drug Strategy 2004-2009, the IGCD will establish a working group drawing in experts from the national research centres and other institutions to develop a National Drug Research and Data Strategy (see also Section 5 on performance measures) which will ensure a systematic approach to drug research by:

- identifying priority areas for new research and areas where evidence needs updating and/or validating
- coordinating research efforts
- facilitating the identification of emerging issues for research
- encouraging the testing and validation of new interventions
- guiding the dissemination of findings and assisting the translation of those findings into practical policies and programs.
Performance measures

Australia has a rich set of data sources relating to alcohol, tobacco, illegal and other drugs. These data sources provide information that contributes towards a better understanding of drug markets, patterns of misuse, the associated harms and patterns of treatment. Under the National Drug Strategy there is a strong commitment to improving data collections and using them to help guide implementation. This Part identifies three high-level performance measures that will help gauge progress and guide implementation of the National Drug Strategy 2010–2015. These measures build on existing performance measures identified in other national agreements such as those identified in the National Preventative Health Strategy, the National Healthcare Agreements and the National Homelessness Strategy.

The performance measures are purposely high-level for several reasons. First, data are not always comprehensive enough to provide robust national measures of activity and progress. Second, it is not possible to directly match the objectives of the Strategy, or each drug type, to a performance measure. Finally, the proposed measures use existing published data sources to help ensure continuity of approach. The performance measures are intended to provide a broad indication of progress against the three pillars of the National Drug Strategy 2010-2015.

Performance Measure 1: Disruption of illegal drug supply

Measures which demonstrate progress in disrupting the production and supply of illegal drugs include:

- the number and weight of illegal drug detections and seizures by drug type domestically and at the Australian border.
- the number of illegal drug traffic and/or supply arrests by drug type.
- the number and scale of clandestine drug laboratories disrupted in Australia.

These measures can provide a broad indication of the volume of illegal drugs entering and circulating within Australia, an indication of the extent of the illegal drug supply network, and an indication of law enforcement success in disrupting the production and supply of illegal drugs.

This measure needs to be interpreted in the context of Performance Measure 2 on prevalence of drug misuse as the scale of illegal drug detections and seizures could reflect the efficiency or intensity of law enforcement services, the effectiveness of detection methods, the availability or supply of drugs, or a combination of all.

Data to support these measures can be sourced from existing data sets published by Australian and State and Territory police agencies, the Australian Customs and Border Protection Service, the Australian Institute of Criminology and the Australian Crime Commission.

Performance Measure 2: Indicators of drug use

Prevalence of drug misuse is a rough proxy measure of progress in demand reduction. Under the National Drug Strategy measures of prevalence vary according to drug type.

- For illegal drugs, prevalence is defined as the proportion of people who used an illegal drug in the previous 12 months, for each drug type.
For tobacco, prevalence is defined as the proportion of people who smoke daily.

For alcohol misuse, prevalence is defined as the proportion of people who consume alcohol at risky levels.

For all drug types, average age of initiation of drug use is also an important indicator.

Progress against this measure will be indicated by falls in prevalence and increases in ages of initiation. However, there is not necessarily a straightforward relationship between prevalence data and success or otherwise in demand reduction strategies. Fluctuations in prevalence may be unrelated to underlying demand. For example, increases in the supply of a particular illegal drug may result in increases in opportunistic use. Prevalence data should be consider alongside other performance measures, and complemented by qualitative and quantitative research and contextual information in order to provide a broad interpretation of the data.

It is also useful to examine prevalence within sub-populations to help guide policy and program responses. For example, in 2007 general population data showed recent misuse of ecstasy as relatively stable, but closer examination showed a significant increase in misuse amongst 14–19 year old females.

Patterns of drug use should also be considered. There may be instances where the general population prevalence for a drug may be decreasing, but amongst regular users the frequency of misuse, and potentially associated harms may be increasing.

Existing published data that will inform this performance measure include: the National Drug Strategy Household Survey and the National Health Survey for the general population; the Australian Secondary Students Alcohol and other Drug survey for youth specific prevalence measures; and the National Aboriginal and Torres Strait Islander Health Survey for this population group.

Over time, consideration should also be given to including treatment data in this measure, as the Alcohol and Other Drug Treatment Service National Minimum Dataset is reviewed and enhanced.

**Performance Measure 3: Harms associated with drug misuse**

Measures of harm associated with drug misuse include:

- the social costs of alcohol, tobacco and other drug misuse to the Australian community
- trends in drink driving and drug driving related deaths and injuries, and alcohol-related violent incidents
- perceptions of community safety regarding illegal drugs, and drunk and disorderly behaviour
- the prevalence and incidence rates of HIV and hepatitis C among injecting drug users
- trends in opioid overdose related ambulance call-outs and overdose mortality
- trends in alcohol-related emergency admissions and hospital separations.
Decreases and falling trends against all these measures (except community safety perceptions, which the Strategy seeks to improve) would demonstrate progress against this measure.

Again, careful interpretation is needed. For example, a statistical increase in the arrests for drink or drug driving may be related to intensification of police operations rather than an actual increase in these behaviours.

Comprehensive national data are not available on all of these measures. Existing data sets published include State and Territory policing data, and Australian Bureau of Statistics and Australian Institute of Health and Welfare reports. National surveys such as the National Survey of Community Satisfaction with Policing, as well as commissioned research on social costs of drug misuse will help inform these measures.

The National Drug Research and Data Working Group will prepare an annual report on data against these measures for inclusion in the annual report of the Intergovernmental Committee on Drugs.
Governance

Council of Australian Governments Agreement

The National Drug Strategy is supported by high-level agreement by COAG that drug misuse issues are a priority for all Australian jurisdictions.

The Ministerial Council on Drug Strategy was established at a Special Premiers’ Conference on 2 April 1985. It was agreed that the Ministerial Council on Drug Strategy would coordinate and direct the (then) National Campaign Against Drug Abuse 1985-92 and have authority to deal with all drug-related matters.

It was also agreed that the National Drug Strategy would make a balanced attack on demand and supply and on minimising the harms drugs cause.

Continued Partnership between Health and Police Portfolios

Consistent with COAG’s agreement, the establishment in 1985 of the Ministerial Council on Drug Strategy as the auspicing group for the National Drug Strategy set up a unique and new partnership between law enforcement, health and education which has enabled great strides to be taken in supply, demand and harm reduction through integrated approaches.

This partnership approach will be maintained under the National Drug Strategy 2010-2015 to continue and consolidate past efforts and ensure that a comprehensive and holistic three-pillar approach continues to be applied to emerging drug trends and issues.

The Intergovernmental Committee on Drugs

The National Drug Strategy 2010-2015 will continue to be supported by the Intergovernmental Committee on Drugs which is a Commonwealth, State, and Territory government forum of senior officers that represent health and law enforcement agencies in each Australian jurisdiction and in New Zealand, as well as representatives of the Australian Government Department of Education, Employment and Workplace Relations and the Ministerial Council on Aboriginal and Torres Strait Islander Affairs.

The Intergovernmental Committee on Drugs provides policy advice to relevant Ministers on drug-related matters, and is responsible for implementing policies and programs under the National Drug Strategy framework.

The Intergovernmental Committee on Drugs will seek to better engage sectors beyond health, law enforcement and education to ensure whole of government and integrated cross-sectoral approaches to more complex drug misuse issues. Representatives of relevant agencies, intergovernmental councils and/or non-government organisations will be invited to the Intergovernmental Committee on Drugs for discussion of particular issues. For example, representatives of liquor licensing authorities will be invited for discussion of alcohol-related issues. A different range of stakeholders may be invited for discussion of drug and alcohol treatment service issues. Different sets of stakeholders may be invited for discussion of precursor chemical control or for pharmaceutical misuse. The Intergovernmental Committee on Drugs will structure its agenda and establish working groups as appropriate to facilitate this approach.
The Intergovernmental Committee on Drugs will also seek cross-representation and other forms of engagement, including joint working groups as appropriate, with other Commonwealth-State officials meetings where issues relevant to the causes and impacts of drug misuse are being addressed. For example, the Intergovernmental Committee on Drugs will conduct joint work with the Australian Health Ministers Advisory Council on the Pharmaceutical Drugs Misuse Strategy. The Committee will also seek to engage with groups addressing homelessness and other issues relevant to social inclusion and addressing social disadvantage.

**Australian National Council on Drugs**

Membership of the Australian National Council on Drugs is appointed by the Prime Minister and includes people with a wide range of experience and expertise on various aspects of drug policy, such as treatment, rehabilitation, education, family counselling, law enforcement, research and work at the coalface in community organisations.

The Australian National Council on Drugs will provide ministers with independent, expert advice on matters connected with legal and illegal drugs. It provides a non-government voice, to facilitate an enhanced partnership between the government and community sectors in the development and implementation of policies and programs to redress drug-related harms. The Australian National Council on Drugs will develop a workplan and will report annually to the Prime Minister and will provide reports to the Ministerial Council on Drug Strategy.
Appendix A

Sub-strategies under the *National Drug Strategy 2010-2015*

- National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan
- National Alcohol Strategy 2006-2011 *Towards Safer Drinking Cultures*
- National Amphetamine-Type Stimulants Strategy 2008-2011
- National Cannabis Strategy 2006-2011
- National Tobacco Strategy 2004-2009
- National Corrections Drug Strategy

Other national strategies relevant to the *National Drug Strategy 2010-2015*

- The Sixth National HIV Strategy 2010-2013
- The First National Hepatitis B Strategy 2010-2013
- The Second National Sexually Transmissible Infections Strategy 2010-2013
- The Third National Hepatitis C Virus Strategy 2010-2013
- The Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy
- National Framework for Protecting Australia’s Children 2009 – 2020
- *Investing in the Early Years – A National Early Childhood Development Strategy*
- National Mental Health Strategy
- National Suicide Prevention Strategy
- Organised Crime Strategic Framework