



SIGGINS MILLER

**Evaluation and Monitoring of the
National Drug Strategy 2004-2009**

Final Report

Volume 1: Findings and recommendations

Siggins Miller, April 2009

Table of contents

The National Drug Strategy: 2004-2009	1
Chapter 1: Introduction to the evaluation and monitoring project	3
Background and purpose of this evaluation of the NDS	3
Overview of the evaluation plan and method	3
Evaluation method	4
Data collation and analysis	5
The context and scope of the evaluation	6
Chapter 2: Drugs in Australia: an overview	7
Drug use in Australian society	7
Current prevalence and trends	7
Trends in treatment modalities	10
International comparisons	11
The social costs of drugs to the Australian community	12
Drug related morbidity and mortality	12
Victims and perpetrators of drug-related harms	13
Drug-related crime	13
Community attitudes towards drug policies	14
Drug availability, and sources of supply	14
Penalties for the sale or supply of illicit drugs, and the legalisation issue	15
Tobacco policies	15
Alcohol policies	16
Illicit drug policies	16
'Drug problems' and acceptability	16
Balancing expenditures on drug education, treatment and law enforcement	17
Conclusion	17
Chapter 3: Context of the National Drug Strategy	18
History and policy context	18
Australia's contributions to drug advice and policy	19
Trends during the currency of NCADA / NDS	20
The National Drug Strategy: 2004-2009	21
Objectives	21
Priority areas	22
Sub-strategies	22
Activities, programs and projects	22
Research, data systems and evaluation	23
Advisory structure	23

Ministerial Council on Drug Strategy (MCDS)	24
Intergovernmental Committee on Drugs (IGCD)	24
The Australian National Council on Drugs (ANCD)	24
The National Expert Advisory Panel (NEAP).....	24
National Drug Research Centres of Excellence (NDRCE)	25
Evaluations of NCADA / NDS	25
Recommendations from the evaluation of the previous phase of the NDS	26
Chapter 4: The National Drug Strategy as a policy framework.....	27
Introduction	27
Findings	28
The National Drug Strategy as an overarching framework.....	28
The principle of harm minimisation.....	29
Prevention	32
Partnership.....	32
Balance of priorities within the framework	34
An evidence-informed approach	36
Summary of findings.....	38
Working towards better practices in drug policy development.....	38
Future needs	39
Recommended improvements	40
Chapter 5: Outcomes of NDS Programs	41
Introduction	41
Aim of the NDS programs	43
Findings	47
Strengthened partnerships	48
Prevention and early intervention.....	49
Improved access to quality treatment services.....	51
Workforce development and structures.....	53
Identification and response to emerging trends.....	55
Research, best practice and education resources	56
Efficiency and effectiveness	57
Chapter 6: NDS Advisory Structure	61
Introduction	61
Findings	62
Achieving consensus and commitment	62
MCDS and COAG	62
The role of the IGCD	63
The role of the ANCD	68
Future needs	69
Future improvements.....	70

Chapter 7: NDS performance in facilitating and guiding the monitoring of drug issues and trends and the outcomes of the Strategy	71
Introduction	71
Evaluation method	71
Approaches to monitoring the NDS	72
Performance information	74
Performance Indicators for the NDS: experiences to date	75
The headline indicators.....	77
Findings	78
Appropriateness	78
Effectiveness	79
Efficiency	83
Summary of findings	84
Recommendations	85
Chapter 8: Enhancing Australia’s drug strategy	86
Overarching conclusions: opportunities for improvement	86
The ‘harm minimisation’ concept and terminology	86
Partnerships and engagement	86
Use of evidence	87
Leadership	88
Social determinants.....	88
Monitoring and evaluation	88
Component 1: NDS as a policy framework	89
Observations about efficiency and effectiveness	89
Future processes and recommended improvements	89
Component 2: NDS program outcomes.....	90
Observations about efficiency and effectiveness	90
Future processes and recommended improvements	91
Component 3: NDS Advisory structure	92
Observations about efficiency and effectiveness	92
Future processes and recommended improvements	93
Component 4: NDS performance in facilitating and guiding the monitoring of drug issues and trends and the outcomes of the Strategy	93
Observations about efficiency and effectiveness	93
Future processes and recommended improvements	94
Concluding remarks.....	95

Executive summary: Evaluation of the NDS 2004-2009

Australia's National Drug Strategy (NDS) began in 1985 as the National Campaign Against Drug Abuse (NCADA). The current phase of the NDS has been monitored and evaluated using a framework endorsed by the Ministerial Council on Drug Strategy (MCDS) and the Intergovernmental Committee on Drugs (IGCD), and guided by an Evaluation and Monitoring Project Working Group appointed by the IGCD. The evaluation framework had four related key components:

1. Evaluate the NDS as a policy framework that informs stakeholders in developing their respective drug related policies and programs
2. Evaluate the outcomes of programs under the NDS, including the cost shared funding model projects
3. Evaluate the roles and workings of the advisory structures that inform development and implementation of the NDS
4. Monitor the performance of the NDS with regard to actual and potential drug issues and drug trends in Australia, during the period 2006-2009.

Each component was assessed for effectiveness, efficiency, future needs, and opportunities for improvements. The logic of the components of the NDS was mapped, and their contribution to the goals of the Strategy was assessed. Extensive information was gathered from reviews of key documents and published literature, consultations with informants, and case studies, and critically compared to make findings and inform recommendations.

Context

The report summarises trends in drug use, community attitudes to drug use, and public attitudes towards Australia's responses. The prevalence of consumption of tobacco, cannabis, painkillers and amphetamines is falling. The use of most other drugs is relatively stable, except for tranquillisers and cocaine, whose use has risen in recent years. No marked changes have emerged over the last two decades in the age of initiation to drug use. Community attitudes to drugs continue to be broadly consistent with research evidence about which interventions are the most effective in preventing and dealing with problems arising from both licit and illicit drugs.

The National Drug Strategy 2004-2009

The current phase of the NDS displays a comprehensive, partnership-based and balanced approach to drug policy. Harm minimisation, a concept that encompasses supply reduction, demand reduction and harm reduction, is a key element of what has come to be known as 'the Australian approach' to drug policy. The Strategy enables collaborations among health, law enforcement and education, among different levels of government, and among government, non-government and private organisations and the community at large. It promotes the use of evidence to inform drug policy and practices. These characteristics play a critical role in the success of Australia's drug policy.

The following national initiatives were designated by the Project Working Group and the Department of Health and Ageing as within the scope of this evaluation on the basis that they are funded under CSFM or alternate funding sources, or explicitly implemented under the NDS framework but not associated with funding, including new legislation and new international relationships: National Cannabis Prevention and Information Centre (NCPIC), National Comorbidity Initiative (NCI), National Drug Research Centres of Excellence (NDARC, NDRI, and NCETA), National Drug Law Enforcement Research Fund (NDLERF), MCDS Cost Shared Funding Model (CSFM), National Drugs Campaigns in Alcohol, Tobacco and Illicit Drugs, Community Partnerships Initiative (CPI), Non-Government Organisation Treatment Grants Program (NGOTGP), National Illicit Drug Diversion Initiative (IDDI), and Amphetamine-type Stimulants Grants Program (ATSGP).

Of course, this does not constitute the totality of effort under the National Drug Strategy. Other initiatives include legislative reform and development of new international relationships, ongoing work in service delivery in the criminal justice, health, education and social welfare systems, and the broader community. Some of this service is delivered in specialised alcohol and other drug agencies, and some in mainstream settings in the government, private and not-for-profit sectors. Much of this is funded from non-NDS sources such as State and Territory budgets.

Component 1: The National Drug Strategy as a policy framework

The NDS policy framework has successfully informed development and implementation of drug policies and strategies at many levels and across government and the public, private and non-government domains. The NDS is broad and flexible enough to enable State and Territory and local drug strategies to be tailored to local needs and priorities. This is an effect of a consistent approach to harm minimisation, partnerships and the use of evidence over a long period. Disagreement still exists over how specific the sub-strategies of the framework should be about mechanisms for delivery and accountability, and whether allocation of financial resources by the Commonwealth is a necessary component of the NDS.

The NDS aims to be evidence-based while providing opportunities for creativity and innovation particularly in response to emerging issues. Even though Australia has only a small drug research community, key elements of evidence have been developed by these researchers, more so in the health sector than the criminal justice sector. However, policy-setting bodies have faced challenges in finding an optimal balance of investment between licit and illicit drugs (tobacco has received insufficient attention) and between supply reduction, demand reduction, and harm reduction (supply reduction continues to attract most resources).

We do not have a strong enough body of evidence to make detailed, definitive statements about the optimal allocation, owing to the complex web of causes of drug use and drug related harm, and the complex relationships between activities and outcomes. Nevertheless, at a much higher level, it is clear that optimal allocation in the broad categories listed here have not yet been attained.

Another challenge to the success of the NDS as a policy framework is the use of ‘harm minimisation’ as the underpinning concept for the framework. It is widely agreed that a new term is needed that encompasses both the *causes* of problematic drug use and responding to drug-related *harms*. Many informants also believe that stakeholders outside federal, State and Territory Governments are not sufficiently engaged in NDS policy development and review.

Component 2: Outcomes of NDS programs

Ten nominated national initiatives were carefully assessed to identify how far these initiatives have been evidence-based and appropriate, efficient and effective, with enough penetration to achieve their goals. The outcomes of these programs have strengthened Australia’s capacity to address drug use and drug-related harms, by investment in the following activities:

Strengthened partnerships and collaborations between levels and sectors of government and the public, private and not-for-profit service delivery sectors. Examples include the State Reference Groups that assess grant applications under the NGOTGP, and the collaborations involved in implementing Project STOP.

Effective prevention and early intervention. This area has not received the focus that it deserves during the current and earlier phases of the NDS. Nevertheless, the NDS Campaigns, CPI, NCI, and NCPIC all provide resources to strengthen early intervention and prevention (in the absence of an explicit prevention agenda within the NDS).

Improved access to quality treatment services. The NGOTGP, IDDI, ATSGP, and NCI have all been important in expanding access to quality treatment. The NGOTGP has been particularly

instrumental in increasing treatment services across the country. Resources for illicit drug treatment services have been allocated on the basis of sound processes that rely on collaboration at the jurisdictional level to deliver reasonable information about local needs, gaps, and opportunities and constraints in the AOD system. There is a need to continue to increase capacity for collaborative needs-based planning, more integrated seamless service delivery, data collection, performance monitoring and review.

Research and best practice resource development. Important achievements in the sector have been made by applying research-based evidence to policy and practice, and Australian researchers have contributed significantly to the evidence base. The National Drug Research Centres have made major contributions, as have researchers from other institutions. While NDLERF provides funds for drug law enforcement research, insufficient work has been done in developing the evidence base in this area, partly because of the lack of NDS-supported drug law enforcement research infrastructure. Still more could be done to use research evidence to respond to drug trends. The NDS still has no integrated national drug research strategy.

Workforce development and structures. An appropriately sized, skilled and qualified workforce is critical in sustaining effective delivery of interventions. Capacity to implement programs has been limited by staff shortages and turnover, and skill gaps in the alcohol and other drug (AOD) sector specifically and in the Australian workforce generally. The NDS contribution to training programs and resources is highly valued, as is the work of NCETA in developing a concept of workforce development far broader than education and training. More attention is needed to building the capacity and profile of professionally-trained, specialist AOD workers. Attention is needed to competitive pay and conditions, incentives and benefits. A new national AOD workforce development strategy, as proposed by NCETA and recently discussed by IGCD, will be an important initiative.

Program performance monitoring and evaluation. Capacity to engage in performance monitoring, review and evaluation is still limited. Important programs have been implemented without documented or funded monitoring and evaluation components built in from the outset. Although a commitment to monitoring and evaluation is part of every phase of the NDS, more action is needed to make it a reality.

Component 3: The NDS advisory structure

The top-level decision-making body for the NDS is the Ministerial Council on Drug Strategy. It is supported by a senior officers group, the Intergovernmental Committee on Drugs. The members of both are drawn from the law enforcement, health and education sectors. The Drug Strategy Branch of the Department of Health and Ageing provides secretariat support. Other components of the advisory structure include the Australian National Council on Drugs (ANCD), appointed by the Prime Minister and providing independent advice to Government; the National Expert Advisory Panel (NEAP); and time-limited expert working groups established by the IGCD. The role of the advisory bodies is to ensure that the MCDS has timely access to the expert and policy advice it needs.

MCDS, IGCD, ANCD and the expert working groups have been useful and appropriate forums for people from the health, education and law enforcement sectors to reach consensus in key policy areas. They have sustained commitment to the principles of the NDS, and have promoted a nationally consistent and coordinated approach to developing and implementing drug policy in Australia's federated system of government.

Many informants believe that the operation of the advisory structures could be improved. There is confusion about the respective functions of the ANCD and the IGCD, and of the ANCD and ADCA in representing the views of the non-government sector. The National Expert Advisory

Panel is an innovative and potentially useful concept, but there may be ways to make it more effective. There needs to be a practical way to access a stratified database listing the knowledge and experience of all the panellists, so that the IGCD/MCDS Secretariat can call on them quickly when their particular special advice is needed.

Component 4: Performance in monitoring drug issues and trends and the outcomes of the NDS

Australia is among the world's leaders in having available information that can be used for monitoring drug-related issues and trends. We have sound data collections covering the extent and nature of drug use and drug-related harms among various populations. Furthermore, two strategic early warning systems, Illicit Drug Reporting System/Ecstasy and related drugs Reporting System (IDRS/EDRS) and Drug Use Monitoring in Australia (DUMA), are particularly highly valued. These resources have been developed over a number of years, primarily within the NDS. In the view of the evaluators and many other informants, it is one of the most significant outcomes and achievements of the NDS over the past two decades.

Nevertheless, the NDS has not been as effective as it could be in ensuring that drug trends and program implementation are monitored, or in evaluating outcomes (only five of the 10 listed programs had any form of evaluation during the current phase). Important gaps in information still exist (eg drug use and harms among Indigenous peoples), and there are delays in producing relevant findings from some important data collections (eg drug-related mortality). The lack of a national drug information system and research strategy means the data collections are not used as well as they could be for monitoring, evaluation, and policy. Decisions about data collections reflect the priorities of the collecting organisations rather than the needs of the NDS for monitoring and policy decisions.

Enhancing Australia's drug strategy

During the course of 2009 action will be taken to develop the next phase of the NDS, as the current phase ends in that year. Undoubtedly the process will include substantial inputs from the AOD and related sectors and the community. Some of the key issues that will need attention, based on our evaluation of the current phase of the NDS, include:

- Finding a more appropriate term than 'harm minimisation' to communicate the essence of the NDS, with greater emphasis on prevention
- Enhancing partnerships and engagement
- Rectifying the imbalance of investment among drug types and intervention sectors
- Further developing and using research-based evidence more effectively in developing and implementing policies and programs
- Strengthening capacity within the NDS framework for evidence-based policy debate in the public arena
- Focusing greater attention on the social determinants of health and drug-related harm, in part through the development of a comprehensive prevention agenda
- Enhancing the role of monitoring and evaluation within the NDS

The greatest strengths of the NDS have been to maintain a consistent approach over a long period, to base policy on the evidence, on needs and appropriate responses, and to act on the basis of mutually-respectful partnerships among diverse contributors. This 'Australian approach' to drug policy continues to be sound. It has produced valued outcomes across the Australian community. However, the context is changing. After a period of stability, new policies, structures, processes, resources and expectations are emerging in many domains. The challenge is to maintain the long-term positive features of the NDS, and at the same time adapt it to contemporary and emerging circumstances.

Recommendations

Recommendation 1: Highlight and further develop a shared public understanding of the causes and consequences of drug-related harm and the need to retain the three pillars of supply reduction, demand reduction, and harm reduction, and consider replacing the term ‘harm minimisation’ with words which better communicate the need for prevention of drug use and drug-related harm.

Recommendation 2: Review investment among law enforcement, health and education sectors; supply, demand and harm reduction strategies; and illicit and licit drugs, and develop and apply funding mechanisms, jointly planned at Commonwealth and State and Territory levels, to make allocations that reflect the relative seriousness of the harms and costs addressed, and the availability of evidence-informed strategies and beneficial interventions for addressing them, in order to ensure that allocations provide cost-effective interventions across drug types and sectors.

Recommendation 3: Progress the development and implementation of a national prevention agenda, for example by:

- 1) using NDRI’s work in documenting the evidence base for a prevention agenda, including the roles of law enforcement in prevention (Loxley *et al* 2004), as a point of departure for developing a formal prevention strategy and action
- 2) developing links between NDS and related sectors and fields to address the social determinants of health
- 1) working to implement contemporary understandings of the social determinants of harmful drug use intersectorally, between drug strategies and other areas of social programming

Recommendation 4: Encourage broader stakeholder engagement in policy processes, in particular, engagement with consumer groups, service providers, and local government, for example by:

- 1) building stronger engagement of the NDS with the education and corrections sectors, and enhancing links with related national strategies and policies (welfare reforms, taxation policy) and sectors (mental health, employment, discrimination)
- 2) identifying and developing structured processes for assessing the views of the broader public through public consultations, providing greater transparency in public policy development and involving more people in shaping the next NDS
- 3) disseminating policy-relevant evidence to the public to bridge the gap in public understanding of the evidence, and ensure that community consultation involves a better informed public and is more likely to meet the ideals of deliberative democracy
- 4) establishing mechanisms to provide feedback on continuing implementation and outcomes to stakeholders such as consumer groups, NGOs, and professional organisations

Recommendation 5: Further integrate treatment services and pathways across the government, non-government and private sectors, and encourage increased investment in comprehensive models of evidence-based interventions, for example by:

- 1) working collaboratively across sectors to develop referral pathways and integration of care, through government and non-government provider co-location, coordinated referral pathways, and shared care arrangements to meet the clinical and non-clinical needs of clients
- 2) increasing capacity across State and Territory, non-government, and private sectors for more collaborative needs-based planning, funding allocation, performance monitoring, and review processes

Recommendation 6: Develop a strategic approach to AOD workforce development to meet current and future needs, for example by:

- 1) addressing structural issues of national concern such as more competitive employment conditions in the AOD sector, better clinical supervision and mentoring, incentives, continuity of entitlements across government, non-government and private providers, and funding for medical, nursing and allied health specialist training in AOD-related conditions
- 2) identifying strategies to ensure a supply of appropriately skilled and qualified workers (such as enhancing their scope of practice, and providing Medical Benefit Schedule (MBS) items for allied health professionals engaged in the AOD sector)
- 3) identifying strategies to ensure a supply of appropriately skilled and qualified Aboriginal and Torres Strait Islander and CALD AOD workforces
- 4) using NCETA's central role to focus on strategic workforce development and modelling to estimate future needs, in collaboration with other bodies, including some of the State AOD peaks and State and Territory AOD agencies

Recommendation 7: Acknowledging the significant volume and quality of Australian AOD research output, further enhance national drug research capacity, for example by:

- 1) developing a coherent national drug research strategy and implementation program (perhaps based on the report of the former National Drug Research Strategy Committee)
- 2) addressing the lack of NDS-supported infrastructure for drug law enforcement research (including dedicated researchers and research centres)
- 3) enhancing collaboration between NDS national research centres and other drug research groups and projects

Recommendation 8: Increase capacity for performance monitoring, review and evaluation to inform future investment, for example by:

- 1) developing an evaluation framework (literature review of existing evidence, program logic, contextual factors, performance indicators, data items and mechanisms for collecting them) as an integral part of the design of new programs
- 2) identifying and developing data collection mechanisms
- 3) training staff to collect and use data to monitor the performance of programs, to ensure that programs remain evidence-based and are in a position to improve the quality of their services
- 4) undertaking regular program review and improvement processes based on performance data

Recommendation 9: Establish an integrative mechanism to address current limitations of the diverse relationships among the IGC, ANCD, NEAP, the working groups, and relevant NGOs/peaks. Its functions could include:

- providing a channel of advice that places identified needs and emerging issues on appropriate agendas, and disseminates the responses
- defining the relationship of ANCD to the NGO sector in encouraging inputs from the non-government and private sectors into policy, program design, implementation, and evaluation
- enhancing the value of the NEAP by creating an accessible, stratified database of preferred suppliers of expertise for the use of all the advisory structures as needed

Recommendation 10: Expand the IGCD's access to expertise and streamline its operations by:

- providing a funding mechanism for IGCD activity
- ensuring a balance of discussion of health and law enforcement issues during meetings
- engaging with challenging agenda items in a timely way
- strategically commissioning research from experts inside and outside the IGCD
- ensuring that its recommendations to the MCDS are supported by evidence-based advice
- adopting decision-making processes that are fully documented and transparent to the field

Recommendation 11: Build monitoring and evaluation into the design of all NDS sub-strategies from the outset.

Recommendation 12: Fill key gaps in Australia's AOD data systems by undertaking a strategic review of AOD data collection systems to prioritise where resources should be applied, including but not confined to:

- developing a process for reviewing, and implementing as appropriate, the findings and recommendations of the 2006 AIHW investigation into data on drug use, drug-related harm and drug interventions among Aboriginal and Torres Strait Islander peoples
- developing a data collection system that provides data on drug-related mortality covering all drugs, at least annually, with minimal delays
- developing a nationally consistent monitoring system regarding the purity of illicit drugs, which includes a national cannabis potency monitoring program

Recommendation 13: Establish an expert committee to develop a national drug information system, including recommendations on contents, structures, resourcing and processes. Its starting point would be this report, the report of the former National Drug Research Strategy Committee and the report of the NDS Data Analysis Project. It could include developing a system for converting the products of core data collections into policy and action within the framework of the NDS.

Recommendation 14: Establish an ongoing system for monitoring drug issues and trends in Australia, based on a further refinement of the Headline Indicators used in this report.

Recommendation 15: Review the validity and reliability of the NDSHS and the Australian School Student Alcohol and Drug Survey (ASSAD) as they are increasingly being questioned. Reviews are needed to assure users that these data collections are sound or, alternatively, to identify problems and suggest remedies.

Abbreviation and acronyms

AA	Alcoholics Anonymous
ABS	Australian Bureau of Statistics
ACC	Australian Crime Commission
ACOSH	Australian Council on Smoking and Health
ACS	Australian Customs Service
ADCA	The Alcohol and other Drugs Council of Australia
ADDR	Australian Drug Data Report
ADFA	Alcohol and Drug Foundation Australia
ADFQ	Alcohol and Drug Foundation Queensland
ADIN	Australian Drug Information Network
AERF	Alcohol Education Rehabilitation Foundation
AFP	Australian Federal Police
AGD	Australian Government Attorney-General's Department
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AIC	Australian Institute of Criminology
AIDR	Australian Illicit Drug Report
AIHW	Australian Institute of Health and Welfare
AIVL	Australian Injecting and Illicit Drug Users' League
AMA	Australian Medical Association
ANCD	Australian National Council on Drugs
AOD	Alcohol and other drugs
AODTS-NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
APDIC	Asia Pacific Drug Issues Committee
ASMI	Australian Self Medication Industry
ASSAD	Australian Secondary Students' Alcohol and Drug Survey
ASSDA	Australian Social Science Data Archive
ASX	Australian Securities Exchange
ATS	Amphetamine-Type Stimulants
ATSGP	Amphetamine-type Stimulants Grants Program
ATSIPCAP	Aboriginal and Torres Strait Islander Peoples Complementary Action Plan
CDD	Chemical Diversion Desks
CERG	Comorbidity Expert Reference Group
CMO	Comprehensive multidisciplinary outline
COAG	Council of Australian Governments
CPI	Community Partnerships Initiative
CPTED	crime prevention through environmental design
CSFM	Cost Shared Funding Model
DALYs	Disability-adjusted life years
DAO WA	Drug and Alcohol Office, Government of Western Australia
DAS SA	Drug and Alcohol Service, South Australia
DEEWR	Australian Government Department of Education, Employment and Workplace Relations
DEST	Australian Government Department of Education, Science and Training [now DEEWR]
DETYA	Australian Government Department of Employment, Training and Youth Affairs
DFZ	Drug-free zones
DHS	Department of Human Services
DoHA	Australian Government Department of Health and Ageing
DPMP	Drug Policy Modelling Program
DUMA	Drug Use Monitoring in Australia
EDRS (formerly ERDS)	Ecstasy and Related Drugs Reporting System
FaHCSIA	Australian Government Department of Families, Housing, Community Services and Indigenous Affairs
FASD	Fetal Alcohol Spectrum Disorder
FECCA	Federation of Ethnic Community Council
GHB	Gamma Hydroxybutyrate
GP	General Practitioner
HCV	Hepatitis C virus

ICD	International Statistical Classification of Diseases and Related Health Problems
ICP	Integrated care pathway
ICT	Information and communication technology
IDDI	Illicit Drug Diversion Initiative
IDDR	Illicit Drug Data Report
IDPC	International Drug Policy Consortium
IDRS	Illicit Drug Reporting System
IDU	Illicit drug users
IGCD	Intergovernmental Committee on Drugs
INCB	International Narcotics Control Board
KPIs	Key Performance Indicators
LAAM	levo-alpha-acetylmethadol
LSD	lysergic acid diethylamide
MBS	Medicare Benefits Schedule
MCDS	Ministerial Council on Drug Strategy
MCEETYA	Ministerial Council on Education, Employment, Training and Youth Affairs
MDA	Methylenedioxyamphetamine
MDEA	3,4-Methylenedioxy-N-Ethylamphetamine
MDMA	3,4-Methylenedioxymethamphetamine (Ecstasy)
MJTF	multi-jurisdictional taskforces
NABIC	National Alcohol Beverage Industries Council
NACCHO	National Aboriginal Community Controlled Health Organisation
NACSDE	National Advisory Committee on School Drug Education
NADA	Network of Alcohol and Other Drugs Agencies
NAS	National Alcohol Strategy
NCADA	National Campaign Against Drug Abuse
NCBADLE	National Community Based Approach to Drug Law Enforcement
NCETA	National Centre for Education and Training on Addiction
NCHECR	National Centre in HIV Epidemiology and Clinical Research
NCI	National Comorbidity Initiative
NCIS	National Coroners' Information System
NCLD	National Clandestine Laboratory Database
NCP	National Competition Policy
NCPIC	National Cannabis Prevention and Information Centre
NDARC	National Drug Alcohol Research Centre
NDCPF	National Drug Crime Prevention Fund
NDLRF	National Drug Law Enforcement Research Fund
NDRCE	National Drug Research Centres of Excellence
NDRI	National Drug Research Institute
NDS	National Drug Strategy
NDSF	National Drug Strategic Framework 1998-99 to 2002-03
NDSHS	National Drug Strategy Household Survey
NEAC	National Expert Advisory Committee
NEACT	National Expert Advisory Committee on Tobacco
NEAP	National Expert Advisory Panel
NEG	National Expert Group
NEPOD	National Evaluation of Pharmacotherapies for Opioid Dependence
NGO	Non-Government Organisation
NGOTGP	Non-Government Organisation Treatment Grants Program
NHHRC	National Health and Hospitals Reform Commission
NHMRC	National Health and Medical Research Council
NHS	National Health Survey
NICNAS	National Industrial Chemicals Notification and Assessment Scheme
NIDAC	National Indigenous Drug and Alcohol Committee
NIDE	National Initiatives in Drug Education
NIDIP	National Illicit Drug Indicators Project
NIDS	National Illicit Drug Strategy
NIROA	Non-injecting routes of administration

NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data
NPI	National Psychostimulants Initiative
NPIERG	National Psychostimulants Initiative Expert Reference Group
NRG	National Reference Group
NSDES	National School Drug Education Strategy
NSP	Needle and Syringe Program
NTS	National Tobacco Strategy
OATSIH	Office of Aboriginal and Torres Strait Islander Health
OECD	Organisation for Economic Cooperation and Development
PDI	Party Drug Initiative
PGA	Pharmacy Guild of Australia
PGAQ	Pharmacy Guild of Australia, Queensland
PHOFA	Public Health Outcome Funding Agreements
PIEDs	Performance and Image Enhancing Drugs
PMA	4-Methoxyamphetamine Paramethoxyamphetamine
PSA	Pharmaceutical Society of Australia
PSFA	Psychostimulants First Aid Training package
PWG	Project Working Group
QADREC	Queensland Alcohol and Drug Research and Education Centre
QPS	Queensland Police Service
RBT	Random Breath Testing
RSA	Responsible Service of Alcohol
SBDP	school-based drug prevention
SCO	Standing Committee of Officials
SES	Social economic status
SHAHRP	School Health and Alcohol Harm Reduction Project
SIF	supervised injecting facilities
SRG	State Reference Groups
TGA	Therapeutic Goods Administration
UNODC	United Nations Office on Drugs and Crime
VADA	Victorian Alcohol and Drug Agencies
WHO	World Health Organization

The evaluation team, Siggins Miller

Dr Mary-Ellen Miller, Director and Principal Consultant: Adjunct Professor, School of Psychology, Griffith University; Adjunct Senior Lecturer in the University of Queensland School of Health Sciences

Professor Ian Siggins, Chief Executive and Principal Consultant: Adjunct Professor in the University of Queensland Medical School

Professor Wayne Hall, Associate: Professorial Research Fellow and Director, Office of Public Policy and Ethics, Institute for Molecular Bioscience, University of Queensland

Professor Robert Bush, Associate: Chair, Community Health Research, Healthy Communities Research Centre, University of Queensland

Mr David McDonald, Associate: Director, Social Research and Evaluation

Ms Geraldine Cleary, Senior consultant

Dr Sally Hsueh-Chih Lai, Senior Consultant

Ms Bonnie Ho, Consultant

Assisted by:

Mr Greg Fowler, Associate: Senior Research Officer, Queensland Alcohol & Drug Research & Education Centre

Mr Michael O'Connor, Research Officer

Dr Crissa Sumner, Senior Consultant

Acknowledgements

In undertaking this monitoring and evaluation project and preparing this report, the Siggins Miller project team are sincerely grateful for the ongoing advice and support of Ms Virginia Hart (Assistant Secretary, Drug Strategy Branch, Department of Health and Ageing), the staff of the Drug Strategy Branch including Ms Karen Price, Mr Robert Byrne, Ms Gunjan Sharma; Mr Patrick Smith, Mr Darius Everett, Ms Chrysanthe Psychogios, and Ms Amanda Taylor, and the current members of the Project Working Group not yet mentioned: Mr Gino Vumbaca (Executive Officer, ANCD), Professor Margaret Hamilton (Co-Deputy Chair, ANCD), Dr Kevin Lambkin (Director, ATODS, Queensland Health), Commissioner Jack Johnston (Tasmania Police), Mr Craig Harris (Assistant Secretary of the National Law Enforcement Policy Branch, Attorney General's Department), and Mr Keith Evans (Executive Director, Drug and Alcohol Services, South Australia).

We are also very grateful to all those who took part in the stakeholder consultations, and whose names are listed in Appendix B.

The National Drug Strategy 2004-2009

Chapter 1: Introduction to the evaluation and monitoring project

Background and purpose of this evaluation of the NDS

Australia's national drug strategy was inaugurated in 1985 as the National Campaign Against Drug Abuse (NCADA). It was rebadged as the National Drug Strategy (NDS) in 1993, and has progressed through four phases. It is currently in its fifth phase.

On endorsing the NDS in May 2004, the Ministerial Council on Drug Strategy also agreed to develop an evaluation and monitoring framework for the current phase of the NDS. The Intergovernmental Committee on Drugs (IGCD) appointed an Evaluation and Monitoring of the NDS 2004-2009 Working Group, which then developed a draft evaluation framework, endorsed by the IGCD and MCDS in 2005, with increased investment and a longer-term approach compared with evaluations of the previous phases.

The evaluation framework had four key components:

1. Evaluate the NDS as a policy framework that informs stakeholders in the development of their respective drug related policies and programs
2. Evaluate the outcomes of programs under the NDS, including cost shared funding model projects (CSFM projects)
3. Evaluate the roles and workings of the advisory structures that inform the development and implementation of the NDS
4. Monitor the performance of the NDS with regard to actual and potential drug issues and drug trends in Australia during the period 2006-2009

These terms of reference were to be applied to assessing each of the four components:

1. The effectiveness of the NDS
2. The efficiency of the NDS
3. Identification of future needs for the NDS
4. Opportunities for future process or other improvements

It was expected that the project would make recommendations to inform development of the next iteration of the NDS.

In 2007, the Australian Government Department of Health and Ageing (DoHA) contracted Siggins Miller to evaluate and monitor the current phase of Australia's national drug strategy within this framework. The purpose of the project was to evaluate and monitor the 2004-2009 phase of the NDS from the perspectives of health, law enforcement, education, Commonwealth, State and Territory governments, non-government organisations (NGOs), and research bodies.

At all stages of the project, the evaluators worked closely with the Evaluation and Monitoring Project Working Group (PWG), and sought the advice of DoHA officers. All aspects of the evaluation method were planned or amended with the approval of DoHA officers and the PWG.

Overview of the evaluation plan and method

The project has been designed and reported around the four components in the evaluation framework: the NDS as a policy framework; outcomes of the national programs funded under the NDS; the advisory structure of the NDS; and the performance of the NDS in actual and potential drug issues and trends in Australia.

While each component is evaluated and presented separately, the four components are intrinsically linked in non-linear, complex ways to influence the achievement of NDS outcomes. The nature and quality of each component has implications for all the others. For example, the

quality of the NDS policy framework and its advisory processes clearly affect the nature and range of the programs, research, and data collection undertaken. External factors in the broader political and social context also influence the intended outcomes of each component.

Evaluation method

Methodological approaches

In order to meet the requirements for evaluating the NDS in terms of its policy framework, programs, advisory structure and capacity to monitor drug issues and trends in Australia, we recommended (and the PWG approved) an overarching systems approach that incorporated use of program logic and contribution analysis.

The systems approach considered the NDS as a whole, and the social, policy, economic and community context in which it operates. Program logic models spelled out the logic of NDS activities, and formed the basis of matrices setting out the outcomes expected from these activities. The PWG approved the resulting models and matrices.

These methods offered a systematic process for first articulating and then studying the diverse range of factors affecting the success of the NDS, and for identifying appropriate research methods, data sources and indicators to evaluate the NDS and its component parts.

This program logic approach was supplemented by a contribution analysis to assess the extent of NDS contribution to changes in drug-related harm in Australia. This analysis recognises that the performance of any government program of effort is complexly determined, and that even large complex government programs only ever make a contribution to outcomes.

Information was gathered from multiple data sources and triangulated to identify key findings and issues and to inform the development of recommendations. For each key component, a set of research activities was performed, consisting primarily of documentation and literature reviews, consultations with stakeholders and case studies.

Documentation and literature reviews

An extensive range of relevant documentation was provided to the evaluators, including background materials, and specific documents and datasets we requested. Topical literature reviews also informed assessment of the issues arising in each component. Document and literature reviews were updated regularly throughout the course of the evaluation.

Stakeholder consultations

As the PWG directed, informants comprised two main groups: 1) those in the most senior positions and roles in the central agencies of government responsible for developing, implementing and evaluating the NDS and its programs; and 2) those in the most senior roles and positions who were involved in development, implementation and evaluation of programs and in development and dissemination of research evidence relevant to the NDS. In most cases, the informants were nominated by the PWG and DoHA. For some case studies DoHA also nominated a contact person to provide the evaluators with further advice on the informants specific to a case study.¹

Stakeholder consultations were done in two stages. The first stage gathered information and opinion about the components of the NDS and the first set of case studies; the second stage collected responses for the second set of case studies and tried to fill gaps in the information gathered earlier from documents, informants, and other data sources. The first interviews were

¹ See Appendix B for the list of informants interviewed

conducted between 10 March and 6 May 2008, and the second between 21 July and 2 September 2008. The length of interviews ranged from about half an hour to two hours.

Informants were invited to take part in either face-to-face or telephone interviews. An interview protocol was provided to the informant about a week before the scheduled interview.

Owing to scheduling difficulties, not all the stakeholders invited could be interviewed. Some nominated other personnel to be interviewed with them, and some nominated representatives to be interviewed on their behalf. Altogether, 139 individuals were interviewed in consultations comprising 103 individual interviews, 18 group interviews and two written submissions.

We used literature on drug interventions, the program logic models and outcome matrices developed in consultation with DoHA officers and the PWG, and models of care and resource allocation to design interview protocols to guide the collection and analysis of qualitative data. Two sets of interview protocols were constructed: a general protocol with four sections corresponding to each component of the evaluation, and case study protocols with eight separate protocols corresponding to the eight case studies².

Plans for further consultation at annual reflection workshops were omitted on the advice of DoHA officers.

Case studies

The PWG agreed that a series of case studies would offer closer analysis of certain elements of this evaluation. Cases were chosen on the basis of agreed criteria: the studies should illustrate issues such as jurisdictional coverage and representation; sectoral coverage (health, law enforcement and education sectors); substance type (alcohol, tobacco, illicit drugs); program size and influence (local or low-level focus, or investment programs vs national or high-level focus and investment programs); and primary funding sources (Australian Government, Council of Australian Governments (COAG), State or Territory).

The cases approved by the PWG for each component were:

- Component 1:* National Alcohol Strategy: 2006-2009 (NAS)
National School Drug Education Strategy: May 1999 (NSDES)
- Component 2:* Project STOP
Non-Government Organisation Treatment Grant Program (NGOTGP)
Tobacco Legislation
- Component 3:* National Psychostimulants Initiative Expert Reference Group (NPIERG)
Alcohol and other drug workforce issues
- Component 4:* Impacts of an NDS data collection: the case of the Illicit Drug Reporting System (IDRS)/Ecstasy and Related Drugs Reporting System (EDRS)

Data collation and analysis

Information gathered from documentation and literature reviews, stakeholder consultations, and case studies was collated and compared, and in accordance with the terms of reference were assessed for effectiveness, efficiency, future needs, and opportunities for improvements. Emerging findings drawn from this triangulation of data sources were assessed for strength and validity in repeated discussions with DoHA officers, the PWG, stakeholders, the IGCD and supplemented by additional data collections throughout the course of the evaluation.

² The consultation protocols may be found in Appendices D & E.

The context and scope of the evaluation

What is described here is not the whole program of effort under the NDS. There are many associated activities that surround and reflect the NDS, and have important implications for its next phase, but are not covered directly in the four components of the evaluation. Ongoing programs and services in law enforcement, treatment and prevention are the core business of many agencies, not all of whom would be immediately identified in their sector, jurisdiction or locality as implementing the NDS.

The NDS Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003 – 2011 (ATSIPCAP) was not evaluated as part of this project, as it is the subject of a separate evaluation. We highlight the need to link the current report with the evaluation report of the ATSIPCAP to inform the next iteration of the NDS.

Chapter 2: Drugs in Australia: an overview

This chapter gives a brief overview of drug use in Australia - the extent and nature of drug use, harms related to drug use, drug-related crime, and public perceptions about drugs and drug policies. The data presented are derived from the NDS Household Survey (NDSHS) (Australian Institute of Health and Welfare [AIHW] 2008b) unless otherwise indicated. It supplements the statistical indicators detailed in Volume 2, where other indicators (not dealt with in this brief overview chapter) are covered, and in AIHW's 2007 publication, *Statistics on Drug Use in Australia 2006*.

Drug use in Australian society

Current prevalence and trends

The recent use of alcohol, tobacco and illicit drugs, as revealed in self-reported data through the NDSHS, are summarised in the following table. For each drug category it shows the proportion of the population aged 14 years and older who reported recently using that drug for each of the surveys conducted between 1993 and 2007.

Table 2.1: Summary of recent drug use^(a): proportion of the population aged 14 years or older, Australia, 1993 to 2007³

Drug/behaviour	1993	1995	1998	2001	2004	2007
	(per cent)					
Tobacco	29.1	27.2	24.9	23.2	20.7	19.4*
Alcohol	77.9	78.3	80.7	82.4	83.6	82.9
Illicits						
Marijuana/cannabis	12.7	13.1	17.9	12.9	11.3	9.1*
Pain-killers/analgesics ^(b)	1.7	3.5	5.2	3.1	3.1	2.5*
Tranquillisers/sleeping pills ^(b)	0.9	0.6	3.0	1.1	1.0	1.4*
Steroids ^(b)	0.3	0.2	0.2	0.2	-	-
Barbiturates ^(b)	0.4	0.2	0.3	0.2	0.2	0.1
Inhalants	0.6	0.6	0.9	0.4	0.4	0.4
Heroin	0.2	0.4	0.8	0.2	0.2	0.2
Methadone ^(c) or Buprenorphine ^(e)	N/A	N/A	0.2	0.1	0.1	0.1
Other opiates/opioids ^(b)	N/A	N/A	N/A	0.3	0.2	0.2
Meth/amphetamine (speed) ^(b)	2.0	2.1	3.7	3.4	3.2	2.3*
Cocaine	0.5	1.0	1.4	1.3	1.0	1.6*
Hallucinogens	1.3	1.8	3.0	1.1	0.7	0.6
Ecstasy ^(d)	1.2	0.9	2.4	2.9	3.4	3.5
Ketamine	N/A	N/A	N/A	N/A	0.3	0.2
Gamma Hydroxybutyrate (GHB)	N/A	N/A	N/A	N/A	0.1	0.1
Injected drugs	0.5	0.6	0.8	0.6	0.4	0.5
Any illicit	14.0	17.0	22.0	16.9	15.3	13.4*
None of the above	21.0	17.8	14.2	14.7	13.7	14.1

(a) Used in the last 12 months. For tobacco and alcohol, 'recent use' means daily, weekly and less-than-weekly smokers and drinkers respectively.

(b) For non-medical purposes.

(c) Non-maintenance.

(d) This category included substances known as 'designer drugs' before 2004.

(e) This category did not include buprenorphine before 2007.

* Difference between 2004 result and 2007 result is statically significantly (2-tailed $\alpha = 0.05$).

³ Source: AIHW (2008b). *2007 National Drug Strategy Household Survey: first results*, AIHW cat. no. PHE 98, Drug Statistics Series, no. 20. Canberra: AIHW <http://www.aihw.gov.au/publications/index.cfm/title/10579>

The trends in recent (last 12 months) use of selected drugs over the period 1993 to 2007 are shown in the following graphs. Importantly, little change has occurred in the prevalence of alcohol consumption (and it is therefore not graphed), and tobacco consumption has fallen steadily. As the authors of the Survey report have identified:

- Between 1993 (29.1%) and 2007 (19.4%) there was a steady decline in the proportion of persons who had recently smoked tobacco.
- The proportion of the population recently using alcohol increased over the 11 years from 1993 to 2004, from 77.9% to 83.6% but declined slightly in 2007 to 82.9%.
- Recent use of marijuana/cannabis has declined since 1998, with the proportion of recent users in 2007 (9.1%) dropping to the lowest proportion seen since 1993 (AIHW 2008b, 5).

Between the 2004 and 2007 surveys, statistically significant reductions in prevalence of recent use were observed for tobacco, cannabis, painkillers, amphetamines, and ‘any illicit’ drug. Tranquillisers and cocaine were the only drugs demonstrating a statistically significant increase in prevalence of use between those two phases of the Survey. While no marked changes have emerged over the last two decades in the age of initiation of either legal or illegal drugs, the prevalence of use of cocaine and ecstasy have increased.

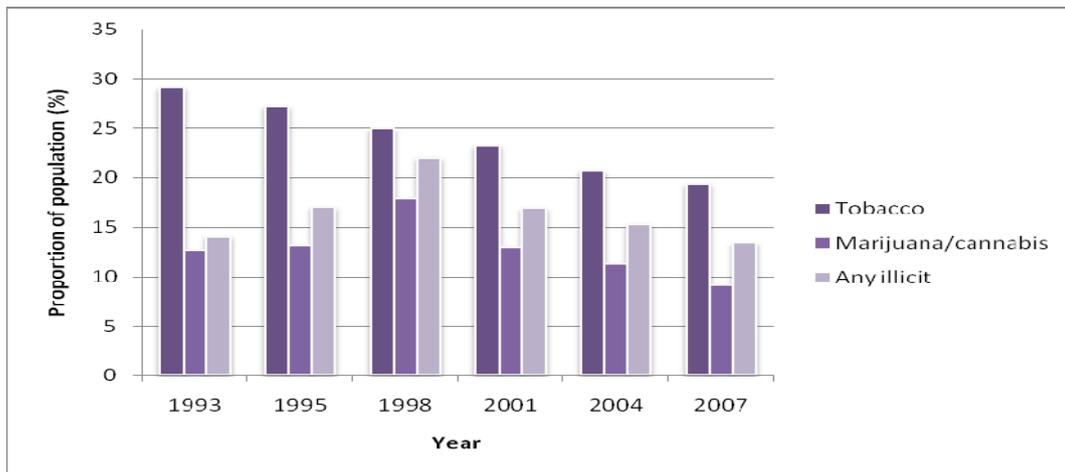


Figure 1. Recent use of tobacco, marijuana/cannabis, and any illicit drugs: proportion of the population aged 14 years or older, Australia 1993 to 2007

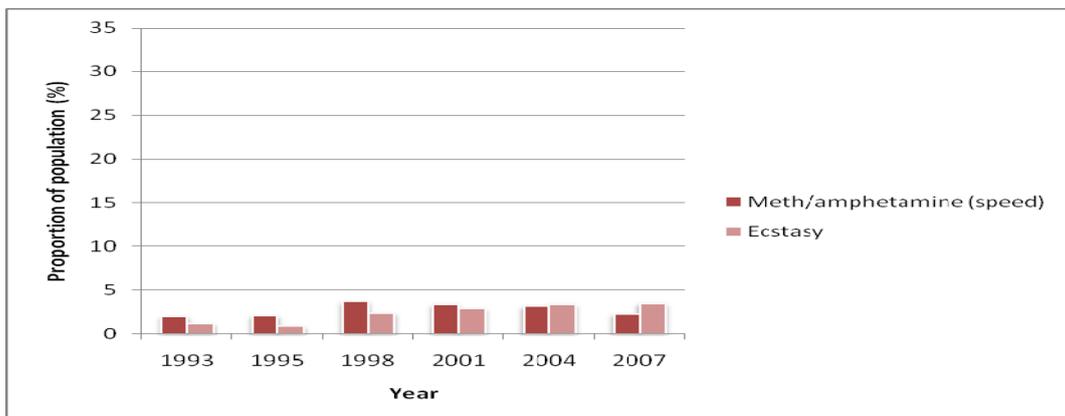


Figure 2. Recent use of Meth/amphetamine and Ecstasy: proportion of the population aged 14 years or older, Australia 1993 to 2007

Illicit drugs

It is important to stress that the vast majority of the Australian population does not use illicit drugs, despite the opposite impression some might gain from media reporting (87% reported no recent use in the 2007 NDSHS). The self-reported recent use of any illicit drug increased in the first decade of the NDS, but has fallen dramatically since 1998, with just 16% of males and 11% of females reporting recent use in 2007 (and most of this was cannabis). Specifically, 13% of the surveyed population reported recent use of an illicit drug, and 9.1% reported cannabis use.

Recent years have seen reductions in the use of most illicit drugs, or at least stable prevalence of use. Only cocaine and tranquillisers show recent increases, and the prevalence of misuse is very low.

In 2007, 87% of the population aged 14 years and above reported that they had not used an illicit drug in the last 12 months, and 62% said they had never used an illicit drug. Nonetheless, illicit drug use is concentrated in young adults, with recent use of any illicit drug over the past 12 months reported by 17% of young people aged 14 to 19 years, 28% of those aged 20 to 29 years, and 17% of those aged 30 to 39 years.

Tobacco

Smoking rates in Australian men were high from the time of colonisation onwards, and among women chiefly since World War II. As the University of Sydney's Tobacco Control Supersite puts it, 'Following the Second World War, nearly three-quarters of the male adult population, and about one-quarter of adult females are smokers'.⁴ Daily smoking has fallen by some 40% since the NDS was instituted in 1985.

In 2007, 18% of males aged 14 years and above reporting daily tobacco use, and 15% of females reported doing the same. Among young people aged 14 to 19 years, the prevalence among females (8.7%) exceeds that of males (6.0%). This pattern is reversed among people aged 20 years and above, among whom the smoking prevalence of males exceeds that of females.

However, socio-economic gradient persists in smoking rates: Indigenous Australians have highly elevated levels of use compared with non-Indigenous people (AIHW 2008e).

Alcohol

Alcohol consumption increased from the end of World War II to reach around 10 litres *per capita* of pure alcohol in the early 1980s, and has fallen since then to around 7 litres *per capita* in 2002-03. The proportion of people who drink daily (in the range 8% to 9%) has been stable for over a decade.

Some 83% of the population aged 14 years or above reported in 2007 that they had consumed alcohol at some stage over the previous 12 months. 8.1% reported that they were daily drinkers, a statistically significant reduction from 8.9% at the previous (2004) survey. The 2007 prevalence (8.1%) is 21% lower than the prevalence in 1991 (10.2%).

Many Australians drink in a manner which places them at risk of harm either in the long term or the short term, according to the National Health and Medical Research Council (NHMRC) guidelines (NHMRC 2001). AIHW reports that 10.3% of Australians aged 14 years or above consumed alcohol in 2007 in a manner considered risky or high risk to their health in the long term. Moreover, 7.8% were drinking at risky or high risk levels for harm in the short term at least once a week, with another 12.6% drinking at risky or high risk levels for harm in the short term at least once a month (but not as often as once a week) and a further 14.2% drinking in this manner once or more a year, but not monthly.

⁴ <http://tobacco.health.usyd.edu.au/site/supersite/resources/pdfs/TLbefore1950s.pdf>

Trends in treatment modalities

Although a number of different data sets exist covering drug treatment, there is no single data set that aggregates them and produces reliable trend data on all the drug treatment services provided by all agencies and all treatment modalities. Nevertheless, some useful information comes from the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS). This data set covers publicly funded agencies (government and non-government) from all States and Territories that provide specialist alcohol and other drugs (AOD) services. It excludes agencies whose sole activity is prescribing or dispensing opioid pharmacotherapy treatment, those whose main function is accommodation (including sobering-up shelters), or health promotion (eg needle and syringe programs, prison AOD services, Commonwealth funded Aboriginal and Torres Strait Islander AOD services, and people being treated in acute care or psychiatric hospitals).

The following table shows the number of agencies contributing to the data set and the total number of treatment episodes annually from 2001-02 to 2005-06.

Table 2.2: AOD treatment services and episodes of treatment, 2001-02 to 2005-06⁵

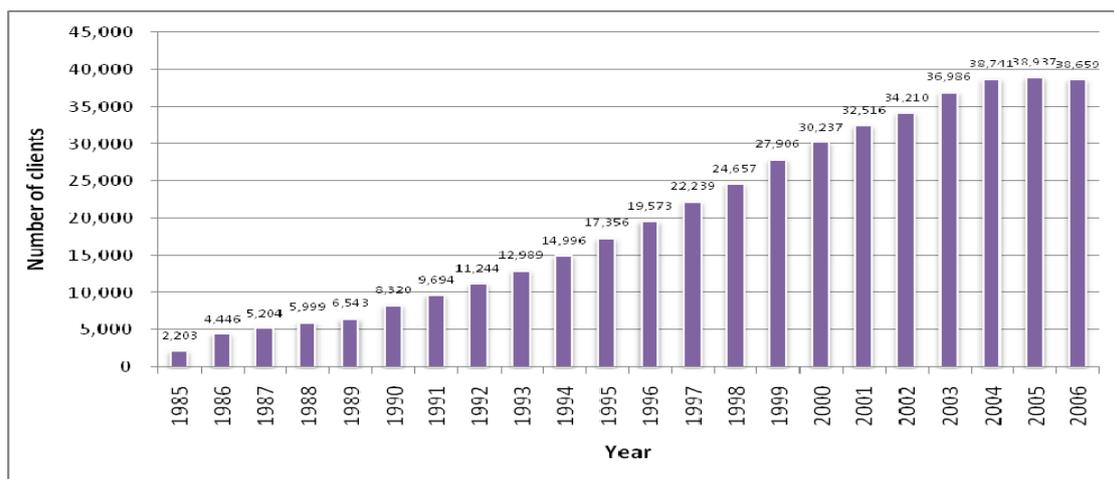
Year	Number of agencies	Number of treatment episodes
2001-02	505	120,869
2002-03	587	130,930
2003-04	622	136,869
2004-05	635	142,144
2005-06	664	151,362

AIHW cautions that care must be taken in comparing NMDS data across collection years, so we emphasise that these figures cover the number of agencies contributing each year and the number of closed treatment episodes reported. The number of agencies reporting has risen by 31% over these four years, and the number treatment episodes reported annually has risen by 25% in the same period.

Opioid substitution therapies

Over the life of the NCADA/NDS, a dramatic increase has occurred in the number of people receiving opioid substitution therapy, predominantly methadone and buprenorphine and related support services. The rise reflects both increasing numbers of users of illicit opioids, especially in the 1990s (Hall *et al* 2000), and increases in the number of treatment places being created.

Figure 3. Clients of methadone and buprenorphine programs, Australia (30 June)⁶



⁵ Source: AIHW: *Interactive alcohol and other drug treatment services data*, 2001-02, 2002-03, 2003-04, 2004-05

⁶ Sources: Consultants' data collections, and AIHW's (2008d) *National Opioid Pharmacotherapy Statistics Annual Data Collection*

International comparisons

International comparisons of drug use are problematic owing to the diversity of methods used in various nations to measure the extent and nature of psychoactive drug use. Nevertheless, the authoritative Organisation for Economic Cooperation and Development (OECD) Health Data collection provides useful comparative data on the prevalence of tobacco consumption (cited in AIHW 2007b, 10-11). It lists the prevalence in 2005 of daily smoking in the population aged 15 years and above for 20 OECD nations. Australia is shown as having a prevalence of just 17.7%. Only three nations have rates lower than this - the United States of America (USA) (17.0%), Sweden (16.2%) and Canada (15.0%).

Data from the Commission for Distilled Spirits, cited by AIHW, shows alcohol consumption for selected countries in the year 2003 (AIHW 2007b, 17-20). Australia is ranked 22nd in the list of the top 45 countries based on *per capita* consumption of total pure alcohol, at 7.2 litres. Luxembourg has the highest level of consumption at 12.6 litres. The Australian level is similar to that of Canada (7.0 litres), New Zealand (NZ) and the USA (both 6.8 litres) and is somewhat lower than that of the United Kingdom (UK) (9.6 litres).

International comparisons of the use of illicit drugs are particularly problematic. Very few nations of the world have such high quality consistent data sets covering illicit drug consumption as does Australia. The published Australian figures are based on sound survey methodology, in contrast to the published data relating to many other countries that are often based on inferior information sources. Nonetheless, since the United Nations Office on Drugs and Crime (UNODC) publishes international comparisons annually, and that they receive considerable media attention, it is worth presenting them here.

Table 2.3: Annual prevalence of illicit drug use as a percentage of the population aged 15-64 years, selected countries, various years⁷

Nation	Ecstasy	Amphetamines	Cannabis	Cocaine	Opiates
Australia	4.4	2.9	11.4	2.0	0.5
NZ	2.6	2.3	13.3	0.8	0.4
England & Wales	1.8	1.3	8.2	2.6	0.9*
USA	1.0	1.6	12.2	3.0	0.6
Canada	1.3	1.0	17.0	2.3	0.3

* United Kingdom

This source – the *World Drug Report* – indicates that Australia has the highest prevalence of use of ‘ecstasy’ of any nation, far higher than most other nations. Our rate is also high in the case of amphetamines: El Salvador (3.0%) is the only nation reporting a higher prevalence of use. While the Australian figure for cannabis exceeds that of many other nations, the prevalence of use is less than some other English-speaking western nations including NZ, the USA and Canada. The reported prevalence of cocaine use is far lower than that in the USA and also lower than that reported for Canada and England and Wales. Similarly, Australia’s reported prevalence rate for opioids is lower than that of the UK and the USA.

While these data are of interest, readers are cautioned not to extrapolate too far from these figures owing to the challenges inherent in making comparisons where the data are derived using different sampling methods, measurement instruments, and time periods.

⁷ Source: United Nations Office on Drugs and Crime (2008). *World Drug Report 2008*. Vienna: UNODC, 273-80

The social costs of drugs to the Australian community

The Commonwealth Department of Health and Ageing commissioned research to estimate the social cost of tobacco, alcohol and illicit drug abuse to the Australian community (Collins & Lapsley 2008). Estimates have been published covering the 2004-05 year, the most recent for which all necessary data are available.

This study found that the total social cost of tobacco, alcohol and illicit drug abuse in this country in 2004-05 was \$55.2 billion, with tobacco accounting for \$31.5 billion (56%), alcohol \$15.3 billion (27%) and illicit drugs \$8.2 billion (15%). The adverse health consequences of the interactions between alcohol and illicit drugs accounted for a further \$1.1 billion (2%).

The tangible costs in the areas of crime, health, lost production in the workplace, lost production in the home, road crashes and fires are summarised in the following table.

Table 2.4. Selected tangible drug abuse costs in 2004-05⁸

	Alcohol (\$m)	Tobacco (\$m)	Illicit drugs (\$m)	Alcohol and illicit drugs combined (\$m)
Crime	1,611.5		3,840.5	1,261.0
Health (net)	1,976.7	318.4	201.7	
Production in the workplace	3,578.6	5,749.1	1,622.9	
Production in the home	1,571.3	9,843.1	495.5	
Road accidents	2,202.0		527.6	
Fires		136.4		

This table reveals the heavy costs burden to the society of alcohol, tobacco and illicit drug abuse in reduced production in the workplace. Heavy tangible costs in the area of crime are linked to illicit drug abuse; very high levels of lost production in the home are linked to the abuse of tobacco; and high costs of road crashes are linked to the abuse of alcohol. It is also clear from this research that the ‘real social costs of illicit drug abuse’ are estimated to have risen between 1998/99 and 2004/05 by 11.3% (consisting of an 11.8% increase intangible costs and an 8.7% increase in intangible costs)’ (Collins & Lapsley 2008, xiii).

Drug related morbidity and mortality

While there are many categories of harm caused by drugs, morbidity and mortality are of particular concern both to those engaged in policy activity and the public at large. Researchers have estimated the burden of drug-related disease and injury in Australia, along with other risk factors, using the common metric, disability-adjusted life years (DALYs) (Vos *et al* 2007).

Using 2003 data it was shown that tobacco, alcohol and illegal drugs combined comprised 12.1% of the total Australian burden of injury and disease in that year. Tobacco was most prominent, the cause of 7.8% of the total burden, followed by alcohol which accounted for 2.3% in net terms (after allowing for the assumed protective effects of alcohol on some classes of disease), and illicit drugs which caused 2% of the total burden.

Considering the burden of disease attributed to psychoactive drugs alone, tobacco accounted for 65%, alcohol 19% and illicit drugs 16%.

⁸ Collins DJ & Lapsley HM (2008). *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05*. Monograph Series no. 64. Canberra: CoA, xii (but see also the figures on p.49 for ‘tangible costs not elsewhere included’). <http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/mono64>

Victims and perpetrators of drug-related harms

While it is clear that the use of some psychoactive drugs produces benefits both for the user and for society more broadly – the responsible use of alcohol is an example – it is widely understood that, in net terms, drugs cause significant harm to Australian society. These harms are borne by diverse sectors of the community, including drug users, families, neighbours, workplaces, and the broader public (MacCoun & Reuter 2001).

Victims of drug-related harm

Population level data are available on the victims of drug-related harms. In the 2007 NDSHS, 25% of respondents said they had been the victims of alcohol-related verbal abuse, 13% were put in fear by a person under the influence of alcohol, and 4.5% experienced physical abuse linked to alcohol use. For other drugs, 11% reported being the victims of verbal abuse, 8% were put in fear and 2% were the victims of physical abuse. Overall, 5% of Australians reported being the victims of drug-related physical abuse in the previous year and, of these, 39% reported that they experienced bruising or abrasions, 10% reported minor lacerations and 4% suffered injuries serious enough to require hospital admission.

Perpetrators of drug-related harm

While a household survey is not an ideal tool for assessing the extent and nature of criminal behaviour, the NDSHS does provide some useful information about the perpetrators of drug-related harm. It records that, in 2007, 12% of respondents said they had driven a motor vehicle while under the influence of alcohol in the previous 12 months; this included 16% of the male and 8% of the female respondents. Six per cent said they had verbally abused someone while under the influence of alcohol, and 5% went swimming while under the influence of alcohol. Four per cent stated that they had gone to work while under the influence of alcohol in the previous 12 months.

In the case of illicit drugs, 3% of respondents said they had driven a motor vehicle under the influence of drugs in the year before the Survey, 1.5% reported that they went swimming, and 1.6% reported that they went to work under the influence of illegal drugs.

These figures show that small but significant numbers of people place themselves and others at risk owing to their use of alcohol and other drugs. To these figures can be added those cigarette smokers who are responsible for emitting environmental tobacco smoke, and the serious health and financial cost to the community it causes (Chapman 2007; Collins & Lapsley 2008).

Drug-related crime

The relationships among drugs, drug use, drug markets and crime are complex and not well understood. As one authority puts it, three basic explanatory models exist for the relationship between drug use and crime: '(1) substance use leads to crime, (2) crime leads to substance use, and (3) the relationship is either coincidental or explained by a set of common causes... Each model may apply to different subgroups of the population of substance-using criminals or to different incidents of alcohol/drug-related crime' (White & Gorman 2000, 170). There is no consensus on the relative strengths and weaknesses of these explanatory models. It seems, however, that each is useful in understanding particular situations.

Data on the number of people arrested for drug offences, or issued with drug offence infringement penalty notices of various kinds, have been collated and published since 2003 by the Australian Crime Commission (ACC), and before the ACC, the Australian Bureau of Criminal Intelligence (ABCI). They show that the number of apprehensions has risen by 6% over six years, from 78,006 in 2000-01 to 82,397 in 2006-07. The proportion classified as 'consumers' rather than 'providers' has been stable in recent years (82% in 2000-01 and 81% in 2006-07).

The proportion of the total that involved cannabis has also been stable (69% of the total in both the 2000-01 and 2006-07 years), as has the proportion of the total classified as cannabis consumers (60% of all drug apprehensions in 2000-01 and 59% in 2006-07).

Illicit drug use among arrestees

Illicit drug use is common among persons arrested by police, as evidenced by the self-report data and the confirmatory urinalysis captured in the Drug Use Monitoring Australia (DUMA), the strategic early warning system managed by the Australian Institute of Criminology (AIC) (Adams *et al* 2008). The most recent report, which covers 2007, reveals that cannabis is the illegal drug most often used by arrestees, as in the general population. Unpublished data received from the AIC cover the self-reported previous 30 days prevalence of use of various drugs among arrestees. With cannabis, it was 45% in the year to 30 September 2008, considerably higher than in the general population, where just 9% of persons aged 14 years and over reported use in the previous 12 months.

Amphetamine/methamphetamine use is also highly prevalent in this population (23%) compared with 12 months prevalence of just 2.3% in the general population. Heroin use in the previous month was reported by 11% compared with a 12 month prevalence of 0.2% in the general population. The use of all the other drug groups was also highly elevated.

Comparing these most recent data with those collected in 2004 reveals that trends in self-reported illicit drug use among the arrestee population largely parallel those in the general community. Last 30 days cannabis use has fallen from 60% to 45%, amphetamine/methamphetamine use from 37% to 23% and heroin use from 14% to 11%. 'Ecstasy' use has remained stable at 9%. While tranquilliser/sleeping pill use rose in the general population over this period benzodiazepine use fell among arrestees from 9% to 6%.

Illicit drug consumer and provider arrests

The Australian Federal Police (AFP), along with the eight State and Territory Police Services, report each year on the numbers and characteristics of people arrested for drug-related offences. In the case of cannabis, these figures include both people arrested and charged with a criminal drug offence, and those given some form of expiation notice in the Australian Capital Territory (ACT), South Australia (SA), Western Australia (WA) and the Northern Territory (NT).

The ACC, which collates, analyses and presents these data in its annual *Illicit Drug Data Report* (IDDR) (ACC 2008), shows that in the 2006-07 year (the most recent for which data have been published) there were 82,372 arrests of illicit drug consumers and providers across the country. Of these, 81% were identified as consumers and 19% as providers. (Consumers are defined as people charged with user-type offences such as illicit drug possession or self-administration. Providers are people charged with supply-type offences such as importation, trafficking, selling, cultivation and manufacture of illicit drugs.) Consumers composed 85% of the 56,859 cannabis arrests, 72% of the 15,216 amphetamine-type stimulants (ATS) arrests, 65% of the 2,161 heroin and other opioids arrests, and 55% of the 695 cocaine arrests.

Community attitudes towards drug policies

Drug availability, and sources of supply

In the NDSHS, people are asked whether they had been offered or had the opportunity to use drugs in the preceding 12 months. AIHW's report on the 2007 survey provides 2004-2007 trend data on the perceived availability of alcohol, tobacco and illicit drugs in the general community. (Note that AIHW has published these data without an assessment of the statistical significance of the reported differences in prevalence between the two surveys.)

Between 2004 and 2007, the perceived availability of most illegal drugs fell: analgesics used for non-medical purposes (-63%), ketamine (-38%), GHB (-33%), methamphetamine (-28%), LSD/synthetic hallucinogens (-23%), cannabis (-17%), naturally-occurring hallucinogens (-14%), tranquillisers/sleeping pills used for non-medical purposes (-12%) and kava (-10%).

Over the same period, the reported availability of steroids used for non-medical purposes rose by 62%, barbiturates for non-medical purposes +38%, cocaine +26%, inhalants +7% and ecstasy +4%. The perceived availability of heroin was the same in 2004 and 2007.

This means that reduced availability was reported for two of the drugs of most concern owing to their harm potential at individual and population levels, cannabis and methamphetamine, with increases reported in two other particularly important drugs, cocaine and 'ecstasy'.

Survey information is available on consumers' sources of supply of illegal drugs. Cannabis is most often obtained from friends and acquaintances (68%) rather than from dealers (19.5%). A similar pattern holds for amphetamines (66% having obtained the drug from friends or acquaintances) and 'ecstasy' (72%). Heroin, by contrast, is most often obtained from dealers (64%) rather than friends acquaintances (29%). Analgesics use for non-medical purposes and inhalants were most often purchased at shops (53% and 41% respectively).

Penalties for the sale or supply of illicit drugs, and the legalisation issue

The Australian community strongly supports increased penalties for the sale or supply of illicit drugs. In 2007, between 82% and 85% of the sample population expressed this view with respect to 'ecstasy', cocaine, meth/amphetamine and heroin. Although support for increased penalties for the sale or supply of cannabis is lower than for the other illicit drugs listed, the proportion supporting increased penalties for this drug category rose from 58% in 2004 to 63% in 2007.

Little support exists in the Australian community at large for legalising illicit drugs. Support for legalisation of cannabis fell from 27% in 2004 to 21% three years later. Only a very small proportion of survey respondents - between 4% and 6% - support legalisation of heroin, methamphetamine, cocaine and ecstasy.

Tobacco policies

Generally speaking, the Australian community supports evidence-based approaches to reducing the problems associated with the use of drugs, both licit and illicit. Over two thirds of the population support increased tobacco control initiatives, and there have been statistically significant increases in support between 2004 and 2007 in the following policy areas:

- Banning smoking in pubs and clubs
- Increasing tax on tobacco products to pay for health education and treatment costs, and to discourage smoking
- Making it harder to buy tobacco in shops
- Bans on point-of-sale advertising and display of tobacco products
- Implementing a licensing scheme for tobacco retailers

The level of support for other initiatives has not changed over the last three years in other areas that have particularly high levels of support, including:

- Banning smoking in the workplace (82% support)
- Stricter enforcement of laws against supplying tobacco products to minors (90%)
- Stricter penalties for sale or supply of tobacco products to minors (88%)

Alcohol policies

Support for evidence-based policies in regard to alcohol has also risen between 2004 and 2007, although the absolute level of support for these initiatives is generally lower than in the case of tobacco control policies. Over the 2004-2007 period, support for alcohol control initiative increased significantly in the following areas:

- Increasing the price of alcohol
- Reducing the number of outlets that sell alcohol
- Reducing trading hours for pubs and clubs
- Raising the legal drinking age
- Banning alcohol sponsorship of sporting events
- Restricting late-night trading of alcohol
- Strict monitoring of late-night licence premises
- Increasing tax on alcohol to pay for health, education and treatment of alcohol-related problems

Over 80% of the population support more severe penalties for drink driving and stricter laws against serving intoxicated customers.

Illicit drug policies

More than two thirds of the population (69%) support legislating to permit the use of cannabis for medical purposes, and 74% of the population supports conducting a clinical trial for people to use cannabis to treat medical conditions.

Similarly, support for evidence-based initiatives in dealing with heroin remains high and has increased significantly between 2004 and 2007 with respect to the following initiatives:

- Needle and syringe programs (67% support in 2007)
- Methadone maintenance programs (68%)
- Treatment with drugs other than methadone (68%)
- Regulated injecting rooms (50%)
- A trial of prescribed heroin (33%).

High levels of support also exist for rapid detoxification therapy (79%) and the use of Naltrexone (75%).

'Drug problems' and acceptability

Since almost everyone in Australia uses some form of psychoactive drug, it is no surprise that the community at large is ready to express views about drugs in Australian society, and about drug policy. However, community perceptions of what is meant by 'drugs' and what constitutes a 'drug problem' differ considerably.

When people are asked what first comes to mind as a 'drug problem', heroin is the most often mentioned, although the proportion who nominated this drug has fallen from 39% to 30% between 2004 and 2007. Next most frequently nominated is cannabis, which showed a similar reduction from 29% of people naming it as a 'drug problem' in 2004 to 25% in 2007. In both years only 10% nominated alcohol, and just 2.6% nominated tobacco in 2007 compared with 3.3% in 2004. By contrast, public perception that methamphetamine constitutes a 'drug problem' tripled between 2004 and 2007, from 5.5% to 16.4%.

Community attitudes about the acceptability or otherwise of psychoactive drug use are also informative. Although there are some difficulties in comparing 2004 with 2007 NDSHS data on this variable, there appear to have been substantial falls in the proportion of the sample population

approving of the use of tobacco (down 64%), alcohol (down 45%), and cannabis (down 72%). Falls in approval were also observed for tranquillisers, steroids, methamphetamine, cocaine, hallucinogens and 'ecstasy'. By contrast, approval of the use of painkillers rose from 8.0% in 2004 to 10.4% in 2007. The reason for this is unclear; it may be an artefact of the survey methodology.

Balancing expenditures on drug education, treatment and law enforcement

The community has quite sophisticated perceptions about the allocation of financial resources to different areas of drug policy. In the NDSHS they are asked how they would distribute \$100 on education, law enforcement and treatment for alcohol, tobacco and illicit drugs generally. In the case of alcohol, the preferred distribution of funds favoured education (\$40 out of the nominal \$100) above treatment (\$31) and law enforcement (\$29). The pattern was broadly similar with tobacco, with education attracting \$44, treatment \$31 and law enforcement \$25. In contrast, the community would like to see a higher proportion of funds expended on law enforcement in the case of illicit drug use (\$40 out of the nominal \$100, above education \$34, and treatment \$26).

These preferences can be compared with estimates of actual government expenditure in implementing drug policies. While not all expenditures have been identified, it has been estimated that 60% of expenditures by Australian governments in 2004-05 addressed crime, 37% health and 3% other sectors (Collins & Lapsley 2008).

Conclusion

This snapshot of drugs in Australia highlights the generally excellent position that Australia is in with regard to its drug information systems. The fact that we are able to provide this snapshot from published information sources highlights the breadth and depth of Australia's data collections. As discussed elsewhere in this report, the information resources that we have available form the basis of a sound system for monitoring the progress of the NDS and for contributing to evaluation, particularly if they were managed through a national drug information strategy and system.

Chapter 3: Context of the National Drug Strategy

History and policy context

Before European colonisation of Australia, Aboriginal peoples had only limited contact with psychoactive substances. In parts of Australia, plant-based stimulants and depressants were used. Alcohol and tobacco were introduced into Arnhem Land by Makassan *trepang* traders (Watson 1983; Latz 1995; Gracey 1998; Brady 2008). After British colonisation and throughout the colonial era, alcohol and tobacco were widely consumed. The colonies had particularly high levels of consumption of the alcohol-opium mixture laudanum.

Commonwealth involvement with drugs after 1901 began with its taxation powers, and expanded into control of pharmaceutical products, particularly through laws to limit the use of cocaine and opioids to medicinal purposes. In 1953, Commonwealth legislation prohibited the possession, use and trafficking of heroin, though there were no significant problems linked to the drug at that time. In the 1960s, American servicemen on leave introduced the recreational use of heroin to Australia, which catalysed corruption of political and law enforcement systems associated with trafficking in heroin and other illicit drugs (Manderson 1993; McCoy 1978). During the same decade, the use of cannabis started to become common among young people (Manderson 1993).

The *per capita* consumption of alcohol was high during the first 200 years of European settlement, with dips during the World Wars and the Great Depression. Both alcohol and tobacco consumption continued to rise until the 1980s, when the trend reversed.

Australia is a party to all the United Nations (UN) drug treaties. In 1964, the 1961 UN Single Convention on Narcotic Drugs came into force in Australia, and its 1972 amendment came into force in 1975. As part of its obligations under these treaties, Australia supplies data to the UN International Narcotics Control Board (INCB) and the UNODC covering the need for and use of psychoactive pharmaceutical products, as well as data on drugs and drug use more generally. Australia became a party to the 1971 Convention on Psychotropic Substances, which came into force in this country in 1982.

In 1977, a Commonwealth Parliamentary inquiry chaired by then Senator Dr Peter Baume argued for far greater attention to the licit drugs alcohol, tobacco, and pharmaceutical products to counter the media and political emphasis on illicit drugs. In the same decade, the Commonwealth, States and Territories were developing responses to the Williams Royal Commission, which was itself a response to the post-Vietnam War rise in illicit drug availability and the associated corruption of law enforcement officials.

In 1984, the then Prime Minister, Bob Hawke, decided to establish a national response to drugs. The Minister for Health, Dr Neil Blewett, asked the Alcohol and other Drugs Council of Australia (ADCA, then known as the Alcohol and Drug Foundation Australia (ADFA)) to bring together key stakeholders and develop consensus-based proposals for a strategy. The resulting February 1985 *Drugs in Australia: National Action Workshop* formulated the 'harm minimisation' policy that has been at the core of Australia's national drug strategy ever since. The workshop report concluded that 'While there are still the traditional polarised views on the use of drugs, there is now increasingly a common ground within the Australian community on appropriate action on the abuse of drugs' (Brown *et al* 1986, 182). It went on to recommend that:

The objective of a national policy on drug use should be to minimise the harmful consequences of the use of drugs to individuals, their families, and the community as a whole including the needs of special groups. Therefore a national, comprehensive approach will be needed (196).

Dr Blewett's leadership was instrumental in having the Workshop's proposals adopted in 1985 by the Special Premiers' Conference on Drugs, which formally established the NCADA.

The NCADA's focus was on all drugs, and on inter-sectoral partnerships between health and law enforcement, between governments and the NGO sector, and between the Commonwealth and the States and Territories. It featured cost-shared funding of agreed-on initiatives, and endorsed the prescribing of methadone for the treatment of opioid dependence.

The NCADA was operated under the leadership of the MCDS, which had been in existence for some years before the launch of the NCADA, and a senior officers' group, the Standing Committee of Officials (SCO) of MCDS. The membership of the MCDS and SCO was drawn from the drug law enforcement and health sectors.

In the early years of the NCADA, there was a disjunction between drugs policy and the Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) policy. These policies were managed in different parts of the Commonwealth Department of Health: reducing the extent and impacts of substance abuse was the thrust of the NCADA, while preventing the development of an HIV/AIDS epidemic among people who inject illegal drugs was a key goal in communicable diseases. Dr Blewett's leadership, as Commonwealth Minister for Health, was instrumental in maintaining progress in both areas simultaneously.

Australia's contributions to drug advice and policy

Australia has long played a key advisory role in international meetings on drug issues. It is an active contributor to meetings of the UN Commission on Narcotic Drugs and the World Health Congress. Australian experts and NGO representatives contribute actively to the International Drug Policy Consortium (IDPC), and Australia has hosted and participated in major international drug forums such as the International Symposium on Global Drug Policy and the International Conferences on the Reduction of Drug Related Harm.

In the face of considerable opposition from various sectors of the community, the Commonwealth supported adoption of the 1988 *UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, which came into force in Australia in 1993. At the same time, Australia made a significant contribution to development of the 1988 *UN Comprehensive Multidisciplinary Outline of Future Activities relevant to the Problems of Drug Abuse and Illicit Trafficking* (the CMO) which was developed in association with the 1988 trafficking convention. This was the first time that the UN drug bodies had seriously addressed demand reduction in addition to supply control, and the need to address licit as well as illicit drugs. The core policies of what had by then become known as 'the Australian approach' to drug policy was reflected, in part, in the CMO.

Australia has earned a high international reputation for its progressive, balanced and comprehensive approach to dealing with the problems posed by the use and misuse of drugs in the community. Australia has made and continues to make significant contributions in law enforcement, treatment, and harm reduction, particularly in the Asia-Pacific region. Its international role is widely acknowledged in local and regional forums.

Australia has also made significant contributions to global multilateral forums, illustrated by our central role in development of the World Health Organization (WHO) Framework on Tobacco Control and in deliberations in the Commission on Narcotic Drugs. A review of international drug reports shows clearly that Australia has contributed substantially to efforts to control the supply of illicit drugs regionally and internationally, and has developed contacts with key international bodies (such as WHO and the UNODC). To maximise the effect and return on investment of the NDS, Australia needs to maintain and enhance its role in, and contributions to, drug issues both regionally and globally, and build partnerships with agencies that have regional and international presence (such as AusAID). New opportunities exist to address the harmful use of alcohol internationally through the planned development, by the WHO, of a global strategy on alcohol, as requested by the May 2008 World Health Assembly.

Trends during the currency of NCADA / NDS

Trends in drug use over the two decades of the NCADA and NDS may be summarised as follows:

- *Per capita* alcohol and tobacco consumption has fallen, although community concern about alcohol use by young people has risen in the past several years
- Illicit opioid consumption has been largely steady, except for the few years from 2001 known as the ‘heroin drought’ (overdose deaths rose sharply through the early 1990s before dropping abruptly in 2001 and remaining at a lower level since then).
- The emergence and rapid uptake of new illicit drugs, especially ‘ecstasy’ and methamphetamine
- The shift in patterns of use of some illicit drugs, especially stimulants, from less potent oral forms of amphetamine to higher potency injectable forms of methamphetamine
- An increase in the use of cannabis during the mid to late 1990s and increased professional and community understanding of its adverse consequences that became apparent in the late 1990s and early 2000s

Other drug policy initiatives have also occurred over the past two decades:

- Many NDS sub-strategies were developed and published, and some of them have been through more than one phase
- 1980s onwards: Australia pulled far above its weight in drug abuse research, particularly regarding drug abuse epidemiology and treatment, and in producing the global evidence base for tobacco control initiatives
- In 1997 the Howard Government promulgated its ‘Tough on Drugs’ Strategy, a ‘zero tolerance’ policy that operated in parallel with the NDS with its harm minimisation underpinnings
- Cautious acceptance of people who use illicit drugs in policy and service delivery forums
- The 1997 High Court decision prohibiting the States and Territories from levying fees on alcohol and tobacco wholesale sales and the resulting loss of wholesale alcohol sales data and the establishment of the Alcohol Education and Rehabilitation Foundation (AERF) in 2001
- The establishment of the Australian National Council on Drugs (ANCD) in 1998 as the Prime Minister’s advisory body on drugs
- Development and implementation, on a state-by-state basis, of COAG’s Illicit Drug Diversion Initiative (IDDI), which was adopted in 1999
- The rise and eventual acceptance of the Families movement, and its impacts on drugs policy and service delivery
- The mid-to late-1990s epidemic of opioid overdose fatalities, which ended in December 2000 with the advent of the ‘heroin drought’
- The 2003 World Health Organisation (WHO) Framework Convention on Tobacco Control: Australia played a prominent role in its development, and was an early signatory
- A shift in the composition of the AOD workforce, from early domination by the medical and psychology professions, to the current situation where nurses and counsellors with limited training form the bulk of the workforce (with the obvious exception of medical and surgical treatment for the effects of smoking)
- A huge expansion in NGO abstinence-oriented treatment services by the Howard Government, including the direct funding of NGOs by the Commonwealth

- An increased focus on evidence-informed patterns of drug law enforcement, in contrast to traditional patterns of policing
- Establishment of ANCD's National Indigenous Drug and Alcohol Committee (NIDAC) in 2004
- Widespread professional, political and community acceptance of harm reduction initiatives, along with supply and demand reduction, and the recent disquiet (exacerbated by Commonwealth Parliamentary inquiries that reported in 2003 and 2007) about the terms 'harm minimisation' and 'harm reduction'.
- Increasing acceptance of the importance of the social determinants of health and well-being, though very limited policy responses to it have yet been seen in the substance abuse field

The National Drug Strategy: 2004-2009

The 2004-2009 phase of the NDS continues to feature the principle of harm minimisation and promote a comprehensive, partnership and balanced approach to drug policy. These characteristics are widely recognised as playing a critical role in the success of Australia's drug policy. Australia's National Drug Strategy is also notable for its emphasis on cross-sectoral partnerships among health, law enforcement and education sectors in policy development and implementation.

The principle of harm minimisation has underpinned Australia's national drug strategies since 1985. It involves taking a wide range of approaches to prevent and reduce drug-related harm encompassing supply reduction, demand reduction (including abstinence-oriented programs), and harm reduction strategies.

Objectives

The current NDS has 12 objectives:

1. Prevent the uptake of harmful drug use
2. Reduce the supply of and use of illicit drugs in the community
3. Reduce the risk to the community of criminal drug offences and other drug related crime, violence and anti-social behaviour
4. Reduce risk behaviours associated with drug use
5. Reduce drug-related harm for individuals, families and communities
6. Reduce the personal and social disruption, loss of life and poor quality of life, loss of productivity and other economic costs associated with harmful drug use
7. Increase access to a greater range of high-quality prevention and treatment services
8. Increase community understanding of drug-related harm
9. Promote evidence informed practice through research, monitoring drug-use trends, and developing workforce organisation and systems
10. Strengthening existing partnerships and build new partnerships to reduce drug-related harm
11. Develop and strengthen links with other related strategies
12. Develop mechanisms for the cooperative development, transfer and use of research among interested parties

Priority areas

In addition, the NDS identifies eight priority areas with recommended responses for each priority. These priority areas are:

- prevention
- reduction of supply
- reduction of drug use and related harms
- improved access to quality treatment
- development of the workforce, organisations and systems
- strengthened partnerships
- implementation of the National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009
- identification and response to emerging trends

Sub-strategies

A number of sub-strategies have been developed under the NDS. They include:

- National Tobacco Strategy 2004-2009
- National Alcohol Strategy 2006-2009
- National Cannabis Strategy 2006-2009
- NDS Aboriginal and Torres Strait Islander People's Complementary Action Plan 2003-2009
- National School Drug Education Strategy (May 1999)
- National Strategy to Prevent the Diversion of Precursor Chemicals into Illicit Drug Manufacture
- National Amphetamine Type Stimulant Strategy 2008-2011
- National Corrections Drug Strategy 2006-2009

Activities, programs and projects

The national program initiatives of the NDS aim to improve the performance of the wider system by building capacity in the health, education and law enforcement sectors to better address drug-related harm. This includes interventions and programs that address the determinants of drug-related harm (eg laws, regulations, policies, prevention strategies and treatment services).

The following national initiatives were designated by the Project Working Group and the Department of Health and Ageing as within the scope of this evaluation on the basis that they are directly funded under the NDS framework, by way of the CSFM or alternate funding sources, or explicitly implemented under the NDS framework but not associated with funding, including new legislation and new international relationships:

- National Cannabis Prevention and Information Centre (NCPIC)
- National Comorbidity Initiative (NCI)
- National Drug Research Centres of Excellence (NDRCE) - National Drug and Alcohol Research Centre (NDARC), National Drug Research Institute (NDRI), National Centre Education and Training on Addiction (NCETA)
- National Drug Law Enforcement Research Fund (NDLERF)
- MCDS Cost Shared Funding Model (CSFM)
- National Drugs Campaign – Alcohol
- National Drugs Campaign – Tobacco

- National Drugs Campaign - Illicit (Phase Two)
- Community Partnerships Initiative (CPI)
- Non-Government Organisation Treatment Grants Program (NGOTGP)
- National Illicit Drug Diversion Initiative (IDDI)
- Amphetamine-type Stimulants Grants Program (ATSGP)

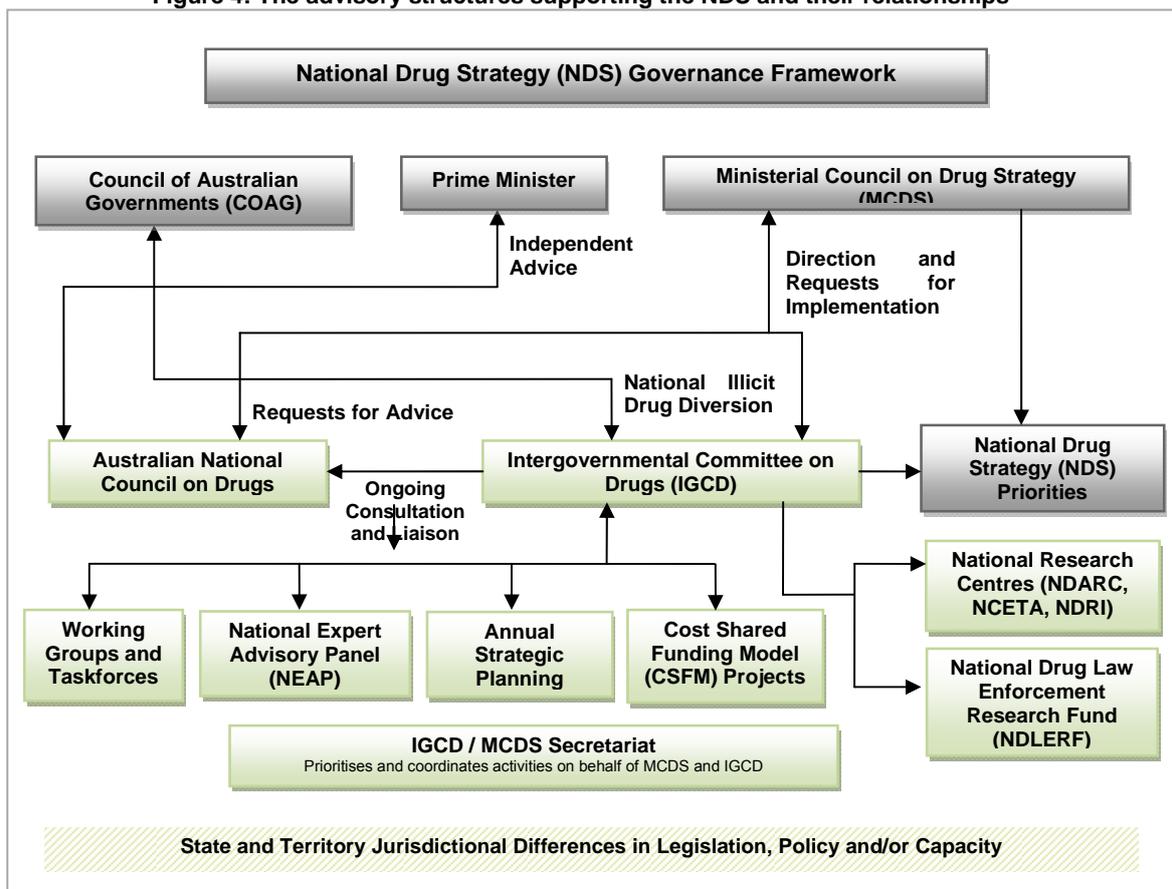
Research, data systems and evaluation

A number of data collections are considered of national significance to the NDS. They are listed and discussed in Chapter 7. Of the national programs that are developed using the principles of the NDS framework, publicly released evaluations have been made of the following programs:

- National Drugs Campaign: Evaluation of Phase Two (2006)
- National Drug Research Centres of Excellence Evaluation (2007)
- Evaluation of the MCDS CSFM (2005)
- Evaluation of the IDDI
 - Police Drug Diversion: A study of criminal offending outcomes (2007)
 - The effectiveness of the IDDI in rural and remote Australia (2008)

Advisory structure

Figure 4: The advisory structures supporting the NDS and their relationships⁹



⁹ Note: This figure illustrates the high level advisory structure, and does not include the sub-committees of the ANCD (eg NIDAC and the Asia-Pacific Drug Issues Committee).

The governance framework of the NDS consists of the Ministerial Council of Drug Strategy (MCDS), supported by an advisory structure that includes the Intergovernmental Council on Drugs (IGCD), the Australian National Council on Drugs (ANCD), the National Expert Advisory Panel (NEAP), and the National Drug Research Centres of Excellence (NDRCE). The Drug Strategy Branch of DoHA provides secretariat support to the MCDS and IGCD.

Ministerial Council on Drug Strategy (MCDS)

As the peak national drug policy and decision-making body, the MCDS is responsible for developing programs to minimise the harm caused by drugs to communities in Australia. The Council comprises Australian and State and Territory ministers of health and law enforcement, and the Australian Government Minister responsible for Education. The role of the MCDS is to promote a nationally coordinated approach to the development and implementation of drug-related policies. The council provides a mechanism for collaboration between the Commonwealth, State and Territory health and law enforcement ministers, with the aim of achieving national consistency in the areas of policy, program development and service delivery. The MCDS meets bi-annually, usually in May and November.

Intergovernmental Committee on Drugs (IGCD)

The IGCD is an executive body that reports to MCDS. It provides policy advice to MCDS on drug-related matters and is responsible for implementing the NDS policies and programs decided upon by MCDS. The IGCD consists of senior officers representing health and law enforcement agencies in each Australian jurisdiction and in NZ. Other committee members include experts in identified priority areas (Australian Department of Education, Employment and Workplace Relations (DEEWR), and the Australian Customs Service (ACS). Meetings of the IGCD take place twice a year in February and September, with an annual strategic direction workshop usually held in July.

The Australian National Council on Drugs (ANCD)

The ANCD plays an advisory, advocacy and representative role in the advisory structure of the NDS. It reports directly to the Prime Minister and has a working relationship with IGCD and MCDS. ANCD provides advice to Government on issues related to licit and illicit drugs. Its members include individuals from non-governmental and governmental organisations with diverse expertise on various aspects of drug policy (such as treatment, rehabilitation, education, family counselling, law enforcement and research).

The ANCD has responsibility for facilitating a partnership between the government and community, and ensuring that the voice of the NGO sector influences the development and implementation of policies and programs. Bi-annual reports are presented to IGCD and MCDS, and a report is presented to the Prime Minister annually.

In addition to its role in the advisory structure of the NDS, the ANCD undertakes other activities that include: commissioning research projects; facilitating non-government agency forums, contributing to public debate on drug-related issues; media comment; conducting community consultations; and supporting initiatives to strengthen the AOD sector. ANCD meets quarterly (in March, June, September and December) each year.

The National Expert Advisory Panel (NEAP)

The NEAP is a multidisciplinary list of experts reporting to IGCD in the current NDS advisory structure. The NEAP identifies emerging trends in the use of alcohol and other drugs; provides expert advice on priorities and strategies for dealing with specific drug-related harm (supply

reduction, demand reduction, and harm reduction); and provides direction and guidance to ensure that strategies targeted at specific population groups (for example, Indigenous communities).

National Drug Research Centres of Excellence (NDRCE)

The National Drug Research Centres of Excellence - the National Drug and Alcohol Research Centre (NDARC), the National Drug Research Institute (NDRI), and the National Centre for Education and Training on Addiction (NCETA) - have a key role in developing products and facilitating research in the priorities areas under the NDS. They undertake research into a variety of drug-related issues, including education and training targeting the drug and alcohol workforce, and provide evidence and advice to the MCDS and IGCD (including advice on emerging issues and trends), based on their research outcomes.

Considering the important roles of law enforcement - particularly policing - in responding to drugs, drug use and drug markets, some observers find it anomalous that we do not have well-developed drug law enforcement research infrastructure in Australia. NDLERF provides research grants in drug law enforcement, but its mandate is to focus particularly on research with operational and tactical focuses, rather than on the deeper evidence base for drug law enforcement and the role of law enforcement in prevention. From time to time the NDS National Drug Research Centres of Excellence have received grants from NDLERF to engage in law enforcement-related research, but this has not been a primary focus of any of the centres.

The existing research centres in the criminal justice area, such as the ARC Centre of Excellence in Policing and Security and university-based research departments, have paid only limited attention to alcohol and other drugs, and in particular to the role of policing.

It has been observed, both in Australia and abroad, that the evidence base for understanding drug issues and intervening effectively is stronger in some areas of health than in law enforcement. While there are many reasons for this, one is the relatively low priority given to developing the needed infrastructure for ongoing, high impact, drug law enforcement research. This is an area that would benefit from attention through the NDS.

Evaluations of NCADA / NDS

The report of the first evaluation of the NCADA (Stephenson *et al* 1988) was released at the conclusion of the Campaign's first three-year phase. Its core findings were that the policy and strategy of the NCADA remained apposite, and that, because achievements would be realised only over the long term, the NCADA should continue with only minor modifications to its mass media component and attend more realistically to its contribution to the HIV/AIDS strategy. As a consequence, the second phase of the NCADA was implemented as an extension of the first.

1992 saw the publication of the second evaluation of the NCADA (Second Task Force on Evaluation 1992). Very few changes were recommended and the third phase of the NDS, the *National Drug Strategic Plan 1993-97*, was implemented accordingly. The Plan included 'Key National Indicators', although they were never used for monitoring the Plan's implementation or evaluating its outcomes.

In 1997, the report on the third evaluation (by Single & Rohl) included an unsuccessful attempt to produce performance indicators for the NDS. As the third evaluation recommended, the term NCADA was later changed to the National Drug Strategy (NDS) and the *National Drug Strategic Framework 1998-99 to 2002-03* (NDSF) (later extended to 2003-04) was adopted. It represented the fourth phase of the NDS.

In 2003, the report of the fourth evaluation *Success Works* was released. The report was released on-line. It had a limited scope, and attracted little attention from the alcohol and other drug sector.

It was followed by the introduction of the *National Drug Strategy: Australia's Integrated Framework 2004-2009*, which is the current and fifth phase of the NDS, and the focus of the current evaluation.

Recommendations from the evaluation of the previous phase of the NDS

The fourth evaluation (Success Works 2003) entailed assessment of the impact of the NDSF on reducing supply, demand and harm to individuals and the community, and proposals for any resulting changes needed to the NDSF. The assessment identified progress towards achieving the NDSF objectives, and recommendations were made about:

- the impact of the NDSF
- emerging trends from supply reduction, demand reduction and harm reduction efforts
- the principle of harm minimisation
- data indicators
- data collections
- development of Action Plans
- governance and management structures
- ANCD-IGCD partnerships
- links to other strategies

The majority of recommendations did not propose significant changes and focused predominately on process considerations rather than on structures or programs. The main exception is the recommendation on the advisory structures, which led to abolition of the national expert advisory committees and establishment of the NEAP and time-limited working groups.

In our assessment of the implementation status of the 31 recommendations, 15 have been implemented, five have not been implemented and 11 have been partially implemented.¹⁰

Some of the recommendations remain apposite, and are reflected in the findings of the current evaluation. They include recommendations calling for greater emphasis on prevention, improving the use of expert inputs by the advisory structure, addressing the communication and roles of the IGCD and ANCD, maintaining an appropriate balance between supply reduction, demand reduction and harm reduction, addressing concerns about the use of the term 'harm minimisation', maintaining the high standard and quantity of research outputs, and maintaining the contribution of the education sector as a core player in the NDS.

¹⁰ See Appendix F for details

Chapter 4: The National Drug Strategy as a policy framework

Introduction

The NDS is Australia's overarching policy framework for responding to drug issues. The purpose of this chapter is to examine how and to what extent the NDS acts as a policy framework to inform the development of drug-related policies and programs. The potential value of the NDS as a policy framework is its ability to involve and inform the different levels and relevant sectors of government (health, law enforcement, education), as well as those beyond government in the public, private and not-for-profit arenas.

The goal of the NDS as a policy framework is to create an environment where the Commonwealth and each State and Territory has drug policies and strategies that are informed by and congruent with the NDS, while allowing flexibility for States and Territories to pursue specific priorities.¹¹ Given this goal, the framework is evaluated in terms of its ability to *appropriately and effectively* produce congruent policies based on agreed principles, approaches, objectives and priorities across jurisdictions and between sectors, in order to *efficiently* address emerging and identified drug-related harms and risks of harm in a timely way, taking into account sound evidence, economic and social conditions and circumstances as well as the cultural diversity of Australia's many communities, including Indigenous communities and regional areas. Three sources of data were collected in order to assess the appropriateness, efficiency and effectiveness of the NDS as a policy framework. First, we collected and synthesised international literature on national drug policy approaches and outcomes.

Secondly, we examined in detail national, state and other major policy documents in Australia, particular attention to the congruence between policies and specificity to different circumstances in Australia.

Thirdly, informants in government, the research community and the public and private sectors were interviewed to ascertain how the NDS as a policy framework informs initiatives to address drug issues across levels of government and sectors. All stakeholders were asked to comment on the objectives and priorities of the NDS and the extent to which the NDS informed and facilitated consistency in drug strategies and policies across levels and sectors of government. They were also asked to suggest possible improvements to the NDS policy framework.

In addition, two case studies – the *National Alcohol Strategy: 2006-2009* and the *National School Drug Education Strategy: 1999* – provide further detailed analysis of the functions and impacts of the NDS policy framework.¹²

Five topics emerged from these approaches to the NDS as a policy framework:

- The NDS as an overarching framework
- The principle of harm minimisation
- The partnership approach to drug policy development
- The balance among priorities in the framework
- The use of an evidence-informed approach

¹¹ See Appendix G for the Component 1 program logic model and outcome matrix.

¹² See Volume 2 for the case study reports.

Findings

The National Drug Strategy as an overarching framework

Over all, the NDS has allowed the development of consensus building in policy development, also incorporating an evidence-informed approach to varying degrees. The uptake of the NDS at State and Territory and community levels is facilitated by the consensus position represented by the NDS, and the regular communication among government stakeholders that occurs at IGCD meetings. There is good evidence that the NDS has facilitated a consistent approach to policy by encouraging a shared understanding among different levels and sectors of government, and over time across the public, private and not-for-profit areas.

Senior government officials, experts and external stakeholders were consistent in their view that Australia's NDS is highly regarded and a leader in drug policies internationally. Our review of international drug strategies and policies indicates that Australia's drug policy framework, based on partnerships among law enforcement, health and education agencies, has gradually been replicated in other countries.

Adoption of NDS policy principles

A number of policy framing documents and initiatives of the NDS have been used to guide the development of State and Territory drug strategies and policies in the health, law enforcement and education sectors. Specifically, it is the principles, approaches, objectives and priorities of the NDS that are widely endorsed and adopted by government and non-government (private and not-for-profit) organisations. For example, in the law enforcement area, NDS principles are explicitly adopted by a high level body such as the ACC and also managers of local community policing. Similarly, NDS principles are widely reflected across the health sector in State and Territory health departments, community-based NGOs, and illicit drug user groups.

The view that the NDS has achieved consensus in policy by striving to be both broad in approach and comprehensive in nature was widely endorsed. It provided flexibility for its stakeholders to tailor drug policies and strategies to specific needs and priorities in a particular context. It also provided the opportunity for innovation (for example, the implementation of Project STOP). However, without an adequate monitoring or early warning system, the NDS is limited in its capacity to be forward-looking. In order for the NDS to be more responsive, there is a need to monitor new drug trends, emerging forms of drug-related harm, the return of older forms of illicit drug use and harm (for example, heroin use and overdose), and new and emerging treatment and prevention technologies such as drug vaccines, new pharmaceuticals, and the use of genetic information that are promised by neuroscience and genetic research on addiction. Processes for responding to emerging trends are important, but they are difficult to achieve in the NDS owing to its size, complexity and the large number of participating organisations and governments.

Some potential challenges

While informants agree that the NDS policy framework has built consensus in policy positions, some disagreement about the role of the NDS as a policy framework remains. Stakeholders hold quite different views about whether the framework should remain broad and non-prescriptive in order to increase the likelihood of achieving consensus, or become more specific in detailing delivery frameworks and establishing mechanisms for accountability. Informants in the government, business and non-government sectors had a wide range of opinions about the feasibility of moving beyond policy facilitation, given Australia's federal system of government.

Informants thought the lack of specific resource allocation and implementation processes (such as action plans) in some policy positions, and the absence of links between financial resources and performance targets or indicators were barriers to implementing the NDS at State and Territory

levels. Where this lack occurs, it contributes to difficulties in determining when and if certain drug-related initiatives have contributed to the intended policy outcomes of the NDS.

This view is consistent with our analysis of available documentation, which showed drug-related strategies were inconsistent in whether they had clear specific resource allocation and offered pathways for implementation. Having enough detail to enable policy implementation is an element of good practice in public policy.

The National School Drug Education Strategy receives federal funding and identifies the outcome and performance indicators for each of its objectives. By contrast, the National Alcohol Strategy provides a consensus statement but does not go on to address matters of accountability, and how action may be resourced with targets or other criteria to measure the benefits of the strategy. Our case study analysis of these two strategies showed that the availability of allocated financial resources through a national strategy facilitated timely uptake and implementation of their objectives, priorities and recommended responses. It is worth noting that, in the case of the National Alcohol Strategy, there were conflicting views among stakeholders about whether the benefit of the strategy depended on facilitating a consensus position, or whether resources and performance targets would have enhanced its capacity to achieve its intended outcomes.

There are notable variations among State and Territory drug strategy documents in the level of detail provided on policy delivery and data indicators. The *New South Wales (NSW) Drug Action Plan: 2006-2010* and the *ACT Alcohol and Other Drug Strategy: 2004-2008*, for example, specify the responsible agencies and the outcome measures associated with each recommended action under each priority area – a level of specification that is not found in other equivalent State and Territory documents.

In the context of the Australian federal system, the NDS faces the challenges of remaining broad in order to achieve consensus and buy-in among its diverse stakeholder groups, while providing enough detail to facilitate more timely and consistent national implementation of agreed strategies.

What the NDS as a policy framework has done well is provide an overarching mechanism that has helped develop the identity of a drug sector which allows diverse stakeholder groups to be a part of a national effort. It has also helped to establish a community of practice and framework for different sectors and professions to work together at the national level, in each State and Territory, and sometimes locally. Sometimes, it has also provided space for specific innovations. There is reasonable consensus that this is the strength of the framework. Whether the framework could or should go further than this facilitating role varied among specific strategies.

The principle of harm minimisation

Key policy making groups broadly endorse continuing harm minimisation as a principle underpinning drug policies and programs in Australia – in particular, its three pillars of supply reduction, demand reduction and harm reduction strategies.

The current NDS defines harm minimisation as ‘policies and programs aimed at reducing drug-related harm. It aims to improve health, social and economic outcomes for both the community and the individual, and encompasses a wide range of approaches, including abstinence-oriented strategies’ (MCDS 2004, 2). The NDS also makes clear that harm minimisation does not condone drug use; rather, it represents a comprehensive approach to drug-related harm that involves achieving a balance between demand reduction, supply reduction and harm reduction strategies.

Inclusion of reductions in supply, demand and harm has made it easier for law enforcement, health and education sectors to come together under the NDS, since these policy platforms make it possible to recognise each sector’s particular roles, functions, expertise and resources within the deliberations of national strategies:

- *Supply reduction strategies* focus on disrupting the production and supply of illicit drugs and the control and regulation of licit substances, and are typically associated with law enforcement and regulatory measures.
- *Demand reduction strategies* aim to prevent the uptake of harmful drug use and include treatment to reduce drug use.
- *Harm reduction strategies* are designed to reduce drug-related harm to individuals and communities, while not requiring abstinence in the short term.

Harm minimisation as a policy platform in the current phase of the NDS can be traced to the inception of NCADA. The term ‘harm minimisation’ as an overarching principle for national drug policies was recommended in the 1997 NDS evaluation by Single and Rohl. They argued that “harm minimisation should be viewed as the middle ground where persons with widely differing views on drug policy can agree with one another regarding practical, immediate ways to reduce drug-related harm. Harm minimisation should foster meaningful alliances and support for as wide a variety of potentially effective interventions as possible from all who share the goal of reducing drug-related harm, even though they may disagree about major policy approaches to the prevention of use *per se*” (1997, 49).

They proposed and emphasised the need to focus on a set of harm minimisation principles:

1. First, do no harm – consider the unintended harm that might result from a policy or program and ensure that benefits outweigh negative impacts
2. Focus on the harms caused by drug use rather than drug use *per se* – the primary goal of harm minimisation is reducing harm rather than the rates of drug use
3. Maximise intervention options for those in front-line treatment, law enforcement and others dealing with drug-related problems
4. Choose appropriate outcome goals, giving priority to those that are practical and realisable – harm minimisation involves the prioritisation of goals and does not conflict with an eventual goal of abstinence and is often a first step towards reduction and even cessation in use
5. Respect the rights of persons with drug-related problems – they should be treated with dignity as normal persons
6. Harm minimisation does not imply support for drug use and should not be equated with the legalisation of drugs – rather, it implies a concern with reducing the adverse consequences of drug use

However, there is some continuing concern in parts of the community about what is meant by ‘harm minimisation’. The term has not entered easily into everyday language except among drug policy experts and those who know the field well. It is not a term that has been easy to sell, since it incorporates a number of complex ideas, and it can lead to concern over the direction of drug policy. ‘Harm minimisation’ and ‘harm reduction’ are often used interchangeably and therefore confusingly. A considerable amount of ideological baggage is now associated with it. Rather than being a useful tool for communicating a complex idea, ‘harm minimisation’ has become a slogan, along with such terms as ‘harm prevention’, ‘harm maintenance’, and ‘zero tolerance’.

There can also be disagreement about the application of the harm minimisation principle to specific policy goals and the most appropriate ways to achieve them. The inherent complexity of multi-sector policy approaches can lead to what are perceived as internal inconsistencies in the NDS policy framework (for example, the potentially conflicting goals of reducing illegal drug use and reducing drug-related morbidity and mortality). On the other hand, such apparent inconsistencies reflect the need to possess several strategies to address a range of objectives in policy around a drug problem effectively.

This suggests a need to revisit the clarity of values and goals of harm minimisation in order to realise the full benefits at individual, family, community and population levels. This could also help ensure greater consistency and coordination in policies to address drug-related harm and achieve broader consensus - particularly in gaining greater bi-partisan and community input and support for implementation of the NDS.

In reviewing the use of 'harm minimisation' in various documents and among stakeholders, we found that one aspect of the controversy is linked with a common perception that 'harm minimisation' addresses the consequences of harmful drug use rather than its causes, and hence does not focus adequately on the prevention of drug use. Another aspect of the controversy is the extent to which 'harm minimisation' embraces a range of treatment goals and modalities, from abstinence-based approaches through to opioid maintenance programs. In particular, we found a perceived need to reinforce the importance of abstinence-oriented interventions to reduce drug-related harm – that is, abstinence and harm reduction can be equally applicable goals and strategies in some circumstances, and need not be considered opposing social norms.

In some instances, the ultimate goal of harm minimisation may be abstinence, even though it is not immediately feasible; but in the case of legal substances, abstinence for everyone may not be a desirable policy objective. A wide range of intervention options, including abstinence-oriented programs in some circumstances, is the best practice for reducing drug-related harm, if they are tailored to the specific circumstances and include a sound basis in evidence.

Such controversy has fuelled arguments for dropping or replacing the term 'harm minimisation', but few adequate alternatives have been proposed to capture the significance of a national policy that addresses supply, demand and harm.

For example, we noted the work of Drug-Free Australia and the Hon. Bronwyn Bishop MP's 2007 House of Representatives Standing Committee on Family and Human Services inquiry into the impact of illicit drug use on families, where the term 'harm prevention' is promoted as an alternative to 'harm minimisation'. They consider that the *'ultimate goal of a national illicit drugs strategy should be harm prevention'*, which is *'to prevent people becoming drug users and to enable individuals who break the law and use illicit drugs to become and remain drug free for the benefit of themselves, their families and the nation'* (Parliament 2007, 92).

They also recommended the development of a national illicit drug policy that *'replaces the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment that has the aim of achieving permanent drug-free status for individuals with the goal of enabling drug users to be drug free; and only provide funding to treatment and support organisations which have a clearly stated aim to achieve permanent drug-free status for their clients or participants'* (118).

It is important to note that this definition addresses only the prevention of harm, and offers a restricted range of options to reduce harm among drug users; if adopted, it would limit a full range of policy options available to governments.

From time to time, proposals have also been put forward for an alternative definition, or greater clarity has been called for in the definition of harm reduction – for example, that *"Harm reduction" in relation to drugs refers to policies and practices intended primarily to reduce the health, social and economic costs of mood-altering drugs without necessarily restricting their consumption'* (Ritter *et al* 2004). This is a position that may also limit efforts for a drug-free community where this is desired in certain circumstances.

National frameworks for drug policy development need to have the scope to address both the causes and the consequences of drug use in ways that maximise the positive outcomes of efforts for the individual, family, community and population. It is important to adopt an approach that is

inclusive of all relevant sectors (public health, clinical medicine, law enforcement, education, social welfare) and provides a balance of strategies across them all. We therefore recommend that the three main strategies to achieve the goal of harm minimisation – supply reduction, demand reduction, and harm reduction – be retained.

However, to reduce confusion and enhance wider shared community understanding of the harm minimisation principle, we recommend revisiting the principles of harm minimisation as set out by Single and Rohl and reinforcing them in the public domain. However, we suggest that the principles be modified to give greater emphasis to the prevention of harmful use of psychoactive substances than was the position advocated in Single and Rohl's second principle ('Focus on the harms caused by drug use than drug use *per se*'), in order to promote a better balance between a focus on the prevalence of use and on the consequences of use.

Nevertheless, we also recommend no longer using 'harm minimisation' as the headline term for the national strategy, and replacing it with a new term that more adequately captures the core concept of the NDS. The new term should comprise a set of words in plain English that explicitly highlight both the prevention and reduction of drug-related harm (both causes and consequences).

This would give higher salience to preventing drug use (addressing prevalence of use) while retaining the current emphasis on dealing with the harmful consequences of drug use, and respond to the diversity of issues within community concerns about drug issues. It may achieve greater bi-partisan and community support for implementation of the NDS, and greater consistency and coordination in policies to address drug-related harm.

Prevention

One of the acknowledged strengths of the NDS since its inception has been its focus on demand reduction, supply reduction and harm reduction and on the interactions between those three elements. Even though prevention has been listed as a priority area since the inception of the Strategy, it is still described as 'missing in action' within the NDS.

IGCD and MCDS made a good start in developing a prevention agenda through commissioning NDRI to research and publish the document *The prevention of substance use, risk and harm in Australia: a review of the evidence* (Loxley *et al* 2004). Despite widespread expectations across the sector that this review would be translated into a prevention agenda as a core component of the NDS, this has not yet occurred. Further work is needed to document potential modes of prevention and what works, in what circumstances, and with which population groups, and to turn this work into an explicit strategy and set of action plans. This developmental work would usefully take into account the actual and potential roles of the criminal justice system in prevention through minimising drug supply, increasing the perception of risk of arrest and case finding, and referral of offenders to treatment through diversion programs (ACPR 2003, Loxley *et al* 2004, Spooner *et al* 2004)

.Partnership

In the context of national public policy, the 'partnership approach' for the NDS is defined 'as a close working relationship between the Commonwealth, State and Territory, and local governments, affected communities (including drug users and those affected by drug-related harm), business and industry, community-based organisations, professional workers and research institutions' (MCDS 2004, 24). Based on this definition, the NDS highlights the need for 'partnerships between health, law enforcement and education agencies, affected communities, business and industry in tackling drug-related harm' (11).

Building and maintaining partnerships is a core element of good practice in much contemporary public policy process¹³. Partnerships are critical for ensuring coordination and consistency in efforts to achieve the intended drug policy outcomes, building support for effort to address drug issues, enlisting expertise, and in many cases coopting the different jurisdictions of government and sectors of public administration and services, and the significant capabilities of the private and not-for profit sectors.

As recognised in the NDS, the partnerships among levels and sectors of government and across public, private and non-for-profit domains are a key strength of the NDS and have become critical to achieving its objectives. Based on available documentation, informant views and case studies, we found that the partnerships approach, promoted through Australia's national drug strategies over time, is now widely accepted, and has been adopted across levels and sectors of government and across public, private and non-for-profit domains. It is not only accepted practice but also expected by key organisations now and into the future.

This is not to suggest that partnership approaches are easy to maintain, or without their difficulties from time to time. Although all stakeholders highly valued and endorsed partnerships between health and law enforcement sectors, the challenge remains to maintain an optimal balance between health and law enforcement perspectives. The perception remains, particularly at the IGCD level, that health and law enforcement representatives focus largely on agenda items specifically related to their own sector and the contributions of the two sectors are not adequately integrated. There are also potential conflicts between the goals of the two sectors. In contrast, it is widely perceived that the partnership between the two sectors works relatively well at State, Territory and local levels.

In multi-sector policy analyses, insufficient attention may be paid to assessing the nett harm, encompassing the different sources and types of harm linked to the various sectors, or making explicit potentially conflicting goals and their implications for policy and implementation.

The central mechanisms in the NDS for developing and implementing policy are the core formal and personal relationships between federal and State and Territory Governments, and among the health, law enforcement and education sectors. Policy deliberations and implementation, however, often involve a broader constituency to generate greater policy impact – local governments, the private and non-government sectors, consumer groups, industry groups, the research community and the wider community are central to policy effectiveness. Yet these sectors engage with the policy process primarily by invitation and on an *ad hoc* basis. In other words, the NDS policy community is largely confined within government unless external input is invited or facilitated through specific programs. The lack of input from experts and external stakeholders in policy development through the full policy cycle is likely to have limited the scoping of the problem in-hand on some occasions, truncated the range of ideas or policy options being for consideration and hence the eventual impact at implementation.

To build better policy through partnerships, it is vital to strengthen the role of sectors beyond government that are involved in service delivery, research, drug user groups, and people affected by drug use. Consultation with a diverse range of stakeholders is recognised as best practice in developing and implementing public policy. In order to widen the range of voices heard in the policy development and implementation process, and to enable more bottom-up processes, we recommend a greater role for public consultation in developing drug strategies. It is also important to educate the community about the evidence in order to generate informed public debate, and so that public consultations can produce meaningful, useful outcomes.

¹³ See Volume 2 for a summary of the literature on public policy practice

Social determinants of health and of drug use

To achieve such greater community involvement and sharing of evidence, we believe there is a need for greater emphasis on the social determinants of health in tackling drug problems. Work done through NDS and ANCD channels has delivered deep understanding of how important the social determinants of harmful drug use can be (eg Spooner and Hetherington 2005). This insight is consistent with recent evidence on the broader impacts on individual health outcomes of social determinants such as socioeconomic status, poverty, homelessness, unemployment, education level, social support, membership in minority groups, and the living environment (Marmot & Wilkinson 2006; WHO Commission 2008).

Material and social deprivation or social disadvantage interact in complex ways and are linked with a wide range of adverse health physical and mental outcomes. Social disadvantage is associated with poor nutrition, dietary habits, and access to health care, as well as negative behaviours such as sedentary behaviour, smoking, drinking alcohol, and illicit drug use. However, very little work has been undertaken and little has been gained by implementing these principles intersectorally between drug strategies and other areas of social programming – a notable exception being the ‘Pathways to Prevention Project’ by Homel *et al* (2006) in Queensland.

To enhance the effectiveness of law enforcement, health and education drug policies and programs, it will be essential to address drug problems in a broader and more coordinated way by establishing closer links with the sectors, disciplines and fields that focus on addressing these social determinants of health.

Balance of priorities within the framework

The NDS emphasises the importance of a balanced approach to addressing drug issues. ‘The Australian Approach’ to drug policy is characterised in the NDS Framework document as ‘...involving a balance between demand reduction, supply reduction and harm reduction strategies’. This includes focusing on both licit and illicit drugs, and on strategies to prevent anticipated harm and reduce actual harm from both sources. However, our analysis of available documentation, informant views, and case studies found imbalances in investment between licit and illicit drug interventions, and across supply reduction, demand reduction and harm reduction strategies.

Specifically, we found that although tobacco accounts for a larger proportion of the total burden of disease in Australian than illicit drugs, there has been a much greater investment in illicit than licit drug use over the past decade.

Using DALYs - a composite measure of years of life lost from premature death and years lived with disability - to compare the contributions of alcohol, tobacco and illicit drugs to burden of disease, the Australian Burden of Disease and Injury study estimated that, in 2003, tobacco, alcohol and illicit drugs accounted respectively for 65%, 19% and 16% of the drug-related burden of disease and injury (Begg *et al* 2007). Moreover, of the estimated total \$55.2 billion in social costs of drug abuse to Australia in the 2004-2005 financial year, tobacco accounted for 56% (\$31.5 billion), alcohol for 27% (\$15.3 billion), illicit drugs for 15% (\$8.2 billion) and alcohol and illicit drugs acting together accounted for another 2% (\$1.1 billion) (Collins & Lapsley 2008). Collins and Lapsley acknowledge that there are still significant gaps in data on drug-related harms - what some refer to as the ‘hidden harms’. Examples include the tangible and intangible costs of drugs in terms of public safety and amenity.

The newly elected Australian Government has allocated substantial investment and made changes to some alcohol excise rates to address alcohol-related harm from binge drinking. This has had the welcome effect of putting alcohol on the Government’s agenda. The current Government made an election undertaking to reinvigorate tobacco campaigns. We commend and support the need for greater focus to address the harm caused by licit drugs, including prescription drugs.

Collins and Lapsley's (2008) recently updated estimate of the costs of drug abuse provides information on government expenditures in this area. With expenditures by the Commonwealth, State and Territory Governments combined, this table shows that, in the 2004-2005 financial year, 50% of Government expenditure on drugs addressed alcohol, 45% illicit drugs, and just 5% tobacco.

Table 4.1: The impact of drug abuse on federal and state budgets 2004-2005 (Collins & Lapsley 2008)

	Alcohol		Tobacco		Illicit Drugs	
	Federal (\$m)	State (\$m)	Federal (\$m)	State (\$m)	Federal (\$m)	State (\$m)
Net revenue	3,075.4	976.5	2,864.1	937.4	(299.5)	0.0
Expenditure	1,272.6	1,363.8	154.8	104.7	127.5	2,264.8
Revenue less expenditure	1,802.8	(387.3)	2,709.3	832.7	(427.0)	(2,264.8)

Note: Figures in brackets are negative.

Examination of the particular sectors and drugs on which the expenditures were made reveals that the total outlays by the Commonwealth and the State and Territory Governments to address drug abuse in the 2004-2005 financial year was \$5,288 million. Of this expenditure, 60% of the total was spent on addressing crime, 37% on health and 3% on other expenditures.

- For *alcohol*, health expenditure was 59%, crime 37%, and other 4%.
- For *tobacco*, health expenditure was 96% and other 4%.
- For *illicit drugs*, crime expenditure was 92%, health 7% and other 1%.

Table 4.2: Expenditures by Australian Governments on drugs, by sector and drug type (2004-2005)¹⁴

Sector		Alcohol		Tobacco		Illicit Drugs		Total	
		\$ million	Alcohol %	\$ million	Tobacco %	\$ million	Illicits %	\$ million	Total %
Health	\$ m	\$1,555	59%	\$249	96%	\$159	7%	\$1,964	37%
	%	79%		13%		8%		100%	
Crime	\$ m	\$975	37%	\$0	0%	\$2,212	92%	\$3,187	60%
	%	31%		0%		69%		100%	
Road crashes & fires, nei*	\$ m	\$106	4%	\$10	4%	\$21	1%	\$138	3%
	%	77%		7%		15%		100%	
Total	\$ m	\$2,636	100%	\$260	100%	\$2,392	100%	\$5,288	100%
Total	%	50%		5%		45%		100%	

The DPMP team has estimated Australia's drug budget with regard to illicit drugs only. Total proactive spending on illicit drug interventions by governments was estimated at \$1.3 billion in the 2002-2003 financial year. Law enforcement and interdiction combined accounted for 56% of the expenditure, while prevention and treatment accounted for 23% and 17% respectively (Moore

¹⁴ Source: Collins & Lapsley 2008, and authors' calculations. *nei = not elsewhere included

2005). This study is usefully seen as a first step towards estimating government expenditures in this area but, as with all studies, it has a number of limitations in both data availability and research methodology. These limitations highlight the need for further research to identify, with respect to all drugs, the relative expenditures on law enforcement, prevention and treatment, and on supply reduction, demand reduction and harm reduction.

The broad findings of Collins and Lapsley's and Moore's research accord closely with the views of many senior informants that attention needs to be paid to Australia's allocation of investment across sectors and drug types in preventing and responding to drug use and drug-related harm. The challenges in making major reallocations of government funding across government programs are substantial. Nevertheless, when the NCADA was developed in 1985, its funding arrangements were specifically directed to overcoming what was then seen as an imbalance in government expenditures in favour of law enforcement, especially in response to illicit drugs. The work of the National Preventative Health Taskforce may prompt governments to direct new resources to tobacco and alcohol, rather than illicit drugs, and to increase investments in health interventions (preventive and curative).

The argument for such a rebalancing reflects a conjunction of two observations. The first is the mismatch between the sources of the social costs of drug abuse and where government funds are expended. The second is the availability of interventions in the tobacco and alcohol areas that have high efficacy and very high cost-effectiveness (Hurley & Matthews 2008; Doran *et al* 2008). Little evidence exists on the efficacy and cost-effectiveness of the available drug law enforcement interventions, and studies comparing the cost-effectiveness of drug law enforcement with prevention and treatment consistently favour the latter (Stevens *et al* 2005).

We therefore recommend that consideration be given in the next phase of the NDS to developing and applying funding mechanisms at both the Commonwealth and State and Territory levels to ensure that allocations provide a better balance of interventions in drug types and intervention sectors. 'Balance' does not mean equal allocation to the various sectors. Rather, it means resource allocations that reflect the relative seriousness of the harms and costs addressed, and the availability of evidence-informed strategies and beneficial interventions for addressing them.

Review of State and Territory drug strategy and action plan documents found inconsistencies in the relative emphases on illicit and licit drugs, and among supply reduction, demand reduction and harm reduction strategies. The NDS is flexible enough to allow States and Territories to tailor their drug strategies to local needs and priorities, but such inconsistencies potentially diminish coordination of efforts across jurisdiction to achieve NDS outcomes.

An evidence-informed approach

Increasingly, the NDS framework has embraced an evidence-informed approach in policy deliberations. Evidence in this context usually means adding value to the policy process by including sound research information that is explicit, rigorous and transparent in its methodology and interpretation of facts (Lin & Gibson 2003). The inclusion of an evidence base in policy deliberations is particularly relevant in the drug field because the field is value laden, culturally embedded in societal norms, and contested by sectional interests. In such circumstances, adopting an evidence-based approach and using the best available evidence to inform policy are in line with best practice in public policy.

Document analysis and informant views suggest that the NDS embraces the principle of including evidence in policy deliberations. But the use of evidence as a lever for change in the policy process is not consistent. For example, while there is demonstrated effectiveness of NSPs in community and prison settings, the evidence has not succeeded in gaining approval for prison-based NSPs in Australia.

Sustained advocacy was required alongside the strong evidence to implement policies to reduce smoking. While some progress has been made on tobacco tax reforms, much more work is still needed (Chapman 2007; National Preventative Health Taskforce Alcohol Working Group 2008).

Similarly, despite overwhelming evidence indicating the high cost-effectiveness of alcohol taxation in reducing alcohol consumption and related harm (National Preventative Health Taskforce Alcohol Working Group 2008), there is ongoing resistance to alcohol tax reforms in Australia in some groups.

Factors that influence the application of evidence to policy

Several factors influence the extent to which policy is based on the best available evidence. They include competing national and State and Territory strategies, policies and interests, media influence, and lobbying by industry and interest groups. For example, in the case of the National Alcohol Strategy, competition policy, differences in State and Territory liquor licensing regulations, and economic interests in the alcohol industry have affected the extent to which policies with demonstrated cost-effectiveness are implemented, and similarly how far the full benefits of implemented policies are realised. Media portrayal of drug issues and public perceptions of effective policy responses to them (such as the use of Naltrexone in ultra-rapid opioid detoxification) have influenced policy decisions. Lobbying by the tobacco and hospitality industries has delayed introduction of smoking bans.

Evidence for effective strategies in law enforcement is limited - for example, optimal allocation of drug law enforcement measures between street-level and intelligence-led policing. Relevant evidence is also under-used. For example, there is sound evidence that hot-spot policing is effective, particularly when it is done through a third party policing model – a measure that involves police efforts to ‘persuade or coerce other regulators or non-offending persons, such as health and building inspectors, housing agencies, property owners, parents, and business owners, to take some responsibility for preventing crime or reducing crime problems’ (Buerger & Mazerolle 1998, 301).

Evidence has been well used to guide policy decisions in the area of treatment, yet there are still significant challenges in access to evidence-based treatment services. For prevention, there is sound knowledge of some effective policy instruments (eg taxation and some types of mass media campaigns), but generally the evidence base is weak.

There is broad endorsement for a culture of evidence-informed policy, but it needs to continue and be encouraged and strengthened into the future so that there are (1) significant advances in drug-related interventions based on sound research; (2) more and wider leadership in implementing interventions for which there is evidence of potential effectiveness; and (3) a concerted effort to research existing gaps in knowledge and evidence for the effectiveness of interventions, in particular, law enforcement interventions.

Availability of evidence

While research evidence has a critical role in informing policy decisions, relevant or good quality evidence is not always available. Scientific evidence is also not always perceived to be sufficient, appropriate or desirable in making policy decisions. Owing to political imperatives or the need to respond quickly to address public concerns, governments will sometimes implement interventions that are not consistent with the evidence, or the need for an intervention outstrips the availability of high quality evidence of effectiveness (Weatherburn 2004).

The openness of the policy framework has provided opportunities for governments to support, or at least tolerate, policies and interventions that are not based on evidence, such as Naltrexone implants, or using former illicit drug dependent people as drug educators in schools.

Stakeholders generally thought that the NDS policy framework has so far focused too narrowly on factors such as the availability of drugs and individual attitudes toward drug use. Their perception on this score is consistent with the compelling argument for addressing social determinants of health in an effort to address drug issues and problems. Accordingly, we recommend broadening the evidence base for the NDS to include social determinants of problematic drug use, making use of research evidence from economics, social psychology, sociology, environmental planning and architecture.

In supporting decision making on illicit drug policy, the DPMP, among others, provides a valuable model for research and the use of research in drug policy making. Rather than being a government-funded project, the DPMP receives funding through a charitable foundation and independent research funding bodies. It is thus independent of government positions.

This independence, combined with an interdisciplinary and intersectoral approach to research, provides immense potential for the wide range of projects developed and executed through the DPMP to inform illicit drug policies in Australia. The work of the DPMP can also be mapped onto the four Components of the NDS. The DPMP has implications for each Component of the NDS and the capacity to contribute to its further development.

Independent research groups working in the area of alcohol and other drugs, such as the DPMP, Assessing the Cost-Effectiveness, Turning Point, and Queensland Alcohol and Drug Research and Education Centre (QADREC), have the potential to contribute much valuable research evidence to illicit drug policy. We recommend greater engagement between the NDS and these types of research groups.

Summary of findings

Working towards better practices in drug policy development

This component has evaluated the NDS as a policy framework to inform stakeholders in the development of their respective drug related policies and programs. The objective has been to establish whether or not the NDS as a policy framework has informed development of drug related policies by stakeholders at each level of government, in each relevant sector (health, law enforcement, education) in the public, private and not for profit arenas.

Six strategic themes emerged from the documents, interviews, and case studies for this component: (1) the overarching functions of the framework in Australia's federal system of government; (2) adoption of harm minimisation as a guiding principle for policy development; (3) building strategy through partnerships; (4) balancing priorities; (5) an evidence-informed approach; and (6) progress towards better practices in drug policy development. Here is a summary of our findings on whether the framework has informed efficient, appropriate and effective advances in drug policy development.

A framework for congruent polices across jurisdictions and between sectors

The NDS policy framework has informed the development and implementation of drug policies and strategies at multiple levels and across sectors of government and the public, private and non-government domains. The NDS is sufficiently broad and flexible to enable the tailoring of State and Territory and local drug strategies and policies to specific local needs and priorities.

The NDS has achieved these outcomes by promoting a consistent approach to harm minimisation, partnerships, and use of evidence across government and its sectors at State and Territory and local levels over a considerable period. Maintenance of the harm minimisation principle and the partnerships approach to policy development, as well as encouragement for evidence-informed approaches, are widely endorsed across governments and have been generally accepted by many private sector organisations and the non-government sector as expected practice.

Address emerging and identified drug-related harms and risks of harm in a timely manner

A broad policy framework provides opportunities for innovative and creative implementation mechanisms.

The NDS promotion of an evidence-based approach has not always been aligned with policy priorities equally and investment decisions have not always aligned with evidence. For example, the relative allocation of resources between licit and illicit drug activities and across supply reduction, demand reduction and harm reduction strategies has not always been consistent.

Challenges to the NDS policy framework

The NDS policy framework also faces a number of challenges. These challenges include the continuing debate on the concept of harm minimisation and its relationships to prevention and abstinence; the balance between health and law enforcement perspectives; the minimal involvement of stakeholders external to federal and State and Territory governments; an imbalance in emphasis and investment between licit and illicit drug initiatives and across supply reduction, demand reduction and harm reduction strategies; inconsistent use of evidence to inform policies; and a limited evidence base in key policy areas.

However, there are some perceived limitations in the NDS policy framework. There is disagreement over the degree of specificity in delivery and accountability mechanisms, identification of financial resources through the strategy, and whether resource allocation is a necessary function of the NDS.

Contemporary public policy practice suggests that good public policy includes a clear understanding of the issue or problem; goals that can be evaluated; an inclusive and highly participatory consultation process and the use of best evidence.

In summary, we have found that the NDS policy framework has informed the development and implementation of drug policies and strategies at multiple levels and across sectors of government and the public, private and non-government domains. Its principles and approaches are widely endorsed and applied by its broad stakeholder groups. At the same time, it also provides scope for diversity and tailoring of drug strategies and policies to meet specific needs and priorities.

Future needs

Our evaluation of the NDS as a policy framework has highlighted a number of needs in its principles and approaches. To further enhance the appropriateness, effectiveness and efficiency of the NDS as a policy framework, there is a need to:

- Ensure that the inclusive approach that has provided a balance of strategies across all relevant sectors continues to be adopted as the way to address drug issues in Australia
- Reduce confusion and enhance wider shared community understanding of the principles and goals that underlie efforts to reduce drug-related harm
- Replace the term ‘harm minimisation’ with a new term that more adequately captures the core concept of the NDS and its scope to address both the causes and consequences of drug use
- Address the balance of priorities, efforts and investment among supply, demand and harm reduction strategies and between illicit and licit drugs with a view to increase efforts in demand reduction and prevention strategies and giving more attention to licit drugs, particularly tobacco
- Strengthen existing partnerships and build and enhance links with related national strategies and policies (eg welfare reforms, taxation policy) and sectors (eg mental health, employment, discrimination) to address drug issues in Australia

- Increase community engagement and involvement of consumer groups, service providers, and local governments in decision-making, planning and resource allocation
- Broaden the evidence base for the NDS to recognise the contribution of disciplines outside the alcohol and other drug field (eg economics, social psychology, sociology, architecture)
- Continue and further encourage and strengthen the culture of evidence-informed policy
- Maintain and selectively enhance Australia's role in, and contributions to, regional and global drug efforts

Recommended improvements

Based on our findings and analysis of the needs and gaps, this section recommends future processes and ways to improve the outcomes of the NDS as a policy framework in the future.

Recommendation 1: Highlight and further develop a shared public understanding of the causes and consequences of drug-related harm and the need to retain the three pillars of supply reduction, demand reduction, and harm reduction, and consider replacing the term 'harm minimisation' with words which better communicate the need for prevention of drug use and drug-related harm.

Recommendation 2: Review investment among law enforcement, health and education sectors; supply, demand and harm reduction strategies; and illicit and licit drugs, and develop and apply funding mechanisms, jointly planned at Commonwealth and State and Territory levels, to make allocations that reflect the relative seriousness of the harms and costs addressed, and the availability of evidence-informed strategies and beneficial interventions for addressing them, in order to ensure that allocations provide cost-effective interventions across drug types and sectors.

Recommendation 3: Progress the development and implementation of a national prevention agenda, for example by:

- 2) using NDRI's work in documenting the evidence base for a prevention agenda, including the roles of law enforcement in prevention (Loxley *et al* 2004), as a point of departure for developing a formal prevention strategy and action
- 3) developing links between NDS and related sectors and fields to address the social determinants of health
- 4) working to implement contemporary understandings of the social determinants of harmful drug use intersectorally, between drug strategies and other areas of social programming

Recommendation 4: Encourage broader stakeholder engagement in policy processes, in particular, engagement with consumer groups, service providers, and local government, for example by:

- 1) building stronger engagement of the NDS with the education and corrections sectors, and enhancing links with related national strategies and policies (welfare reforms, taxation policy) and sectors (mental health, employment, discrimination)
- 2) identifying and developing structured processes for assessing the views of the broader public through public consultations, providing greater transparency in public policy development and involving more people in shaping the next NDS
- 3) disseminating policy-relevant evidence to the public to bridge the gap in public understanding of the evidence, and ensure that community consultation involves a better informed public and is more likely to meet the ideals of deliberative democracy
- 4) establishing mechanisms to provide feedback on continuing implementation and outcomes to stakeholders such as consumer groups, NGOs, and professional organisations

Chapter 5: Outcomes of NDS Programs

Introduction

The general goals of the national program initiatives developed using the principles and priorities of the NDS are to help improve public amenity, reduce drug use and drug related harm, reduce the supply of drugs, prevent harms caused by licit and illicit drug use, and ultimately improve health, social and economic outcomes.

These national program initiatives aim to improve the performance of the wider system by building capacity in the health, education and law enforcement sectors to better address drug-related harm. This includes interventions and programs that address the determinants of drug-related harm (eg laws, regulations, policies, prevention strategies and treatment services).

This chapter examines how these goals and aims have been attained by ten NDS initiatives. The following national initiatives were designated by the Project Working Group and the Department of Health and Ageing as within the scope of this evaluation on the basis that, during the period 2004 – 2009, they were developed using the principles and priorities of the NDS framework and funded by way of the CSFM or alternate funding sources, or explicitly implemented under the NDS framework but not associated with funding:

- National Cannabis Prevention and Information Centre (NCPIC)
- National Comorbidity Initiative (NCI)
- National Drug Research Centres of Excellence (NDRCEs) - National Drug and Alcohol Research Centre (NDARC), National Drug Research Institute (NDRI), National Centre Education and Training on Addiction (NCETA)
- National Drug Law Enforcement Research Fund (NDLERF)
- MCDS Cost Shared Funding Model (CSFM)
- National Drugs Campaigns: - Alcohol, Tobacco, Illicit Drugs (Phase Two)
- Community Partnerships Initiative (CPI)
- Non-Government Organisation Treatment Grants Program (NGOTGP)
- National Illicit Drug Diversion Initiative (IDDI)
- Amphetamine-Type Stimulants Grants Program (ATSGP)

Other elements of the program of effort

Of course, these ten programs are not the whole program of effort under the NDS. The reality is that a significant proportion of effort is not captured in these initiatives. Ongoing programs and services in law enforcement, treatment and prevention are the core business of many State and Territory efforts, and many agencies across the public, private and non-government sectors, not all of whom would be immediately identified as implementing the NDS in their sector, jurisdiction or locality, but actively contribute to Australia's capacity to prevent and treat problematic drug use.

Examples include continuing school drug education programs, and emergency counselling – for example, Lifeline, and community level policing of alcohol-related harm.

It is also noteworthy that the State and Territory criminal justice agencies are funded almost entirely from State and Territory budgets, whereas the health sector at that level receives substantial funding from the Commonwealth. One result of this is that drug law enforcement, particularly policing, has to be highly responsive to local needs and expectations, as well as operate within the broad national framework of the NDS. Another implication is that very little financial resources for drug law enforcement are provided, at the State and Territory level, through the NDS.

Recently, NDS programs have also been complemented by national funding of other programs, such as the Aboriginal and Torres Strait Islander Substance Use Program (2006-07), and in 2007 the expanded AOD services initiative under the COAG *National Strategy for Action to Overcome Violence and Child Abuse in Indigenous Communities*, and the *Improved Services for People with Drug and Alcohol Problems and Mental Illness* initiative (Improved Services), under the COAG *National Action Plan for Mental Health 2006-2011*, which complements the National Comorbidity Initiative.

Scope of the evaluation

The scope of the evaluation of these initiatives was discussed in detail with the PWG and DoHA's Drug Strategy Branch officers. Agreement was reached about the specific initiatives to be covered and their outcomes. It has been useful strategically to focus on the ten prominent initiatives that have been acknowledged as particularly important during the 2004-2009 phase of the NDS.

The evaluation has considered whether these initiatives implement evidence-based programs in an appropriate, efficient, and effective way, with sufficient penetration to achieve their goals at Commonwealth, State, Territory and local levels, and evaluate and disseminate results to inform future program and policy review.

On the basis of document reviews, informant interviews, and case studies, we have explored whether the initiatives have addressed the priority areas of the NDS. We have also asked if they used the best available evidence, influenced public perceptions, are adequately resourced, target specific sub-populations with special needs, gathered good data to monitor and review their performance, and widely disseminated the results to inform future policies and activities.

Data sources

Four sources of data were collected and compared: available program documentation, evaluations, literature and data reviews, and informant interviews and case studies.

Information available for assessing the outcomes of the specified initiatives was limited. Only five of the ten initiatives had undergone any form of evaluation during the current phase of the NDS, and only four were provided to the evaluators. Some of the largest, most expensive initiatives, for example the NGOTGP, had not been evaluated at the national level. Individual treatment services funded under NGOTPG have been monitored for compliance with funding agreements by the State and Territory offices of the Department of Health and Ageing.

The available data focussed on inputs, processes and outputs, with little data to connect the outputs to the outcomes. We applied program logic and contribution analysis to those initiatives that had not yet been evaluated and did not have an evaluation framework, in order to make explicit their inputs, processes, outputs and outcomes, based on the data available.¹⁵ Draft program logic models were used to assess how far the outcomes of these initiatives could be evaluated, and to specify inputs, outputs, processes and outcomes that could be assessed in future.

As the PWG directed, senior informants in government (including those responsible for developing, implementing and evaluating the initiatives), the research community, and the public and private sectors were interviewed to illuminate how far the initiatives were evidence-based and implemented at Commonwealth, State and Territory and local levels;¹⁶ whether the initiatives had sufficient reach and penetration to achieve their intended outcomes; and the extent to which

¹⁵ See Appendix H for proposed program logic models for NDS programs to be evaluated

¹⁶ See Appendix B for the list of informants

the initiatives had been evaluated and the results disseminated to inform future program and policy review.¹⁷

In addition, three case studies – Project STOP, the NGOTGP, and Tobacco Legislation – were chosen to illuminate the development, implementation and evaluation of NDS programs.

Contribution to NDS priorities

The NDS programs aim to improve the performance of the wider system by building capacity in health, education and law enforcement to address drug-related harm in accordance with the priority action areas of the NDS. This is a brief account of the ten initiatives nominated for this evaluation of the outcomes of NDS programs.

The ten initiatives have addressed priority areas of the NDS: (1) prevention, (2) reduction of drug use and drug-related harm, (3) improved access to quality treatment, (4) development of workforce, organisations and systems, (5) strengthened partnerships, and (6) identification and response to emerging trends. Each of these priorities has been addressed by at least one of the initiatives described below.

The NDS *Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003 – 2011* is the subject of a separate evaluation.

NCPIC

The NCPIC was established under the National Cannabis Strategy to inform the Australian population about the risks associated with cannabis use and to support drug services in addressing cannabis use. It is a consortium of drug and alcohol organisations led by NDARC, including NDRI, Orygen Youth Health, the Australian Institute of Criminology, NCETA, the Ted Noffs Foundation, and Lifeline Australia. Consortium members are responsible for providing information, support and capability in their areas of expertise. Its mission is to reduce the use of cannabis by preventing uptake and the harms associated with its use. The Commonwealth allocated \$14 million over four years, beginning in 2006-07, to NCPIC.

The products of the NCPIC include evidence-based community information on cannabis-related harms, prevention of its uptake and continuation of its use, and evidence based intervention to assist service providers to improve their responses to people experiencing cannabis-related problems. Work is under way to explore new models of delivering interventions via the telephone, web and post.

NCPIC's program of effort is chiefly applied to the priority areas of prevention, reduction of drug use and harms, and access to treatment.

National Comorbidity Initiative (NCI)

The NCI's aim is to improve service coordination and treatment outcomes for people with coexisting mental health and substance use disorders (often referred to as comorbidity). DoHA is responsible for implementing the NCI, with advice from a Comorbidity Expert Reference Group (CERG) of eleven members with expertise from AOD, mental health and general practice fields.

The purpose of the NCI is to raise awareness of comorbidity among clinicians and health workers, and promote examples of good practice resources and models; support general practitioners (GPs) and other health workers to improve treatment outcomes for comorbid clients; facilitate and improve access to resources and information for consumers; and improve data systems and collection methods in the mental health and AOD sectors to manage comorbidity more effectively.

¹⁷ See Appendices D & E Component 2 Interview protocols

In terms of the priority areas of the NDS, NCI seeks improved access to quality treatment for people with comorbid conditions, and development of workforce and systems for their treatment.

National Drug Research Centres of Excellence (NDRCE)

The National Drug Research Centres of Excellence (NDRCE) are funded by DoHA to provide research in drug-related issues. There are three research centres of excellence:

The *National Drug and Alcohol Research Centre* (NDARC), based at the University of New South Wales, conducts high quality research and dissemination to increase the effectiveness of treatment and other intervention responses to alcohol and other drug-related harm. In addition to its research and publications, NDARC is responsible for drug monitoring projects including the Illicit Drug Reporting System, the Ecstasy and related Drug Reporting System (EDRS) and the National Illicit Drug Indicators Project (NIDIP).

The *National Drug Research Institute* (NDRI), part of Curtin University in Perth, conducts and disseminates high quality research on primary prevention of harmful drug use and reduction of drug-related harm in Australia. In addition to projects such as the National Alcohol Indicators Project, review of National Competition Policy and Liquor Regulation, and a national project to translate alcohol treatment evidence into Indigenous services, NDRI disseminates its research nationally and internationally through journal articles, monographs, technical reports, books and conference presentations.

The *National Centre for Education and Training on Addiction* (NCETA), located in Flinders University in Adelaide, contributes to developing a skilled, sustainable AOD workforce and the capacity of organisations to manage alcohol and drug-related issues. Its research is supplemented by resource development activities such as Alcohol Action in Rural Communities, an information and resource package for responding to workplace AOD issues, and design of education and training materials for AOD workers.

NDRCE programs jointly address most of the NDS priority areas:

- NDARC – access to treatment, and response to emerging trends
- NDRI – prevention, reduction of harm, and response to emerging trends
- NCETA – access to treatment, and workforce development

National Drug Law Enforcement Research Fund (NDLERF)

The *National Drug Law Enforcement Research Fund* (NDLERF), established by MCDS in 1999, funds projects of national significance to facilitate research, evaluation and review of drug law enforcement and drug harm reduction outcomes, with the aim of preventing and reducing the harmful effects of licit and illicit drug use in Australia. The program is administered by a Board of Management with representatives from law enforcement agencies from all States and Territories; the AFP; the ACS; the Commonwealth Attorney-General's Department; the NDS Unit of DoHA; and a health agency from one of the States or Territories. NDLERF is funded by DoHA, and managed through an auspicing arrangement with the Tasmanian Department of Police and Emergency Management.

The role of NDLERF is to support the implementation of the NDS by commissioning research which leads to quality evidence-based practice in drug law enforcement, facilitating experimentation and innovation, and enhancing strategic alliances and linkages between law enforcement personnel, human service providers, and research bodies. The outcomes of its activities have been published in a substantial monograph series.

NDLERF's research work focuses on the priority area of prevention, reduction of harm, and partnerships, and supply reduction. It has been pointed out that much of the research funded by NDLERF has had a valuable operational or tactical emphasis. However, NDLERF has had

limited capacity to contribute to the core evidence base for effective drug law enforcement. NDLERF has provided some grants to the NDS National Centres of Excellence for drug law enforcement–related research, but this area is not a high priority for any of the National Centres.

NDLERF drug law enforcement research was the only supply reduction program included in the ten NDS initiatives reviewed for this evaluation.

Cost Shared Funding Model (MCDS-CSFM)

The *Cost Shared Funding Model of the Ministerial Council on Drug Strategy* (MCDS-CSFM) was adopted in 2002 to cost-share funding for projects of national significance in the AOD field to provide a forum for the Australian Government, State and Territory Governments and the NZ Government to fund projects of mutual and national interest concerning drugs; promote a consistent and coordinated national approach to research and projects; and fund projects equitably. The Australian Government provides 50% of the CSFM's funds, and the remainder is provided by the States and Territories calculated and adjusted yearly on a *per capita*. NZ contributes a fixed amount annually. DoHA is the fund holder responsible for collecting, holding and administering funds.

Some projects are managed by DoHA, but in other cases the lead agency may be a State health department, local government, or an appropriate special purpose agency. Examples of projects funded during the life of the CSFM include the Ecstasy and related drugs reporting system (DoHA); Monitoring the introduction of suboxone in Australia (NSW Health); the National AOD Workforce Development Strategy (DAO WA Health); Development of the information and resources on psychostimulants for frontline workers (Queensland Health); National guidelines for the management of drug dependency during pregnancy, delivery and the early development years of the newborn (NSW Health); Exploration of frameworks to control nicotine in Australia (DHS Victoria); National Local Government Drug Electronic Network (Brisbane City Council); Building Illicit Drugs Forensic Capacity across Australia (AGD); National Committee for the review of alcohol advertising (DHS Victoria); Indigenous AOD national train the trainer pilot program (DAO WA Health); the South Australian Pain Collaborative project – reducing inappropriate use and diversion of prescription opioids (DASSA); and the intentional misuse of pharmaceutical drugs prevention initiative (DHS Victoria).

CSFM funds a diverse range of programs in almost all areas of the NDS priorities.

National Drugs Campaigns

National Drugs Campaigns aim to increase the public awareness of the health impacts of drug use. They have provided young people, their families and communities with evidence and advice about responsible drinking, the harmful effects of smoking, access to treatment and the negative consequences of illicit drug use, and encouragement and support to parents to talk their children about drugs, alternatives to drug use, and ways to seek the help they need. The campaigns have been designed to normalise treatment for people with drug problems, rather than emphasising law enforcement.

Notable National Drugs Campaigns have included:

- the National Tobacco Campaign
- the National Safe Use of Alcohol Media Campaign
- the National Drugs Campaign – Illicit (now in its third phase)

National Drugs Campaigns have concentrated on the priority areas of prevention, reduction of drug use and drug-related harms, and access to treatment.

Community Partnerships Initiative (CPI)

The *Community Partnerships Initiative* (CPI) was developed in 1997 under the NIDS and the then Prime Minister's 'Tough on Drugs' policy. Since then, 380 community-based organisations have had projects funded through four instalments of the CPI, at a cost of more than \$31 million.

The CPI's aim has been to reduce drug use and drug-related harms through community projects that promote and support establishment of community-driven illicit drug prevention and early intervention initiatives to improve individual, family and community well being. The focus is on young people, but includes individuals and groups in the community who deal with young people in their social environments. For most of its life, the program has focused on illicit drugs, but also poly-drug use, and in some jurisdictions the problematic use of solvents and petrol sniffing. It has recently been re-profiled to concentrate on youth binge drinking. Projects seek to increase the capacity of communities to develop effective prevention activity in a self-sustainable way. Among CPI projects, those with multiple and flexible approaches (peer programs, parent based programs, basic life skills, job preparation, and recreational activities) have proved the most effective.

CPI projects cover prevention, reduction of harm, and community partnerships, previously in the area of illicit drugs, but recently redirected to binge drinking.

On 10 March 2008 the Prime Minister announced the \$53.5 million National Binge Drinking Strategy. The strategy comprises three measures to address the problem of alcohol misuse among young Australians:

- \$14.4 million to invest in community level initiatives to confront the culture of binge drinking, particularly in sporting organisations;
- \$19.1 million to intervene earlier to assist young people and ensure that they assume personal responsibility for their binge drinking; and
- \$20 million to fund advertising that confronts young people with the costs and consequences of binge drinking.

The Community Partnership Initiative has been re-profiled as part of this strategy to form the Community Level Initiative.

Non-Government Organisation Treatments Grants Program (NGOTGP)

The *Non-Government Organisation Treatments Grants Program* (NGOTGP) has been operating since 1997. Between 1997 and the end of the 2007-08 financial year the Commonwealth has allocated approximately \$291.2 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, to expand the NGOTGP over the next four years to better support families and youth.

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.

Treatment options available under the NGOTGP include counselling, outreach support, peer support, home detoxification, medicated and non-medicated detoxification, therapeutic communities, and in- and outpatient rehabilitation. Particular emphasis is placed on filling geographic and target group gaps such as women, youth, and families with children, co-morbidity, psycho-stimulant users and Aboriginal and Torres Strait Islanders.

NGOTGP by definition is devoted to the priority area of improved access to quality treatment.

Illicit Drug Diversion Initiative (IDDI)

The *Illicit Drug Diversion Initiative* (IDDI) program was implemented in 1999 by the COAG. The MCDS developed a nationally consistent framework for IDDI through its IGCD working groups and the ANCD. DoHA is the lead agency responsible for managing the implementation of the IDDI program.

The IDDI involves diversion of offenders by police or from the courts to assessment and referral to appropriate drug education, assessment or a diverse range of clinically acceptable drug treatment or counselling services, and waiving a criminal conviction for those who comply with these requirements.

It targets those charged with drug offences for the first time or who have little or no involvement with the criminal justice system, and those apprehended for use or possession of small quantities of any illicit drug. DoHA is the lead agency responsible for implementing the IDDI.

The Commonwealth, States and Territories share responsibility for funding and service delivery, assessment of treatment education, capacity building, and training.

IDDI is designed to achieve outcomes in the priority areas of prevention and reduction of drug use, foster partnerships between sectors, build capacity and provide training.

Amphetamine-Type Stimulants Grants Program (ATSGP)

The *Amphetamine-Type Stimulants Grants Program* (ATSGP) is a Commonwealth \$22.9 million one off grants funding round package which is part of the \$111.6 million in the 2007-08 federal Budget to “further combat illicit drug use” The ATSGP is the responsibility of DoHA.

It is designed to better equip services to meet the needs of ATS users. In addition to the \$79.5 million enhancement of the NGOTGP, the ATS package includes \$22.9 million over two years (2007-08 and 2008-09) for a treatment grants program to equip NGOs to tailor treatment and support services for ATS drug users – for example, infrastructure upgrades, better information and educational resources, or funding to engage staff with particular expertise in the treatment of ATS dependence.

In terms of the priority areas of the NDS, ATSGP seeks improved access to quality treatment.

Findings

NDS program outcomes had contributed to Australia’s capacity to reduce drug use and drug-related harm in line with the principles, objectives and sub-strategies of the NDS Framework. The NDS programs formed part of a broader system involving the complementary investments and activities of Government, non-government, private and community sectors. Investment in NDS programs has contributed to public understanding of drug issues and community knowledge and acceptance of drug treatment.

The NDS program outcomes have strengthened Australia’s capacity to address drug use and drug-related harms, through investment in:

- Strengthened partnerships and collaborations between levels and sectors of government and the public, private and not-for-profit service delivery sectors
- Effective prevention and early intervention
- Improved access to quality treatment
- Workforce development and structures
- Research and best practice resource development

- Program performance monitoring and evaluation
- Public acceptability

Strengthened partnerships

Collaboration has been critical to efficient and effective delivery of NDS program outcomes. The NDS initiatives have been developed and implemented using collaborative processes to deliver research, evidence and workforce training and education products that improved prevention and reduced drug use and drug-related harm. While the extent and nature of collaboration between Commonwealth, State and Territory Governments, NGO peaks consumer groups and the private sector varies across jurisdictions, it had been a major factor in achieving the intended reach and penetration of the initiatives.

Sectors responsible for programs and activities addressing broader system issues and social determinants have also contributed to the success of AOD specific investment. However, coordination of effort across governance and implementation structures remains a significant challenge. Of course, these challenges are not specific to the AOD field. Over the years, both here and abroad, attempts have been made to develop ‘whole-of-government’ responses to complex problems, with very few examples of success. This highlights the need for explicit, resourced structures and processes in research, policy activity, program implementation and evaluation to deal with complex issues in an integrated manner.

For example, to varying degrees Office of Aboriginal and Torres Strait Islander Health (OATSIH) and Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) are involved in NDS program resource allocation decisions across jurisdictions, but there is no formal mechanism for coordination with other sectors responsible broader strategic agendas, such as COAG, the National Preventative Health Taskforce, Closing the Gap on Indigenous Life Expectancy, the National Health and Hospitals Reform Commission, the Australia and New Zealand Policing Advisory Agency, and sectors responsible for services supporting the broader social determinants of drug-related harm.

In recent years, increased collaboration across jurisdictions and sectors has been critical to more efficient and evidence-informed allocation of NGOTGP resources, through joint assessment of funding applications needs and the use of evidence of effectiveness in planning, resource allocation and implementation of programs.

In the case of the NGOTGP 2007-08 funding round, all State Reference Groups (SRGs) (the assessment panels) involved State or Territory representatives and in some jurisdictions representatives of NGO peak bodies. Some jurisdictions used State or Territory planning data (needs, target populations, and system capacity) to inform NGOTGP allocation processes, and some States and Territories had collaborated with their counterparts in the Commonwealth to identify indicators of performance and data collection mechanisms to resource, implement and monitor the performance of local systems of treatment and care. This collaboration has also been enhanced with sustained investment in relationships between DoHA NGOTGP State and Territory project officers and NGO peaks or representatives through regular formal and informal contacts.

The NDRCE have increased the amount of funding by partnering with a range of funders in the private and public sectors through state, national and international competitive grants processes. The evaluation of the NDRCE found that, while they had developed collaborative relationships within the research and academic sectors, more work was needed to strengthen partnerships across a range of organisations in the AOD sector, including research bodies and groups and the service delivery sector. The evaluation noted, and informants confirmed, that while each centre initially had its particular focus (NDARC treatment, NDRI prevention, and NCETA workforce training and education), this separation blurred as the centres grew. Their areas of interest often

overlap. Informants agreed with the evaluation finding that the NDRCE were generally regarded as working in a complementary fashion and saw value in strengthened partnerships to achieve their outcomes more efficiently and effectively.

A lack of integration between AOD and mental health services has led to each type of service focusing on its core client group, resulting in many clients 'bouncing' between services and/or falling between the cracks. The recently established National Comorbidity Collaboration consisting of Commonwealth and state and territory drug and alcohol and mental health officials has provided the opportunity for shared priorities and interests in a whole-of-government way.

Public acceptability

An important contribution of the NDS initiatives has been to increase public awareness, understanding, and acceptance of the objectives of the NDS.

Over the years, implementation of the NDS Framework has supported development of a climate of acceptance of the evidence for treatment services and in many circumstances the appropriateness of providing drug treatment rather than law enforcement responses to people with drug problems. While there are community lobby groups who do not support the NDS objectives, the community is now more informed about drug issues and accepting of treatment and treatment services.

The presence of quality prevention, diversion and drug treatment services in the community contributes to public acceptability when they involve government, non-government and private partnerships, maintain the bipartisan commitment to community education, and provide data and information about results to support a long term outlook.

The NDSHS asks questions about the acceptability of drug-related policies. As outlined in Chapter 2, the Australian community generally supports evidence-based approaches to reducing the problems associated with the use of drugs, both licit and illicit.

The National Drugs Campaigns have delivered health and safety messages and given information about referral to treatment and support services, and were designed to normalise drug treatment for people with drug problems rather than emphasising law enforcement. They have provided young people, their families and communities with evidence-based advice about responsible drinking, the harmful effects of smoking, access to treatment and the negative consequences of illicit drug use, and encouragement and support to parents to talk their children about drugs, alternatives to drug use, and ways to seek the help they need. The evaluation of the National Drugs Campaign – Illicits: Phase Two demonstrated that its messages were credibly and effectively conveyed. The Phase Three evaluation found that the NDC had made it easier for parents to talk to their children about drugs, and 78% of 13-24 year olds felt the campaign had influenced their resolve to think more about illegal drugs and their consequences.

CPI delivered community-driven projects to promote and support prevention and early intervention initiatives to reduce drug use and related harm. In 2008 the CPI was re-profiled as part of the new National Binge Drinking Strategy.

The NCI produced mental health and alcohol comorbidity resources and information for consumers of drug services and their carers.

More recently, the NCPIC was established under the National Cannabis Strategy to inform the Australian population about the risks associated with cannabis use and support drug services in addressing cannabis use.

Evaluation of the NDRCE found that their work was widely published and critical to increasing political and community awareness of drug issues and trends.

The level of understanding among politicians and the community about the individual and community benefits produced by the NDS, together with epidemiological data and program outcome information, should be actively maintained and fostered.

Effective prevention and early intervention

Our evaluation of the outcomes of the NDS programs highlights the need for sustained community education and information about drug problems and ways to address them.

Funding for the National Drugs Campaigns, CPI, NCI and NCPIC has progressively increased system capacity for and community access to a range of health promotion and prevention resources.

The design of the National Drugs Campaign – Illicits was based on formative research with young people aged 13-24 years and pre-testing of media messages with young people, parents and the National Drug Strategy Reference Group for Aboriginal and Torres Strait Islander Peoples. The evaluation of Phase Two showed that the campaign was effective in reaching its target audiences and reinforcing the negative consequences of using cannabis, amphetamines and ecstasy. It also demonstrated credible alternatives to drug use and encouraged discussions about illicit drugs among young people and their parents.

Evaluation of the CPI in 2003 found that the strategies implemented were effective in delivering to the community the intended outputs of education about illicit drugs, information resources, training and community development projects. These strategies have therefore made significant progress towards achieving the CPI's aims. However, the evaluation did not assess how far the projects had achieved their long term outcomes - macro-level behaviour change - because it was too soon to assess the long term effects. On the basis of the 2003 evaluation, funding for the CPI was continued until 2007-08. In March 2008, the CPI was re-profiled to become part of the (\$53.5 million) National Binge Drinking Strategy.

Reduction of drug use and related harms

The NCPIC and the IDDI programs were designed to increase system capacity to reduce drug use and drug-related harm. The products of the NCPIC include evidence-based community information on cannabis-related harms, prevention of its uptake and continuation of its use, and evidence based intervention to assist service providers to improve their responses to people experiencing cannabis-related problems. While it was too early in the implementation of the NCPIC for an evaluation to take place, our analysis indicates that these products are in line with their intended outcomes to reduce drug-use and related harm.

The evaluation of the IDDI in rural and remote Australia noted that, since its inception in 1999, the IDDI has led to development of at least 22 programs in rural and remote Australia, thereby increasing access to police and court diversion and referral to education, assessment, brief early interventions or treatment. There is good evidence that diversion programs are effective in minimising harm by diverting young people experimenting with illicit drugs from the criminal justice system (Bull 2005).

The evaluation of the IDDI in rural and remote Australia showed that it had increased numbers of diversions over time, but the data available were insufficient to assess the extent to which it had increased the number of illicit drug users who were diverted into drug education, assessment and treatment, or had reduced the number of people who were incarcerated for use or possession of small quantities of illicit drugs. Without shared indicators and mechanisms for data collection across the criminal justice and health sectors, the evaluation of the implementation of the IDDI was unable to assess the program's outcomes and effects. Although there were no outcome data available to show that the IDDI had reduced drug use, its outputs were in line with its intended aim of reduction in illicit drug use and related harm.

The evaluation conducted by the Australian Institute of Criminology (Payne *et al* 2008) demonstrated positive results of the IDDI in reducing the level of offending among people who received interventions through police diversion. As the authors point out:

As a whole, the findings were generally very positive. Across all jurisdictions, the majority of people who were referred to a police-based IDDI program did not reoffend in the 12 to 18-month period after their diversion. In most cases, those who did reoffend did so only once during that time. Perhaps the best indication of changes in criminal behaviour after diversion comes from comparing the pre and post-offending records of each individual. Again, the results were very positive, particularly in relation to those individuals who had a prior offending history. Among this group, the majority were apprehended for either no or fewer post-program offences than before, and this finding was consistent across all jurisdictions. Similarly, of those individuals who had not offended in the 18 months prior to diversion, the majority (ranging from 70% in Tasmania to 86% in New South Wales) remained non-offenders for an equal period after diversion (pp. x-xi).

Senior informants regarded the IDDI as adequately resourced, but lacking the capacity to tailor responses to local legislative and regulatory contexts and service delivery.

Improved access to quality treatment services

NCI, ATSGP, the IDDI and NGOTGP initiatives aimed to increase the capacity of the NGO sector to provide quality treatment services.

NCI undertook a range of projects to address quality improvement issues, workforce development and activities to support Aboriginal or Torres Strait Islander people experiencing comorbidity, or people working with these clients. In the case of the NCPIC, work is under way to explore new models of delivering interventions via the telephone, web and post.

ATSGP provided one-off grants over two years to NGOs that offered drug treatment services to increase their capacity to cater for and treat ATS users including infrastructure resources and equipment upgrades and specialist expertise. The ATSGP outputs include infrastructure upgrades, program improvements, more information, training and educational resources and staff with particular expertise in the treatment of ATS dependence.

IDDI funded treatment places in order to increase the capacity of NGO drug treatment services to cater for clients who were diverted from the criminal justice system to early intervention and treatment services.

NGOTGP included providing additional illicit drug treatment places across a range of treatment options such as counselling, outreach support, peer support, home detoxification, medicated and unmedicated detoxification, therapeutic communities and residential and non-residential rehabilitation.

These initiatives are one element of drug treatment service system funding. They complement State and Territory funding and other sources of Commonwealth funding to NGO drug treatment services. For example:

- In 2007-08, additional resourcing 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* (Improved Services) initiative which 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*.

- NGO programs such as *OzCare* residential AOD services in Queensland, or the activities of *Turning Point* in Victoria, and many other such services across the jurisdictions.

While NCI, ATSGP and NGOTGP had not yet been evaluated, our analysis indicated that their outputs were in line with their intended outcomes to reduce drug-use and related harm.

The findings of our case study on the NGOTGP illuminated the efficiency and effectiveness of aspects of the NGOTGP processes, and how these processes linked to the NGOTGP outputs and intended intermediate outcomes. We discuss the case study findings in some detail in the next two subsections because they give valuable insight into NDS program funding processes and their potential contribution to the reach, penetration and specificity that will achieve improved access to quality drug treatment.

Evidence-based continuum of treatment services

Evidence of the effectiveness of drug treatment services justifies support for an integrated continuum of drug treatment services, including voluntary and mandatory treatment, withdrawal services, outpatient treatment, residential rehabilitation, therapeutic communities, relapse prevention, counselling, care planning and management, and aftercare/community liaison.¹⁸

The NGOTGP 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, increased counselling, outreach, care planning and follow-up. The NGOTGP funded a range of services for which the evidence was clear.

The early funding rounds were predominantly in abstinence-based services - specifically residential rehabilitation and unmedicated detoxification. 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 across the spectrum of drug treatments.

Informant views, and our own experience in the sector,¹⁹ indicate that potential capacity exists among AOD NGO providers to deliver services, but the need remains to build an appropriately skilled and qualified staff and the organisational capacity to deliver the full range of services that are both effective and cost-effective.

Service reports and informant data indicated that the NGOTGP provided little or no funding to aftercare and relapse prevention modalities, even though there is good evidence that these modalities increase the effectiveness of the continuum of care. The recent funding round allocated resources to a prison-based service using a therapeutic community model - an example of NDS program funding to target a high needs group.

In summary, we found that treatment initiatives had been developed in line with research and evidence on effective interventions, and with knowledge of constraints and opportunities at the regional or local level, but limited data were available to quantify improvements in access, reach and penetration of treatment initiatives. The needs of target population and sub-population groups and gaps in the system's capacity for service delivery have been progressively addressed through NDS initiatives, planning and funding allocations:

- Resources for illicit drug treatment services have been allocated based on sound processes which rely on collaboration at the jurisdictional level to deliver reasonable information about local needs, gaps, and opportunities and constraints in the AOD system. There is a need to increase capacity for collaborative needs-based planning, more integrated seamless service delivery, data collection, performance monitoring and review

¹⁸ See Volume 2 for literature reviews on AOD models of care

¹⁹ eg ACT Health (2007) Siggins Miller Report on the *External Review of the ACT AOD Service System*

- NDS drug treatment funding programs had focused on some treatment modalities within an evidence-based comprehensive model of care, (including residential rehabilitation and unmedicated detoxification, psychosocial therapies, counselling and care planning), but there were some gaps in modalities for which the evidence for cost effectiveness is clear (including aftercare, relapse prevention, opioid-pharmacotherapies and smoking prevention programs).²⁰

Need-based resource allocation processes

Drug-related harm is complex in its aetiology and multi-factorial in nature. As a result, capacity to draw evidence and lessons from the evaluation, history, evidence of effectiveness and return on investment of a range of interventions is currently limited. We found the concept of evidence-informed resource allocation and its practice was well documented, and senior informants believed it a desirable approach. However, administrative and evaluation results for monitoring and reviewing programs and interventions were not readily available. Few initiatives had been evaluated during the current NDS, and the evaluations that were made focused primarily on outputs.

The literature on resource allocation indicates that treatment initiatives have been developed in line with research and evidence on effective interventions and with knowledge of constraints and opportunities at the regional or local level.²¹

Over the life of the program, the NGOTGP and the AOD sector have made progressive improvements in equity, shared responsibility, comprehensiveness, recognition of the broader environmental influences that shape our health, planning and monitoring, transparency, accountability and reporting, a culture of quality improvement, public participation, and delineation of roles and responsibilities of federal, State and Territory governments, and the private and non-government sectors.

The formula used for determining the allocation of NGOTGP resources takes into account the size of the population and socio-economic indicators, cross-cultural factors, community health and isolation. We found that the NGOTGP increased funding of the number and type of services available and improved the reach and penetration of the program from 2003-2008. However, the availability of NGOTGP specific output data to quantify and describe NGOTGP specific episodes of care, unmet need, and the reach and penetration of the program limits the capacity to assess, monitor and review how far resources were allocated to an evidence-based continuum of treatment services, or to those most in need.

Workforce development and structures

An appropriately sized, skilled and qualified staff is critical in sustaining good practice and ensuring effective delivery of evidence-based interventions. The capacity to implement programs as planned has been limited by staff shortages and turnover, and skill gaps in the broader system and in the AOD prevention and treatment sectors. The extent of investment in workforce training and education programs and resources is indicated by the number and quality of outputs in this area. The NDS contribution to training programs and resources is well-recognised and highly valued.

Senior informants consistently said that training programs at Certificate IV level had been the focus of the AOD sector in recent years. NCETA had a specific responsibility for developing education and training resources, along with its important work on broader workforce development strategies. The outputs of NCETA, NDRI, and NDARC were effective in improving the number of appropriately skilled and qualified people. The missing area of investment was recruitment of new workers, retention of the existing AOD workforce, and investment in modelling to estimate future needs and identify strategies to ensure future supply of an appropriately skilled and qualified workforce.

²⁰ While smoking cessation programs have very high cost effectiveness, they are of limited value at the population level owing to the low levels of uptake of the cessation programs and the high levels of relapse. In fact, there is some evidence that cessation programs are counterproductive at the population level (eg Chapman 2007).

²¹ See Volume 2 for the literature review on AOD resource allocation

Efforts had been made to increase the capacity of the NGO AOD sector to recruit appropriately skilled and qualified staff, but limited workforce capacity in the AOD sector and more broadly in the health and human services sectors has reduced the efficiency with which services have been able to recruit and retain staff. There was a shortage of health workers in general, and of GP prescribers and AOD specialist clinicians in particular. Some senior informants thought that, over time, the level of education and qualifications of the personnel retained in the drug treatment sector had decreased. It used to be that the majority had tertiary qualifications. By contrast, the educational level in the police services increased over the same period.

Heightened understanding of substance abuse and mental health comorbidity has drawn attention to the importance of cross-sectoral services. This is developing reasonably well between the substance use and mental health sectors, but most other curative activity happens in mainstream rather than AOD specialist facilities. GPs and the staffs of community health centres, hospital emergency and other departments continue to provide the bulk of health sector responses. In parallel, general duties police officers, rather than those specifically trained for drug crime, are the front line for alcohol and drug misuse in the community. Further workforce development should attend to the needs of generalists who deal with substance abuse and its consequences.

In recognition of the importance of cross-sectoral services, the Cross Sectoral Support and Strategic Partnership (CSSSP) project has been funded through the COAG initiative, *Improved Services for People with Drug and Alcohol Problems and Mental Illness*. This project is designed to complement the capacity building grants program, and involves funding non-government AOD peak bodies (or equivalent state-based support organisations) to assist non-government AOD treatment services to build partnerships with other health sectors, identify workforce development and training opportunities and to undertake service improvement activities. There was strong support among informants for building the capacity and profile of specialist AOD clinicians in the workforce. Many informants identified the need for competitive pay and conditions, incentives and benefits to be offered by government and NGO service providers. At the system level, the demand for nurses across all sectors and fields is high, and the AOD sector is less attractive than some others. An unintended negative consequence of MBS items for psychology services in mental health has been the loss of psychologists from public sector agencies to more lucrative arrangements in private sector mental health services.

Substantial work was done on a workforce strategy in 2005 on behalf of the IGCD, and endorsed.²² The strategy was recommended to the States and Territories for consideration, but no significant implementation steps or outcomes were realised. Since then, some States and Territories had developed their own AOD workforce strategies, relying on partnerships and collaborations across sectors. In recent years, the AOD NGO peaks had increased their roles in workforce development, with peak bodies now operating in all six States but not yet in the NT or ACT. In the ACT, the Territory Government takes it upon itself to support the AOD NGO sector through joint planning, workforce networking and other collaborative activities.

Effective resource allocation depends on investment in organisational and workforce capacity (ANCD 2005). In other areas of the health system (such as mental health or aged care), workforce modelling studies have provided the sector with analyses to inform investment in the short, medium and longer term, in this critical area of capacity and sustainability. Based on the 2008 scoping paper NCETA prepared for an IGCD workshop, which estimates future needs and identifies strategies to ensure the future supply of an appropriately skilled and qualified workforce,²³ the recent initiative of IGCD to commission a new national workforce development strategy has the potential for better outcomes.

²² See the case study in Component 3.

²³ Roche AM, Pidd K (2008). *National AOD Workforce Development Strategy: Scoping Paper*. Prepared for the IGCD. Bedford Park: NCETA.

Identification and response to emerging trends

The CSFM projects, NDRCE, NDLERF, NCI, and more recently NCPIC have delivered a range of research, data and evaluation outputs that have contributed significantly to Australia's capacity to monitor, identify and respond to emerging drug trends, inform the development of its workforce training education and best practice resources, and develop evidence-informed policy, strategies, and resource allocation to programs, initiatives and projects.

The recent NDRCE evaluation, and our informants, both acknowledged the capacity of the Drug Research Centres to produce expert advice about emerging trends at short notice. Their work had been widely published and highly valued in the international drug research arena, and made a fundamental contribution to knowledge in most of the priority areas of the NDS.

We also collected and analysed evidence on the volume and quality of their research publications drawn from the annual reviews of the three Centres by their parent organisations, the University of NSW, Curtin University, and Flinders University. In the period 2004-2008, NDARC published over 580 research documents, NDRI 290, and NCETA 100. These outputs demonstrated that all three Centres meet national standards for research quality and productivity. The impact of NCETA on the national AOD field has grown substantially over the past five years; NDARC has a well established international reputation for research excellence; and NDRI is gaining international recognition in its areas of expertise.

Experts in the drug law enforcement field have drawn attention to the fact that much of the currently-available data about emerging trends, while useful, does not adequately capture some important areas, including the harms—both tangible and intangible—created by alcohol and other drugs in terms of crime, the community, public safety and amenity. NDS research resources could usefully be directed towards identifying and quantifying these 'hidden harms'.

The evaluations of CSFM and the NDRCE recommended that more use be made of out-of-session and web-based circulation of reports and updates, and dissemination processes improved.

The CSFM evaluation found that there had been larger investment in health than law enforcement projects, and recommended that this be redressed in future allocation of project funds. While we support this recommendation, we believe that one-off CSFM projects are not the appropriate vehicle for developing the core evidence base for drug law enforcement, nor for improving the role of law enforcement agencies in identifying and developing responses to emerging trends. We believe that work is needed to develop monitoring and research capacity in drug law enforcement. This needs to include an emphasis on research infrastructure as well as project activities.

Very few of our informants felt well informed about NDLERF. A number of researchers felt that the 'hands-on' approach of the senior representatives of police agencies (who make decisions about NDLERF funding) did not produce optimal research outcomes because they did not use appropriate research criteria in approving funding. The Department of Health and Ageing provides approximately \$1.4 million per annum to NDLERF, most of which is expended in the form of research grants. Senior informants from the policing sector have advised that studies funded through NDLERF have been valuable at the operational and tactical level, but do not fill the role of broad-based research that has the potential to improve the core evidence base for drug policing. It is for this reason that we recommend that new NDS resources be directed at improving the research infrastructure for drug law enforcement, and that this occur on an ongoing basis rather than as one-off funding.

There was consensus among senior informants on the need for law enforcement to have greater capacity in evidence-informed responses to drug trends and issues on the ground through workforce training, education, policy and practice, and specific research and evaluation expertise.

Policy and practice relevant research

Both the NCI's and the NCPIC's research-related outputs are designed to be disseminated among target populations and groups. Their work is system interventions designed to contribute directly to prevention, reducing drug use and drug related harm quality treatment, and strengthening partnerships.

One of the NCI's objectives involves developing resources and system enhancements to improve data systems and collection methods within the mental health and AOD sectors to manage comorbidity more effectively. Another involves facilitating resources and information on comorbidity for consumers of drug services and their carers. The NCI's research related outputs are in line with its intended outcomes but the initiative had not been evaluated.

The NCPIC's activities focus on providing community access to information on cannabis and related harms, the uptake, prevention and continuation of cannabis use, and supplying service providers with evidence-based interventions to respond to people experiencing cannabis related problems.

The evaluation of the NDRCE found many illustrations of the relevance of their work to policy and practice nationally. They included dissemination of findings, high level research involving rigorous methods, best practice guidelines and programs, information and education resources, and maintenance and coordination of monitoring systems.

Research, best practice and education resources

There have been major successes in the AOD field as a result of the application of evidence to policy and practice, including improvement in the quality of the techniques for drug treatment and secondary and tertiary prevention as a result of research, its effective dissemination and the development of training resources. However, still more could be done to achieve evidence-informed responses to drug trends.

As discussed above, the extent and depth of research conducted in Australia on alcohol and other drug epidemiology and treatment has been one of the great successes of the two decades of operation of the NDS. Central to this success has been the development of research capacity, particularly through the National Drug Research Centres of Excellence. Large numbers of researchers have been trained, and the Centres have been successful in attracting external, competitive research funds. In contrast, the area of drug law enforcement research has received very little attention either through the NDS or other entities. This, combined with some inherent challenges in criminal justice research, is one of the reasons for the relatively shallow evidence base underlying criminal justice interventions, particularly policing, under the broad scope of the NDS. A start needs to be made on developing the research infrastructure required to remedy this situation.

Integration of research capacity

Research that informs policy and practice is increasingly seen as continuous across prevention, treatment and system capacity. Accordingly, the need for a more coherent research program was highlighted in the report of the former NDS National Drug Research Strategy Committee. All the data sources for this evaluation confirm that a longer-term, more strategic national research program is still needed. While our informants were very aware of the activities and achievements of the three NDS funded research centres, they pointed out that a large amount of high quality research is also done in other research environments and funded by other bodies. Examples included the work of Turning Point in Melbourne, QADREC in Brisbane, the burden of disease team in the School of Population Health at the University of Queensland, AIHW, and university based scholars funded directly by the ARC, NHMRC, and the Criminology Research Council. They urged more effective dissemination, and development of new processes for better communication and interaction among AOD researchers and research organisations.

Implementation of the recommendations of the evaluations of MCDS-CSFM and the NDRCE will improve their efficiency and effectiveness. These evaluations also identified the challenge of disseminating research findings and engaging with a wider range of research users. In line with the recommendations of both evaluations, there was much discussion of the need to maximise the return on current and future investment by delivering a more coordinated strategically-focused research-to-practice effort.

Efficiency and effectiveness

We found that the initiatives under the NDS had contributed to increases in the availability of evidence-based programs (national and State and Territory-based drug-specific treatment programs, new legislation, published guidelines and research, industry/government partnerships, and new data collections).

They contributed to increasing the number and types of prevention and treatment services, filling some service delivery gaps and gaps in an evidence-based continuum of drug treatment and care (including additional residential rehabilitation beds, increased counselling, outreach, care planning and follow-up), positive changes in many drug use trends, and in attitudes towards drug use and the acceptability of drug treatment.

While NDS program outcomes as a whole were appropriate, the efficiency and effectiveness with which they were delivered was limited by broader system and AOD sector specific issues including the shortages of generalist and specialist workers discussed above, and limited data to inform performance monitoring review, evaluation and its dissemination.

The balance of investment in NDS programs

Even though alcohol and tobacco produce 92% of drug-related mortality (Begg *et al* 2007), between 2004 and 2007 there was a greater investment in prevention and treatment programs to address illicit drug use and related harms. In 2008, the focus shifted towards licit drugs with announcements of a \$53.4 million strategy to reduce binge drinking and funding for the reinvention of the National Tobacco Strategy and Indigenous Control Initiative totalling \$28.5 million. This rebalancing of investment across licits and illicit is in line with the NDS Framework commitment to a comprehensive and balanced approach to reducing drug use and related harm.

Consistent with the bipartisan commitment to the NDS Framework's comprehensive approach to drug-related harm, in 2004/05 governments outlaid \$5.3 billion on supply reduction, demand reduction and harm reduction (or between prevention, treatment and law enforcement), a large proportion of which was expended on the routine operations of health and law enforcement agencies.

Despite efforts under the NDS and the longstanding recognition of the need to balance investment across prevention, treatment and law enforcement, the balance continues to be in favour of law enforcement, especially around illicit drugs. As discussed in Chapter 4, this imbalance also represents a mismatch between the sources of the social costs of drug abuse and where government funds are expended.

Based on the financial data available, our analysis of the investment in the ten NDS initiatives from 2004 to 2009 indicate that \$411 million of the total investment of \$461 million was directed towards illicit drugs. More than 50% of the total allocation to initiatives to reduce illicit drug use and related harm was for the IDDI, and more than 25% percent was for the NGOTGP, including an increase in NGOTGP funding for the period from 2008 to 2011.

The NDS Framework stresses the importance of harnessing the research evidence on the effectiveness and cost-effectiveness of interventions addressing drug use and drug-related harm. This principle has been implemented to a significant degree, but some interventions for which the strongest evidence base exists have not been systematically implemented. This includes, especially, the use of the taxation policy instrument to reduce alcohol and tobacco consumption at both the population level and among particular population sub-groups.

Increased efforts and resources would also help address more effectively the needs of Aboriginal and Torres Strait Islander peoples through ATSIPCAP, and those in correctional facilities through the NDS Corrections Drug Strategy.

Existing program evaluations

Most evaluations undertaken between 2004 and the present (with the exception of the National Drugs Campaign - Illicits: Phase Two), evaluated output rather than outcomes. This is understandable given the early stage of program implementation and the lack of consistent data indicators and data collection instruments. The terms of reference of the evaluation of the MCDS-CSFM specified an evaluation of processes (distribution of funding, management, and administration).

Evaluations of the previous National Drugs Campaign - Phase One (and other specific studies) were used to inform development and implementation of Phase Two. The evaluation of the Phase Two Campaign had evaluation built in from the beginning, with clearly defined indicators of performance specified in terms of intended outcomes data and investments in data collection. The National Drugs Campaign - Illicits: Phase Two was implemented as planned and when evaluated it was found to be efficient and effective. It provides a good example of the value in building evaluation in from the beginning and of developing consistent performance indicators and data collection instruments as an essential part of the program design.

This is an example of good evaluation practice that was not followed in the evaluation of the IDDI, which was limited by the insufficient quality, usefulness and range of data on program outputs, and the absence of data on its outcomes. The data systematically available to quantitatively assess national access, reach and penetration of the IDDI was limited.

In the case of the NGOTGP, performance reporting data varied greatly among organisations, States and Territories. More consistent reporting performance data will be collected in future to support evaluation. Criteria for reporting were revised in Round 3 contracts with funded NGOs in order to achieve greater uniformity in agency reporting against a set of performance indicators.

Our NGOTGP case study indicated that while services provided data to the AODTS-NMDS (in compliance with their service agreements), the quality of outcome data at the program level was variable, and its availability limited. In the case of Project STOP, the availability of quality data and mechanisms to collect it were limited. The data available to inform planning, future resource allocation, review and evaluation was also limited. Effective and efficient evaluation requires investment in high quality administrative performance data on outputs and outcomes and the capacity to analyse performance data about variations in implementation that may affect the success of the implementation of the initiative within and across jurisdictions.

In the case of initiatives for which a sound evidence-base has been established (for example, NSPs, diversion of offenders from the criminal justice system, and drug treatment and care services), regular monitoring and review of program performance are important quality improvement processes. Where the quality, utility and accessibility of the data required for monitoring program delivery elements are limited, the capacity for quality processes such as review, reflection, learning and program changes based on relevant data is reduced or lost. If the initiative is innovative (as in the case of Project STOP), it is important to identify at the outset a clear program logic, review and reflection points, data items and data collection mechanisms.

Performance monitoring and evaluation

It is important to monitor program performance to provide greater understanding of the extent to which the NDS and complementary are implemented as planned and have adequate reach and penetration to achieve their intended outcomes. Program monitoring and evaluation supports the implementation of initiatives in line with best evidence and contributes to growing the knowledge base regarding the impact of different sub populations and contexts on the achievement of the desired outcomes for clients, families and communities.

Program evaluation is currently limited by the failure to identify an explicit program logic as an integral part of program design. These issues could be addressed by establishing a clear logic linking inputs, processes, outputs and outcomes and specifying data required for evaluation at the beginning.

Capacity to collect data, report on program performance, and use these results to review and improve service and system level performance has been limited. The available administrative data (such as progress reports and AODTS-NMDS) are confined to processes and outputs (activities). In order to inform a national evaluation and monitoring, it is necessary to identify relevant data indicators, and ensure that collection instruments include measures that are able to assess the program outcomes and impacts.

Efficiencies would accrue if reporting requirements were integrated across complementary funding streams that resource the same type of service episode and client, and could be achieved by identifying a set of common performance indicators across all treatment funding streams, and streamlining, clarifying and improving the consistency of data collection mechanisms and tools.

Evaluation reports on those NDS initiatives that had been evaluated had been disseminated among those stakeholders most closely associated with the initiatives, but with some prominent exceptions such as the National Drugs campaigns, dissemination to the broader AOD sector had not commonly occurred, and as a result little use was made of evaluation results to review and develop future initiatives. Informants commented that web-based dissemination of evaluations would increase capacity to reflect on service delivery and make changes to improve performance.

Steps to enhanced efficiency and effectiveness

The efficiency and effectiveness of the NDS program outcomes could be enhanced by:

- integration of the existing research effort across the key government, NGO and independent AOD research groups and projects, to avoid duplication and form partnerships that increase capacity to translate research into practice
- integration of treatment services across a continuum of care and care providers
- strategies to recruit and retain a skilled and qualified AOD workforce, in the face of a looming crisis in resourcing health and welfare services into the future
- continued efforts to balance investment across licits and illicit in line with the Framework commitment to a comprehensive and balanced approach to reducing drug use and harm
- capacity for law enforcement research, including evidence-informed responses to drug trends through workforce training, education, policy and practice, and specific law enforcement research and evaluation expertise
- capacity to monitor and report on system performance through better methods for data collection, monitoring of performance, and a set of common performance indicators
- evaluations built in from the beginning of programs, and measures identified that can assess outcomes and effects
- investment in performance monitoring and quality processes to ensure the program remains evidence-based at the point of delivery and monitoring

- dissemination of the lessons from practice and evidence for what works, particularly in the areas of workforce planning and development, law enforcement, and delivery of health and education services

Future processes and improvements

We recommend these future processes to improve the outcomes of programs:

Recommendation 5: Further integrate treatment services and pathways across the government, non-government and private sectors, and encourage increased investment in comprehensive models of evidence-based interventions, for example by:

- 1) working collaboratively across sectors to develop referral pathways and integration of care, through government and non-government provider co-location, coordinated referral pathways, and shared care arrangements to meet the clinical and non-clinical needs of clients
- 2) increasing capacity across State and Territory, non-government, and private sectors for more collaborative needs-based planning, funding allocation, performance monitoring, and review processes

Recommendation 6: Develop a strategic approach to AOD workforce development to meet current and future needs, for example by:

- 1) addressing structural issues of national concern such as more competitive employment conditions in the AOD sector, better clinical supervision and mentoring, and incentives, continuity of entitlements across government, non-government and private providers, and funding for medical, nursing and allied health specialist training in AOD-related conditions
- 2) identifying strategies to ensure a supply of appropriately skilled and qualified workers (such as enhancing their scope of practice, and providing MBS items for allied health professionals engaged in the AOD sector)
- 3) identifying strategies to ensure a supply of appropriately skilled and qualified Aboriginal and Torres Strait Islander and CALD AOD workforces
- 1) using NCETA's central role to focus on strategic workforce development and modelling to estimate future needs, in collaboration with other bodies, including some of the State AOD peaks and State and Territory AOD agencies

Recommendation 7: Acknowledging the significant volume and quality of Australian AOD research output, further enhance national drug research capacity, for example by:

- 1) developing a coherent national drug research strategy and implementation program (perhaps based on the report of the former National Drug Research Strategy Committee)
- 2) addressing the lack of NDS-supported infrastructure for drug law enforcement research (including dedicated researchers and research centres)
- 3) enhancing collaboration between NDS national research centres and other drug research groups and projects

Recommendation 8: Increase capacity for performance monitoring, review and evaluation to inform future investment, for example by:

- 1) developing an evaluation framework (literature review of existing evidence, program logic, contextual factors, performance indicators, data items and mechanisms for collecting them) as an integral part of the design of new programs
- 2) identifying and developing data collection mechanisms
- 3) training staff to collect and use data to monitor the performance of programs, to ensure that programs remain evidence-based and are in a position to improve the quality of their services
- 4) undertaking regular program review and improvement processes based on performance data

Chapter 6: NDS Advisory Structures

Introduction

This Chapter considers the roles and workings of the advisory structures that inform the development and implementation of the NDS and the extent to which they have achieved their intended intermediate outcomes:²⁴

‘Advisory structures provide evidence-informed advice to governments for policy, investment strategies, and program development

‘Advisory structures achieve their stakeholders’ engagement and buy-in to the National Drug Strategy and its implementation’.

The purpose of the advisory structure is to ensure that the MCDS has timely access to the expert and policy advice it needs to achieve the goals of the NDS. As the diagram in Chapter 3 shows, in pursuit of this primary goal, a range of councils and committees, reporting relationships, programs, and time-limited expert working groups contribute to the policy making, planning and advisory process.

The key challenge for this evaluation in assessing the advisory structure is that the elements within it are not all of like kind. The IGCD is part of the machinery of Government, working with it to write and refine policy on the basis of advice. The ANCD provides independent advice to the Prime Minister and the Government. The National Drug Research Centres provide advice to government, non-government and community stakeholders. The expert working parties provide advice to IGCD.

The evaluation therefore considers the extent to which the IGCD, ANCD and the other specified elements of the NDS advisory structure provide evidence-informed advice, and achieve their members’ engagement and buy-in to the NDS in appropriate, efficient, and effective ways, but within the limits and opportunities that their place in policy making and planning hierarchy allows.

That is, do they provide advice that supports the development and implementation of drug-related policies in line with the principles and aims and objectives of the NDS? Do the IGCD, the ANCD and the centres, working groups, and expert panels provide best possible research evidence and advice to the MCDS? Do the MCDS and the IGCD use the best possible advice and research evidence in decision-making? Is advice is provided in a timely manner to inform responses to emerging issues? Do the IGCD and the ANCD engage stakeholders and generate ‘buy-in’ to the NDS and its implementation? Are public debate and community views incorporated into decision-making?

Data sources

Four sources of data were collected and analysed and synthesised: 1) documentation of the workings of the advisory structure, 2) literature on good governance and policy best practice,²⁵ 3) informant interviews, and 4) two case studies.²⁶

We examined a very large number of documents generated by the major advisory bodies and the working parties that reported to them. Most of these sources minuted process, but contained scant documentation of policy discussions and reasons for decisions made by IGCD or MCDS. The literature on governance and best practice suggests that consistent recording of reasons for decisions and resulting actions is essential to policy development and review.

²⁴ As set out in the program logic model and outcome matrices for Component 3 - see Appendix I.

²⁵ See Volume 2 for a comparative review of literature on efficiency and effectiveness in policy practice

²⁶ See Volume for the two Component 3 case studies

As the PWG directed, we interviewed senior informants in government (including those in very senior roles in the advisory structure), the research community, NGOs, and the public and private sectors. We structured those interviews around the agreed success factors identified in the Component 3 outcomes matrices.

The two case studies – the Advisory Role of the NDRCE with respect to AOD Workforce Issues and the National Psychostimulants Initiative Expert Reference Group (NPIERG) - were chosen by the PWG to illustrate processes the advisory bodies have used in developing evidence to inform policy development. Even though our informants included those in senior advisory roles, the number of respondents able to comment on many of the issues was relatively small, and their views were not always unanimous. Occasionally, therefore, we report views whose validity we were not able to verify independently, and we signal this limitation where it occurs.

Findings

Achieving consensus and commitment

The MCDS and the IGCD, the ANCD and the working groups of the IGCD have been useful and appropriate forums for health, education and law enforcement policy makers to reach consensus on key policy areas that involve the health, law enforcement and education sectors. They have sustained bipartisan commitment to the principles of the NDS, and promoted a nationally consistent and coordinated approach to the development and implementation of drug policy in Australia's federated system of government.

MCDS and COAG

MCDS sits at the peak of the NDS advisory structure as the authoritative recipient of the advice generated by IGCD and all its supporting activities.

MCDS's responsibility is to develop and implement drug policy and program initiatives, and to support and advise the COAG process, and then, as required, oversee the implementation of related policy reforms and planning and program initiatives agreed by COAG.

This relationship with COAG allows the drug and alcohol sector to work proactively and reactively with those responsible for the policy areas that together address the broad social determinants of drug related harm. This is a great advance and the working relationship between the NDS and the broader government environment that the COAG process supports (beyond health, justice, law enforcement and education) needs further development.

The experience to date is that the relationship between COAG and MCDS is a top-down decision-making process. Informants felt that a more bi-directional relationship would allow MCDS to put issues forward to COAG, and enable MCDS to address the social determinants of problematic drug use more effectively.

The NDS recognises that collaboration among the levels and sectors of government is critical for achieving its objectives. However, some informants said the partnership between MCDS and government stakeholders outside the NDS advisory structure was not always strong. We suggest that it would pay dividends if endorsements of AOD initiatives by COAG meetings were routinely referred back to MCDS for implementation (as, for instance, with the Binge Drinking Initiative agreed to by COAG in July 2008), as the NDS structures and processes have well-developed pathways for funding with the States and Territories and the non-government sector. The NDS also has good and improving data collection mechanisms that can ensure that the process burden of reporting does not continually grow as the reporting requirements of different agencies and programs of effort multiply.

The role of the IGCD

The IGCD operates largely in accordance with its terms of reference and the scope of work defined by the NDS. It provides policy advice to MCDS on matters of drug-related policy development, and implements the policies and programs endorsed by MCDS.

The composition of the IGCD reflects representation across health, law enforcement, and education portfolios. However, some informants inside the advisory structure thought over time the level of content specific expertise in the AOD field had lessened, even though there was a high level of expertise in public administration and policy development more generally.

Several informants also believed there was an imbalance of effort in favour of supply reduction over treatment in recent years and that this is because, in their opinion IGCD did not appear to provide advice that might ensure that the balance of investment reflected the evidence for effectiveness rather than the imperatives of the media and political attention.

IGCD processes

Documents recording IGCD meeting agendas show that the majority have consisted of standing items rather than policy level papers and discussions with concrete resolutions. It is difficult for us to know if this is the result of the style of record keeping or the need for better documenting of meetings and activities (for example in action minutes mapping deliverables to timeframes on a work plan and assigning responsibility for action, as happens in other similar level committees).

The performance of bodies such as IGCD is determined by where it sits in the policy and planning framework of Governments, and reciprocally its performance will determine how much it is consulted and used by Government in policy and planning. That is, circumstances can act to marginalise committees' influence; broader factors in the recruitment policies of the public sector (moves to fill senior posts with generic policy or management skills rather than content experts) can change the nature of their capacity; and then stakeholders used to one way or the other can find fault in the space opened up by one or another emphasis. Committees such as IGCD can from time to time be criticised for policy naiveté and at others for a lack of real content expertise.

Similarly, their performance is very much tied to the policy agenda of the government of the day and the priorities of that government, as it should be in a democracy. Very often, though, committees take flack for what is perceived from outside government as reluctance to take timely action or a tendency to defer consideration of difficult issues. The IGCD has lost some ground in recent years in terms of reputation and standing in the sector in transparency and accountability, and in its perceived capacity to take proactive initiatives up to Government (a case in point was the three year delay in developing a national strategy on AOD workforce development).²⁷ Both MCDS and IGCD could benefit from reflecting on the meaning and implications of these perceptions for how they work together in the public interest.

Access to and use of research evidence and expert advice

Our document review showed that the IGCD informs its advice to the MCDS by commissioning a range of research and evidence, including research reports, working group papers and recommendations, projects commissioned under the CSFM, and presentations by external and internal stakeholders. The pool of expertise available to IGCD includes the members themselves, the NDRCE, the NEAP, IGCD working groups and taskforces, and the ANCD. The expertise represented in these bodies has been an important source of up-to-date information and expert advice to inform policy development and implementation. In addition, these bodies have had the capacity to work proactively as well as reactively to present timely advice to government and use research and evidence to influence the priority of issues that are placed on meeting agendas.

²⁷ See the component 3 case study in Volume 2

NDRCE

The National Drug Research Centres of Excellence remain an important source of research and expert advice to the IGCD. Over the years, NDARC, NDRI and NCETA contributed substantially to the evidence underpinning the development and implementation of the NDS.

However, contributions to policy activity, particularly through the formal NDS advisory structures, receive little attention in the strategic and business plans of the three Research Centres. Considering that they were established by DoHA and receive their core funding from it as a key component of the NDS, and that the evidence they help produce and disseminate is central to sound policy activity, we might have expected more explicit mention of their contributions to policy activity. On the other hand, since the NDRCE were established and receive core funding from DoHA rather than from the various bodies that compose the advisory structures, it is perhaps more appropriate that their advice is delivered in the first instance to DoHA rather than directly to the advisory structures. However, our informants did not agree with this approach, arguing it was important that the NDRCE make contributions to IGCD and ANCD directly.

IGCD can request the NDRCE to provide them with advice on particular issues. The Centres were instrumental in developing some NDS sub-strategies, including the 2006 National Cannabis Strategy (NDARC) and the 2008 National Amphetamines Strategy (NDRI). Advisory relationships with the IGCD have varied to some extent among research centres. Informants said IGCD approached NDARC more often than NDRI and NCETA for evidence-based advice, though it regularly invited NCETA to provide advice on workforce issues.

With the abolition of the NDS National Expert Advisory Committees in 2004, the contributions of the Research Centres of Excellence in the advisory structures were reduced. The NDRCE's formal membership of most if not all of the former National Expert Advisory Committees (NEACs) provided a direct link to the IGCD and the MCDS. In the absence of the expert standing committees, NDRCE lost a significant channel of input to policy activity. However, informants said there were informal processes through which the NDRCE could influence the agendas of advisory bodies. For example, informal collegiate networks were used to raise workforce development issues among policy makers and to keep them before the IGCD.

There has been a stronger emphasis on workforce development in recent years. NCETA's focus has changed over the years from developing and delivering AOD training programs (it filled a problematic gap in this area in its early days) to research on workforce development issues. This research has provided much of the evidence for workforce development policies and action plans.

Our informants have pointed out that Australia is an international leader in AOD workforce development research, primarily through the work of NCETA, and that this is one of the positive outcomes of the current phase of the NDS. This leadership has not yet been translated into a national workforce development strategy and implementation plan.

The extent to which the Research Centres work together affects their capacity to produce quality research. Many informants believed there was much collaboration among the research centres (in particular, NDARC and NDRI), but they also commented that the effectiveness of the NDRCE was limited by the competitive demands for funding and influence that characterises the university sector in Australia. The results of the recent evaluation of the NDRCE indicated that the research centres would benefit from greater collaboration and partnerships between the Centres and with other AOD research bodies and projects.

NEAP

The IGCD created the NEAP in 2004 to replace the previous NEACs. The NEAP is a list of 284 people appointed by the IGCD and the ANCD and managed by the IGCD/MCDS Secretariat. The panellists in NEAP have expertise in drug and alcohol issues and represent health, law

enforcement, government, non-government, local government, and the Indigenous, education and other relevant sectors. The purpose of the Panel is to provide expertise in drug areas and identifying emerging trends to the IGCD (though not to ANCD).

The NEAP is used as a source of expert members for various IGCD working groups. Expertise within the NEAP has helped inform policy development and implementation. Information on the members involved and their areas of expertise was not available to the evaluation, and we were therefore not able to determine which members of working groups were drawn from the Panel. Few informants were aware of the membership of the NEAP, including informants from the IGCD and ANCD. Apart from its establishment, the Panel is not referred to in documents of the MCDS, IGCD or ANCD.

Until the establishment of the NEAP in 2004 and the creation of the IGCD working groups, the IGCD had relied on a system of NEACs for research and advice. The evaluation of the NDS Framework 1998-99 – 2003-04 found that the NEACs' processes were not considered to be effective, efficient, transparent or accountable, and suggested that an alternative advisory and consultative mechanism be considered.

Many informants agreed that some of the former NEACs had developed their own agendas, and made direct contacts with researchers and experts in the field. Some said this increasing independence had led to political tensions with the IGCD and generated a climate of competition for influence and resources. Others believed the former NEACs were effective in creating an alliance between policy makers and experts outside IGCD, and had made significant contributions to the NDS by providing robust, evidence-based advice and facilitated sharing of information.

While a number of informants said they would prefer the NEACs were recreated, most who argued for a return of the former NEACs were unable to comment on the workings of the NEAP.

It is our view that the NEAP is an innovative and potentially useful concept, but there may be ways to make it more effective. For a body of expert contributors of this large size to maximise its usefulness to IGCD, there needs to be a practical way to access a stratified database listing the knowledge and experience of all the panellists, so that the IGCD/MCDS Secretariat can call on them quickly when their particular special advice is needed. In light of the need for regular and timely expert advice, and in order to enhance the interest of NEAP panellists in the advisory structure, IGCD might consider inviting the chairs of working parties to present to the Committee when it seeks advice on particular policies, and acknowledging the role of the NEAP members.

IGCD working groups and taskforces

Documents from DoHA list the following IGCD working groups and taskforces from 2004 to the present:

- Evaluation and Monitoring of the National Drug Strategy 2004-2009 Working Group
- Foetal Alcohol Spectrum Disorder Working Party
- Illicit Drug Diversion Initiative Evaluation Reference Group
- Monitoring of Alcohol Advertising Committee
- National Clandestine Laboratory Database User Advisory Group
- National Competition Policy Working Group
- Pathways to Prevention Working Group and Prevention Toolkit Working Group
- Secondary Supply of Alcohol Working Group
- Tobacco Advertising and Sales over the Internet Working Group
- Wholesale Alcohol Sales Data Working Group

- National Inhalant Abuse Coordination Group
- Harms from Alcohol and Other Drug Use Working Group
- National Drug Strategy Data Analysis Working Group (disbanded in July 2007)
- Performance and Image Enhancing Drugs Working Group (completed in November 2007)

The majority of IGCD working groups worked to their terms of reference. Memberships of working groups were documented for all groups, with the exception of three groups that provided us with very little data (the Pathways to Prevention Working Group, the Prevention Toolkit, and the Harms from Alcohol and Other Drug User Working Group).

The composition of expertise in the working groups was representative of the jurisdictions and sectors (health and law enforcement, and industry). However, public administration and policy expertise was predominant in the health sector working groups, and there appeared to be an under-representation of health experts involved in clinical service delivery. Few working groups had representatives from the education sector.

Only a minority of the IGCD working groups have worked to a specific work plan that detailed key deliverables against expected reporting points and timeframes. A small number appeared to have used work plans as a guide. It was difficult to determine the extent to which working groups were accountable for their actions and decisions, because limited documentation did not specify actions that had been accomplished or deferred.

It is important that the purpose and objectives of IGCD working groups are explicit, and that the roles and responsibilities of members and the secretariat are clearly defined. Clarity of role is important to the effective and efficient functioning of a working group, yet a minority of the working groups spelled out the role of members in their terms of reference. Only three of the 15 groups nominated a secretariat and described its role and responsibilities. There was also little clarity about what was expected of members, or the arrangements about expenses incurred in attending working group meetings (sitting fees, travel, and incidental expenses).

Informants generally thought that the time-limited nature of the working groups inhibited learning from previous experience, and hence their capacity to contextualise their advice and contribute to cumulative policy development. It is our view that there is an important place for well-defined and well-resourced working groups to deliver specific research and policy products within timeframes and budgets. They should draw on the expertise of members with extensive previous experience with translating research into policy.

Liaison with other bodies

An objective in IGCD's terms of reference is 'to liaise with other intergovernmental agencies on matters relevant to the NDS Framework, and to consult with the NGO sector, including the ANCD'. IGCD has had limited capacity to engage with other parts of the machinery of government, such as the senior officers groups supporting various Ministerial Councils, and the National Preventative Health Taskforce. Informants attributed this disconnection to the limited role of the IGCD Secretariat. The Secretariat's role was largely to provide operational support (circulating IGCD meeting documents to members and correspondence). There was no mechanism within IGCD to develop relationships with other government bodies.

Currently there is no formal mechanism within IGCD to receive feedback and advice from the NGO sector. This is possibly a role that ADCA and its affiliates, the professional organisation APSAD, and AERF could perform. A formal link with these bodies would allow IGCD to incorporate advice on service delivery from the field, and in the process strengthen their role.

Informants strongly supported greater investment by IGCD in activities to engage in a whole-of-government approach to addressing the social determinants of health. Such a role could be fostered by formalising and investing in better links between the NDS advisory structure and other parts of the machinery of government and its processes (COAG, other Ministerial Councils, the National Preventative Health Taskforce) and government stakeholders outside the NDS advisory structure.

There is potentially an opportunity for the IGCD/MCDS Secretariat to broker relationships between IGCD and other government agencies. Time limited working groups, or other options such as presentations or briefs, could be set up on behalf of IGCD to contribute to and receive inputs from the operation of other bodies. An example is the 'Early Childhood – Invest to Grow' program of the Department of Families, Housing, Community Services and Indigenous Affairs which, as part of their broader Stronger Families and Communities Strategy, is addressing some of the social determinants of childhood and adult dysfunction.

Members of bodies parallel to IGCD, such as the Corrective Services Administrators' Conference, could be invited to brief IGCD at key stages in policy development, and IGCD could be proactive in offering similar briefings to such bodies. Collaborative policy activity could ensue.

The National Comorbidity Collaboration is one example of a whole-of-government approach that has been implemented recently. The Collaboration was established and met for the first time in September 2008, following agreement by both the IGCD and Mental Health Standing Committee at meetings in February 2008. The partnership assists the Commonwealth and States and Territories to focus on comorbidity issues and identify opportunities for shared priorities and interests in a whole-of-government way.

The implementation of some of our recommendations would be facilitated by this type of collaborative activity. For example, developing a substance abuse prevention agenda, a long-standing item for the NDS, could not be realised within the narrow drugs field. Collaboration and integrated action with other sectors would be essential. New structures and processes will be needed to create a viable prevention agenda. Similarly, any work to develop a national drug research strategy would benefit from collaboration with officers of the Department of Education, Employment and Workplace Relations and NHMRC owing to their roles in funding research nationally.

Often stakeholders outside IGCD reported that they had been given limited opportunity to contribute advice to inform NDS policy-making and decision-making processes. A common belief among informants was that experts outside IGCD were often excluded from contributing advice to policy development because IGCD typically sought advice only from the NDRCEs and *ad hoc* working groups. In order to incorporate a broader range of relevant expertise in policy development, the IGCD needs to consult more with external experts. IGCD should also consider ways it can engage with and encourage public consultation and debate as a way to incorporate community views into decision-making.

In summary, three key challenges exist in ensuring that the MCDS has best available advice in order to make decisions in the best interest of Australian drug policy:

- The capacity of the IGCD to provide evidence-informed advice in a timely manner to the MCDS decision making processes
- The capacity of the IGCD to engage with stakeholders outside the IGCD and the ANCD in activities to inform policy-making and implementation including:
 - other parts of the machinery of government, across and its processes (eg COAG, other Ministerial Councils and the National Preventative Health Taskforce)

- government stakeholders outside the NDS advisory structure (eg departments and bodies responsible for policies in areas relevant to the broader social determinants of drug problems use
- the community and the private sector
- drug research bodies and projects
- The capacity of the IGCD, ANCD and working groups to engender public debate and incorporate community views into decision-making

The role of the ANCD

Our evaluation found that the ANCD has been highly effective in providing timely, evidence-based advice to the IGCD and the Prime Minister. It has been able to do so by relying on the expertise of its own members and the research it has commissioned. ANCD's membership has represented experts in various fields of drug policy, including clinical treatment and rehabilitation, education, law enforcement and research.

ANCD's achievements were largely aligned with its terms of reference for the period 2004-2007. The ANCD, including its National Indigenous Drug and Alcohol Committee (NIDAC) and its Asia Pacific Drug Issues Committee (APDIC), has played an important role in policy development as the independent, non-government body within the NDS advisory structure.

Informants believed that there was a close network between ANCD and other bodies inside and outside the advisory structure. Documents show that the recipients of ANCD's advice included DoHA, FaHCSIA, Department of Education, Science and Training (DEST, now DEEWR), the ABS, the Prime Minister's Office and other State and Territory and federal ministers.

Informants said that ANCD used timely and efficient processes to contribute to the implementation of the NDS. The resources, diverse experience and high level of expertise in the AOD field of its members gave ANCD an advantage over IGCD in this respect. The fact that ANCD had direct access to the Prime Minister's Office also enabled it to function more efficiently than IGCD.

Some stakeholders believed that ANCD's access to the Prime Minister and Ministers enabled it to accomplish tasks that would otherwise have been politically difficult (such as advising on COAG agenda items) by making recommendations directly to Government and bypassing standard bureaucratic channels of referring issues to IGCD and MCDS for consideration and endorsement. . Informants were about equally divided about whether this was a good or a bad thing. Some argued that ANCD's direct relationship with the Prime Minister's Office could challenge the task of creating synergy in policy development

ANCD's relationship with IGCD

The NDS governance framework and the IGCD's terms of reference define the relationship between the ANCD and the IGCD as one of ongoing consultation and liaison. The MCDS may direct the ANCD or the IGCD and make direct requests to them about implementation of the NDS.

Their executives hold joint meetings, and the IGCD may request independent advice from the ANCD. Despite these practical steps to ensure cooperation and communication between the ANCD and the IGCD, informants said ANCD and IGCD had often pursued different agendas over the past five years, leading at times to duplication of effort and competition for scarce funds.

In the opinion of some informants, the ANCD's partnership with IGCD and MCDS could be stronger (this was also a recommendation of the Success Works evaluation of the NDS Framework 1998-2003.)

Articles and reports that have critically examined the advisory structure have highlighted the need to review ANCD's role and relationship in the advisory structure (Fitzgerald 2005; Fitzgerald & Sowards 2002; Success Works 2003). It would be timely, with the change of Government, to review ANCD's role in the advisory structure, and specifically address its relationship to IGCD and MCDS. Any such review would need to ensure that the effectiveness of ANCD is not diminished but that its capacity to work in partnership with the formal machinery of Government is strengthened while preserving its capacity to give frank advice in the public interest.

Incorporating public debate and community views into policy and decision-making

Contemporary public policy practice and governance principles emphasise the importance of engagement of the public in policy-making activities and informed policy debate (Fischer 2003; Australian Securities Exchange (ASX) Corporate Governance Council 2003; National Health and Hospitals Reform Commission (NHRC) 2008)

IGCD is limited in its capacity to consult with NGOs involved in service delivery. There are no formal processes for IGCD to receive advice directly from NGOs to inform policy development and implementation, and its decision-making processes are limited by the resulting lack of opportunities for policy debate and feedback.

The ANCD has played a major role in facilitating partnerships between the government and community. Though ANCD's terms of reference do not include a formal role to represent AOD NGO sector issues in policy making, and was not explicitly funded to undertake such an advocacy role, it has assumed responsibility for ensuring that the voice of the NGO sector is heard in developing and implementing policies and programs. Informants generally believed the ANCD was effective in advocating for the NGO sector through its regular agency forums.

Future needs

The roles and functions of the advisory structures to MCDS need to be improved so that they can more effectively:

- engage the community (including local government) in policy development
- enhance the links between evidence, policy, and investment
- re-engage with the broader machinery of government
- build capacity to monitor the outputs and outcomes of the NDS and its sub-strategies

Stronger links need to be created with other groups outside of the NDS advisory structure, for example the senior officers groups supporting various Ministerial Councils and the National Preventative Health Taskforce

There is a need to strengthen the role of the IGCD/MCDS Secretariat to link to senior officials in other arms of government involved in addressing the social determinants of health (eg health services, primary care, housing, education, employment etc) in order to:

- strengthen collaboration between COAG and MCDS to allow MCDS to put issues forward to COAG
- create formal mechanisms within IGCD to increase its networking with other government bodies outside of the advisory structure

We also identify a need to:

- ensure that drug use and related harm receives adequate attention in newly established ministerial mechanisms such as the National Preventative Health Taskforce.
- reduce the culture of competitiveness for funding and influence by encouraging more collaboration between research centres

- make better use of the national research effort, including the outputs disseminated to the field and woven into policy and program development

The IGCD could improve its efficiency by:

- addressing shortcomings in the design and implementation of the NEAP to improve IGCD access to expertise
- adopting more effective and efficient operations to ensure that challenging agendas are addressed in a more timely way
- considering ways to ensure a balanced discussion of major areas of interest during its meetings (regarding licit vs illicit drugs; and health, law enforcement, and education adopting more transparent processes by inviting experts outside IGCD to provide advice and by providing more information to the field
- establishing a formal process for receiving advice from NGOs to inform policy- and decision-making.

We consider that ANCD is an efficient and effective advisory body that should continue with its current composition and operations, but with a clearer statement of its relationship with the rest of the advisory structure.

Future improvements

We make these proposals for processes to improve the effectiveness of the NDS advisory structures for the future.

Recommendation 9: Establish an integrative mechanism to address the relationships among IGCD, ANCD, NEAP, the working groups, and ADCA. Its functions could include:

- providing a channel of advice that places identified needs and emerging issues on appropriate agendas, and disseminates the responses
- defining the relationship of ANCD to the NGO sector in encouraging inputs from the non-government and private sectors into policy, program design, implementation, and evaluation
- enhancing the value of the NEAP by creating an accessible, stratified database of preferred suppliers of expertise for the use of all the advisory structures as needed

Recommendation 10: Expand the IGCD's access to expertise and streamline its operations by:

- providing a funding mechanism for IGCD activity
- ensuring a balance of discussion of health and law enforcement issues during meetings
- engaging with challenging agenda items in a timely way
- strategically commissioning research from experts inside and outside the IGCD
- ensuring that its recommendations to the MCDS are supported by evidence-based advice
- adopting decision-making processes that are fully documented and transparent to the field

Chapter 7: NDS performance in facilitating and guiding the monitoring of drug issues and trends and the outcomes of the Strategy

Introduction

The objective of component 4 of the evaluation is to assess the Strategy's performance in facilitating and guiding the monitoring of actual and potential drug issues and trends. It has two linked elements:

- An analysis of the ability of the NDS to facilitate and guide the monitoring of actual and potential drug issues and trends
- Presentation and analysis of data and information on monitoring drug prevalence, showing snapshots of the NDS in action and over time, with case studies, prevalence data and other indicators of harm.

One objective of the current phase of the NDS is: *'Promote evidence-informed practice through research, monitoring drug-use trends, and developing workforce organisations and systems'*. NDS Priority Areas also include: *'Identification and response to emerging trends'*.

The National Drug Strategy Data Analysis Project forms part of the context of this component. This was a DoHA consultancy implemented by Campbell Research and Consulting. The final report of the project was submitted to the Department in August 2007 and subsequently tabled at IGCD. It was not endorsed for public release. According to its terms of reference, the main objective of the Project was to:

Identify and analyse the information needed to inform the implementation and measurement of initiatives developed under the National Drug Strategy and its related strategies within existing budgetary constraints. It will also produce recommendations.

We have critically reviewed and taken account of the findings and recommendations of that Project, which we support, and in the interests of efficient use of resources have not duplicated the data collection and analysis it entailed.

Evaluation method

The method for evaluating this component (based on the corresponding program logic model and outcome matrices²⁸) involved a range of activities:

- Identifying and mapping key indicators for the NDS to the Priority Areas of the NDS
- From this mapping, identifying Headline Indicators that can be monitored and subsequently communicated effectively to key audiences
- Analysing existing uses of the data within the NDS
- Analysing the usefulness of existing data as a baseline for the evaluation
- Presenting and updating baseline monitoring data for the Interim and Final Reports
- Stakeholder mapping and analysis
- Conducting stakeholder interviews
- Analysing the findings and recommendations of the NDS Data Analysis Project
- Conducting a case study of the IDRS/EDRS as a strategic early warning system

²⁸ These may be found in Appendix I

Approaches to monitoring the NDS

Monitoring has been defined by the OECD as ‘...a continuous function that uses the systematic collection of data on specified indicators to provide management and the main stakeholders of an ongoing ... intervention with indications of the extent of progress and achievement of objectives and progress in the use of allocated funds’ (OECD 2002, cited in Kusek & Rist 2004, 12).

Our approach to monitoring follows this process, but is not as broad as the OECD approach. Instead, we tie our monitoring activities to the stated Priority Areas for action of the NDS, acknowledging that other monitoring processes are already in place to address other aspects, including the financial monitoring undertaken by government departments and others, and the reporting and accountability requirements of annual reports.

We begin by framing the monitoring in terms of the expected outcomes of the NDS and their related priority areas. We then discuss the nature of performance information, detail eleven headline indicators that are mapped to the NDS priority areas, and discuss the usefulness of other Key Performance Indicators.

Headline Indicators tied to the NDS Integrated Framework

It is increasingly acknowledged that, in developing a monitoring framework, agreement should be obtained at an early stage on the objectives and expected outcomes of the intervention, and tie indicators to these outcomes (OECD 2002, cited in Kusek & Rist 2004; Owen 2006). The NDS strategy document *The National Drug Strategy: Australia’s Integrated Framework 2004-2009* provides this information.

The *Framework* includes a statement of the NDS’s mission, twelve objectives, and eight Priority Areas for action. While the objectives are not explicitly mapped to the priority areas for action, we have with the guidance of the Working Group focussed performance indicators on the documented priority areas, and used our own judgments to determine the links among the objectives, priority areas and the mission of the NDS.

The mission, the Australian approach, objectives and priority areas

The mission of the NDS is ‘*To improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society*’. This is usefully seen as a statement of the ultimate outcome the NDS seeks to attain. The performance indicators should address and be read in conjunction with the Framework’s description of ‘The Australian Approach’.

The eight priority areas for action under the NDS are prevention, reduction of supply, reduction of drug use and related harms, improved access to quality treatment, development of the workforce, organisations and systems; strengthening partnerships; implementation of the NDS ATSI/PCAP; and identifying and responding to emerging trends.

Priority areas for action and the related NDS objectives

To identify highly useful performance indicators, we have mapped the Framework’s stated objectives to the priority areas, as follows (some objectives fall under more than one priority area):

Prevention

- Prevent the uptake of harmful drug use
- Increase access to a greater range of high-quality prevention and treatment services
- Promote evidence-informed practice through research, monitoring drug-use trends, and developing workforce organisation and systems
- Develop mechanisms for the cooperative development, transfer and use of research

Reduction of supply

- Reduce the supply and use of illicit drugs in the community as a means of reducing drug-related harm.
- Promote evidence-informed practice through research, monitoring drug-use trends, and developing workforce organisation and systems
- Develop mechanisms for the cooperative development, transfer and use of research among interested parties

Reduction of drug use and related harms

- Reduce the supply and use of illicit drugs in the community
- Reduce the risks to the community of criminal drug offences and other drug-related crime, violence and antisocial behaviour
- Reduce risk behaviours associated with drug use
- Reduce the personal and social disruption, loss of life and poor quality of life, loss of productivity and other economic costs associated with harmful drug use
- Increase community understanding of drug-related harm
- Promote evidence-informed practice through research, monitoring drug-use trends, and developing workforce organisation and systems
- Develop mechanisms for the cooperative development, transfer and use of research among interested parties

Improved access to quality treatment

- Increase access to a greater range of high-quality prevention and treatment services
- Promote evidence-informed practice through research, monitoring drug-use trends, and developing workforce organisation and systems
- Develop mechanisms for the cooperative development, transfer and use of research among interested parties

Development of the workforce, organisations and systems

- Promote evidence-informed practice through research, monitoring drug-use trends, and developing workforce organisation and systems
- Develop mechanisms for the cooperative development, transfer and use of research among interested parties

Strengthened partnerships

- Strengthen existing partnerships and build new partnerships to reduce drug-related harm
- Develop and strengthen links with other related strategies

Implementation of the *NDS Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009*

- Strengthen existing partnerships and build new partnerships to reduce drug-related harm
- Develop and strengthen links with other related strategies

Identification and response to emerging trends

- Promote evidence-informed practice through research, monitoring drug-use trends, and developing workforce organisation and systems
- Develop mechanisms for the cooperative development, transfer and use of research among interested parties
- Strengthen existing partnerships and build new partnerships to reduce drug-related harm

Some of the priority areas lend themselves to routine monitoring using performance indicators (eg monitoring opioid-related overdose mortality to address 'reduction of drug-related harms'). By contrast, some of the priority areas do not lend themselves to this type of monitoring (eg 'strengthening partnerships'). These areas need to be assessed using other methods.

Priority areas amenable to monitoring

Four of the Priority Areas for action in this phase of the NDS have been identified as amenable to some degree of monitoring using performance indicators. They are the first four: prevention, reduction of supply, reduction of drug use and related harms, and improved access to quality treatment. The others have been addressed in other components of the evaluation by other means including case studies, informant interviews and documentary analysis.

Performance information

Some of the issues that have informed our approach to selecting a set of indicators for monitoring the NDS include:

- It is useful to clarify the purpose of the indicators. We conclude that they are for both performance proving and performance improving, to cite one familiar distinction (O'Shaughnessy 2001).
- It is often useful to link performance indicators to the targets of the interventions, usually quantitative targets. That is the rationale for the above discussion of the NDS Mission, Objectives and Priority Areas. We have no history in the NDS, however, of successful using quantitative targets, as discussed below.
- Decisions need to be made about the scope of the indicators, e.g. do they cover all or just some of the inputs, activities, outputs and outcomes? This project is not designed primarily to monitor NDS implementation or activities. Rather, its focus is on outputs and outcomes.
- The proposed indicators are quantitative. They are supplemented by other research in Component 4 and the other Components that is qualitative and so able to explore and add understanding that clarifies the issues underlying the quantitative values of the indicators.
- Both direct indicators (eg the recent use of any drug) and indirect indicators (eg the purity of illegal drugs as a proxy for drug availability) have been used (Kusek & Rist 2004, 70).²⁹

The UK Treasury Department has paid close attention to the development and use of performance indicators for public sector programs, especially large and complex interventions. They have identified the properties of high quality performance information systems: the FABRIC of performance information:

- **F**ocused on the organisation's aims and objectives
- **A**ppropriate to, and useful for, the stakeholders who are likely to use it
- **B**alanced, giving a picture of what the organisation is doing, covering all significant areas of work
- **R**obust in order to withstand organisational changes or individuals leaving
- **I**ntegrated into the organisation, being part of the business planning and management processes
- **C**ost-effective, balancing the benefits of the information against the costs

²⁹ It is important to acknowledge that the performance indicator movement has been subjected to searching criticism. See, for example, Perrin 1998.

The final framing point is the value of being explicit about the criteria used to select the key performance indicators for the NDS. Again we use HM Treasury's criteria (listed below). We also take into account the more familiar SMART criteria (Specific, Measurable, Achievable/attainable, Realistic/Relevant and Timely), and the CREAM criteria: Clear, Relevant, Economic, Adequate and Monitorable (Kusek & Rist 2004, p. 68).

The core criteria for sound indicators, in the HM Treasury approach, that we have adopted are:

- **Relevant** to what the organisation is aiming to achieve
- Able to **avoid perverse incentives** - not encourage unwanted or wasteful behaviour
- **Attributable** – the activity measured must be capable of being influenced by actions that can be attributed to the organisation, and it should be clear where accountability lies
- **Well-defined** - with a clear, unambiguous definition so that data will be collected consistently, and the measure is easy to understand and use
- **Timely**, producing data frequently enough to track progress, and quickly enough for the data to still be useful
- **Reliable** - accurate enough for its intended use, and responsive to change
- **Comparable** with either past periods or similar programmes elsewhere
- **Verifiable**, with clear documentation behind it, so that the processes which produce the measure can be validated

Performance Indicators for the NDS: experiences to date

The desirability or otherwise of having a central body to manage performance indicators for the NDS has a long history. As long ago as 1979-1980, the Williams Royal Commission recommended that Australia develop a centralised National Drug Abuse Information Centre that would be responsible for monitoring and evaluating the nation's efforts with respect to illegal drugs (Royal Commission of Inquiry into Drugs 1980). The Centre was established within the then Commonwealth Department of Health and, as a result, performance indicators for the NDS (then called NCADA) were published annually for the first few years of the Campaign. (This was the forerunner of the current AIHW series *Statistics on Drug Use in Australia*.)

After operating for a few years, the Centre was abolished. The 1997 NDS evaluation conducted by Single and Rohl made a similar recommendation that was not implemented. The consultancy recently conducted for the National Drug Strategy Branch by Campbell Research & Consulting (the NDS Data Analysis Project) has made similar recommendations.

The NDS is now in its fifth phase. In only one of the previous phases were serious efforts made to use the Key Performance Indicator approach to monitor progress and goal attainment. That was the 1993-97 phase: the *National Drug Strategic Plan 1993-97*.

A large number of quantitative indicators were documented there, such as 'The proportion of street youth aged 19 years and under which has used drugs illicitly in the past 12 months', with the baseline value of 'all illicit drugs 98%, hard drugs 90%' and the source for this baseline being the 1991 NCADA Sydney Street Youth Survey. Movement towards achieving the goals implicit in this approach was documented in depth in the 1997 NDS evaluation: *Progress of the National Drug Strategy, key national indicators, evaluation of the National Drug Strategy 1993-1997*.

Although the NDS has not been formally monitored using quantitative indicators since then, the IGCD now reports annually to MCDS. These reports generally contain little performance data.

In recent years there have been a number of reviews that have provided recommendations for monitoring the NDS. Interestingly, these have been criminal justice system based, but each goes well beyond the criminal justice system in its scope. The reviews include the following:

- Weatherburn D (2000). *Performance indicators for drug law enforcement*, Crime and Justice Bulletin no. 48. Sydney: Bureau of Crime Statistics and Research
- Urbis Keys Young (2004). *The relationship between drugs and crime: prepared for National Law Enforcement Policy Branch by Urbis Keys Young*. Canberra: Australian Government Attorney-General's Department
- Willis K, Homel PJ, Gray K (2005). *Developing and implementing a performance measurement framework for drug law enforcement in Australia*. Adelaide: National Drug Law Enforcement Research Fund
- Homel PJ, Willis K (2007). *A framework for measuring the performance of drug law enforcement*, Trends & Issues in Crime and Criminal Justice, no. 332. Canberra: Australian Institute of Criminology

A number of reviews of data collections, covering both the criminal justice system and other sectors such as health, welfare and education, have also been conducted and are documented in the NDS Data Analysis Project report. However, they are not specifically concerned with performance indicators, in contrast to the criminal justice system reviews listed above.

During this evaluation we heard little enthusiasm for using targets, and quantitative performance indicators tied to them, for the purpose of monitoring the NDS.

Prominent Australian, inter-sectoral, and national models

It is widely agreed by people interested in public sector performance measurement, that the approach taken by the Productivity Commission's Steering Committee for the Review of Government Service Provision relating to *Key Indicators of Overcoming Indigenous Disadvantage* is a particularly useful and effective model for monitoring complex interventions (Steering Committee for the Review of Government Service Provision 2007). It involves identifying a small number of priority outcomes (three in this case), headline indicators (12); and a number of strategic change indicators addressing each of seven strategic areas for action. This model cannot be applied directly to the NDS - nor is it appropriate to do so - since the NDS Framework does not include a concise listing of intended or hoped-for outcomes. Its value, however, is to demonstrate the use and power of headline indicators.

Another prominent model is ABS' work on *Measuring Australia's Progress* (ABS 2006). It also uses headline indicators, pointing out that this is the 'suite-of-indicators' approach, as contrasted with using composite indices with their inherent challenges in construction, interpretation and use (Scott & Marshall 2005).

Key data sets

The NDS has available to it a very large number of data collections that can be used for monitoring and in policy activity.

Key compilations

The following compilations are produced annually and widely used:

- Australian Crime Commission, *Illicit drug data report*
- Australian Institute of Criminology, *Australian crime: facts & figures*
- Australian Institute of Health and Welfare, *Statistics on drug use in Australia*.

Two ongoing projects funded under the NDS produce reports either on a regular or irregular basis that draw upon data from various collections:

- National Alcohol Indicators Project (NDRI)
- National Illicit Drug Indicators Project (NDARC)

Specific data collections

The following data collections and sources are considered of national significance to the NDS.

- ABS Causes of Death collection
- Alcohol and Other Drugs Treatment Services National Minimum Data set (AODTS-NMDS)
- Australian Secondary Students' Alcohol and Drug Survey (ASSAD)
- Clients of Needle Syringe Programs (NSP Survey)
- Drug Use Monitoring in Australia (DUMA)
- Ecstasy and related Drugs Reporting System (EDRS)
- Illicit Drug Reporting System (IDRS)
- National Coroners' Information System (NCIS)
- National Drugs Strategy Household Survey (NDSHS)
- National Aboriginal and Torres Strait Islander Social Survey (NATSISS)
- National Health Survey (NHS)
- National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD)
- National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey
- National Survey of Mental Health and Wellbeing of Adults
- National Hospital Morbidity Database

Other data sources, not as well-known but of potential value to the NDS, include:

- Longitudinal Study of Australian Children
- National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)
- Victorian Adolescent Health Cohort Study
- Western Australian Aboriginal Child Health Survey
- Western Australian Child Health Survey
- Women's Health Longitudinal Survey

The headline indicators

We have identified eleven headline indicators as particularly useful for monitoring drug issues and trends in Australia and that are readily communicated to a range of audiences. These reflect the criteria of excellence in performance indicators discussed above, and discussions between the evaluation team, the PWG, and officers of the Drug Strategy Branch (DoHA).

In Volume 2 we provide details on the headline indicators, showing why they are important and useful, how they map to the NDS Framework's priority areas for action and objectives, and how they meet criteria of excellence as performance indicators, along with their contents, source and availability. The 2004 baseline values of the indicators are presented, along with the most recent data and indications of longer trends, updated to October 2008. The implications of the data are also analysed there.

The eleven headline indicators classified by NDS Priority Area for action are:

Table 7.1: The Headline Indicators

NDS Priority Area	Headline indicator
Prevention	1 Average age of uptake of drugs
Reduction of supply	2 Illicit drugs seized 3 The availability of illegal drugs, as perceived by people who use illegal drugs 4 The purity of illegal drugs, as perceived by people who use illegal drugs
Reduction of drug use and related harms	5 Recent use of any drug: people living in households 6 Arrestees' drug use in the month before committing an offence for which charged 7 Victims of drug-related incidents 8 HCV and HIV/AIDS incidence 9 Drug-related burden of disease, including mortality
Improved access to quality treatment	10 Drug treatment episodes 11 Opioid pharmacotherapy clients

In Chapter 2, as part of our discussion of the context for the evaluation, we have provided a brief summary of key trend data derived from some of these indicators.

Findings

This component of the evaluation covers two areas: (1) presentation and analysis of data and information on the monitoring of drug prevalence to show snapshots of the NDS in action, and over time, and (2) an analysis of the ability of the NDS to facilitate and guide the monitoring of actual and potential drug issues and trends. The headline indicators dealing with the first of these are detailed in Volume 2, so we now turn to our findings on the second of these areas. Specifically, we present our findings about the performance of the NDS in facilitating and guiding the monitoring of drug issues and trends as well as the outcomes of the NDS in terms of their appropriateness, effectiveness and efficiency.

Appropriateness

Although there is no single, documented national drug information system to inform the NDS, Australia has a set of drug data collections that is broadly appropriate in meeting stakeholders' needs to monitor drug related issues and trends in Australia and contribute to policy activity. Indeed, commentators both within Australia and abroad have pointed out that our drug data and information resources are among the best globally in terms of their quality, comprehensiveness and potential usefulness (Campbell Research & Consulting 2007; Caulkins J, personal communication 8 Aug 2008).

As discussed under the heading 'effectiveness', the potential of the available data sources is not fully realized because there is no formal system for interrogating and synthesizing the data and other information into policy-relevant form.

The data collections are far from appropriate for meeting the evaluation needs of the NDS either in terms of its individual components or the NDS as an entity. This was discussed above, particularly in chapter 5 where we considered the outcomes of NDS programs. It is clear from that discussion that many of the core funded activities of the NDS do not have data collection systems that can be readily used in evaluation. Other activities that compose the NDS are similarly deficient.

In the absence of any organisation responsible for interrogating data and identifying significant issues and trends, these functions are undertaken on an *ad hoc* basis by policy analysts, the NDS research centres and independent researchers. This is a relatively ineffective and inefficient way of using the information.

Effectiveness

Use of data in policy activity

There is limited evidence of the systematic use of the products of drug information systems in policy activity. This suggests that the system is of limited effectiveness for policy development, implementation and evaluation. Although briefings to MCDS, IGCD and ANCD on specific topics make reference to the evidence base (including NDS related data collections), they focus on a single issue that has been identified in a top-down manner as of political and/or policy importance. There is limited capacity for new trends in drug use or drug-related harm to emerge from data analyses to influence the policy agenda. No identifiable individuals or organisations are charged with this responsibility.

One of the best-known publications covering NDS-relevant data and information is *Statistics on Drug Use in Australia* which is published approximately every two years by AIHW on contract to DoHA. This publication is well known and much used and appreciated by people in the field, including those engaged in policy activity and service delivery. Indeed, it is a source of much of the baseline data that can be used for monitoring the NDS. Users of that publication will be aware, however, that the AIHW simply present the quantitative data, along with some limited discussion to help the reader interpret the figures. It does not draw attention to the policy implications of the data that it presents.

This is in accordance with the policy of AIHW, which sees its role as providing its clients and to the AOD sector and the public more broadly with information that will be used for diverse purposes. The publication is therefore not particularly effective for monitoring the performance of the NDS, because its contents are not mapped to the Strategy's objectives or priority areas, and they do not identify the policy implications of the data presented.

We have examined the extent to which drug data collections have been used to develop new sub-strategies under the NDS. A number of the recently developed sub-strategies do not reveal, in the way they have been documented, just how they were based on information derived from Australia's drug data collections. This issue was analysed in the NDS Data Analysis Project (Campbell Research & Consulting 2007). Its report discussed the extent to which the National Alcohol Strategy and the National Cannabis Strategy, endorsed at the same MCDS meeting in 2006, were transparent in their information sources, and more particularly how the information was shown to have informed their findings and the strategic directions documented. The Data Analysis Project found, among other things, that the two strategies differ considerably in the extent to which the reader is able to see the connection between the available research evidence and products of data collections, on the one hand, and the policies adopted, on the other. Specifically, the National Alcohol Strategy documents far more explicitly the evidence base than does the National Cannabis Strategy.

The people who drafted these strategies are familiar with the available data, and have used them in the strategy development processes, but the strategy documents often do not make clear that the data were used in an effective manner.

Data and information gaps and delays in the release of data and information

Our investigations have identified some significant information gaps and problematic delays in the release of data and their analyses. The following areas are of particular importance.

Tactical early warning systems

A major deficiency in the NDS at the State, Territory and local levels is tactical early warning systems - for example, real-time or close to real-time information from hospital emergency departments, ambulance services, prison entrants, active illicit drug users, etc. These types of data are particularly important for alerting people to emerging issues locally that may call for rapid, often short term, local responses. Examples include the appearance of new types of drugs and of changes in the potency of locally-used drugs. The need for these local-level, *tactical* early warning systems is highlighted by contrasting their general absence with the availability of highly useful *strategic* early warning system data collections at the national level. The IDRS/EDRS data collection is well known, widely used and generally accepted as being of high quality in providing 'big-picture' information at the National and State/Territory levels. The data are collected annually and the results of their analyses are published reasonably promptly following data collection.

The same comment applies to the DUMA data collection: data are collected quarterly and the findings are returned, within a month, to the police agencies whose arrestees are covered by the data collections. An annual report is published which also helps to fill the strategic early warning function.

Drug-related mortality

There are problems in the timely publication of data on drug-related mortality, with regard to both licit and illicit drugs. There are a number of reasons for this. They include the lengthy delays between the time a death occurs and when it is registered at the State/Territory level, incorporated into the ABS national data sets and published by them.

The ABS causes of death data do not, as published, provide much information on drug-related deaths as most such deaths are not coded, in the ABS collections, as 'drug-related'. Separate research, applying attributable fractions to many different causes of death, is needed to produce a comprehensive picture. This applies particularly to tobacco, the leading cause of drug-related deaths.

Considering the high saliency of drug-related mortality data and its significant policy relevance, it is problematic that timely data are generally unavailable. The current situation is that no frequent and regular publication of all-causes drug-related mortality data exists. The most recent data are for 2003, published in May 2007, from the Burden of Disease and Injury in Australia research project conducted by scholars from the School of Population Health, University of Queensland and AIHW. This updates the 1996 data, published in 1999.

Other sources of information related to mortality for specific drug types are:

Opioids, cocaine and amphetamines (annually):

Degenhardt L, Roxburgh A, Black E, Dunn M. (2006a). *Accidental drug-induced deaths due to opioids in Australia, 2004*. Sydney: NDARC

Degenhardt L, Roxburgh A, Black E, Dunn M (2006b). *2004 Cocaine and amphetamine related drug-induced deaths in Australia*. Sydney: NDARC.

Alcohol:

Chikritzhs T, Catalano P, Stockwell T, Donath S, Ngo H, Young D, Matthews S (2003). *Australian alcohol indicators, 1990-2001: patterns of alcohol use and related harms for Australian states and territories*. Perth: NDRI, Curtin University of Technology

Data on mortality from tobacco, the drug that causes far more deaths than alcohol and illicit drugs combined, are not available from any ongoing data collection. Further, the NDRI data on alcohol-related mortality are out-of-date: 2001 deaths are the most recently published for Australia as a whole.

Improving the availability of data on drug-related mortality is particularly important. Great value would be derived from commissioning a research body to analyse the ABS Causes of Death data, upon their release annually, to compile estimates of mortality related to *all* classes of drugs. Alternatively, the task could be distributed between different research centres that specialise in research into particular classes of drugs, with one being responsible for collating the results. Having to rely on intermittent, one-off studies conducted by researchers is an inadequate way of monitoring this important indicator.

The purity of illicit drugs

A valid and reliable information system on the purity of illicit drugs would be valuable for NDS monitoring and evaluation, because purity has been identified as the best single indicator of illicit drug availability (Moore *et al* 2005). The ACC works hard to obtain and use data from the AFP and the State and Territory police services on the purity of illicit drugs, but the absence of any common data standards means these data are of very limited use. This is highlighted by the fact that the ACC, in its annual *Illicit Drug Data Report* (IDDR), presents somewhat patchy purity data on a state-by-state basis but cannot provide a national overview. The 2006-07 IDDR comments on the scope and quality of the purity data in the following terms:

The purity tables do not represent the purity figures for all seizures of that drug type, only those that have been analysed at a forensic laboratory. Drug purity figures for Victoria, Queensland, and the Australian Capital Territory represent the purity level of drugs seized by police during the relevant quarter. Figures for South Australia, Western Australia, Tasmania and those supplied by the Australian Forensic Drug Laboratory represent the purity level of drugs received at the laboratory during the relevant quarter. Specifically, the Western Australian Forensic Science Laboratory does not analyse all seizures less than two grams. As a result, the purity table will underestimate the number of samples that are tested.

The time between the date of seizure by police and the date of receipt at the laboratories can vary from a few days to several months, and in isolated cases, years. The purity table represents those seizures analysed during the financial year 2006–07, not necessarily all seizures made during that period.

New South Wales Analytical Laboratory only tests for purity levels on cases larger than the trafficable level—three grams for amphetamine, methylamphetamine, heroin, cocaine and 0.75 grams for phenethylamines. Additionally, the laboratory will only test a limited number of samples per case. The laboratory also tests purity levels on controlled operations for the New South Wales Police, including undercover units.

As drug seizures are not routinely tested in the Northern Territory, the Northern Territory Forensic Laboratory was unable to provide purity data for this report.

ACT Policing does not test for purity on all seizures—only those which are larger than the trafficable amount. All samples lodged by ACT Policing with the ACT Government Analytical Laboratory are tested, but not all are tested for purity. ACT Policing provided the purity data for inclusion in this report from analysis results provided by the ACT Government Analytical Laboratory (100).

Over the years there have been many calls for establishing a consistent, coherent national system for monitoring the purity of illicit drugs as a key indicator of drug availability, and by extension the success of drug law enforcement agencies in reducing drug availability. We recommend that an implementation plan for developing a coherent national system be established.

Cannabis potency

Australia has no national system for monitoring the potency of cannabis even though this drug is by far the most commonly available and used illicit drug in Australia. No cannabis potency testing program has been set in place despite community concerns, for over a decade, generated by speculative media reports, of large increases in the potency of cannabis products and of the adverse health consequences of increased potency. Researchers have identified the importance of having sound trend data on the potency of this drug (Hall & Swift 2000; McLaren *et al* 2008). The USA, in contrast, has been monitoring cannabis potency for many decades and those data are used for diverse purposes. For example, it has been claimed that the potency of cannabis in Australia has markedly increased in recent decades with the shift in users' preferences from cannabis leaf to cannabis tops and from outdoors-grown to hydroponically-grown cannabis. It has also been claimed that the increase in potency is linked to the marked increase in the number of people presenting to treatment agencies, in recent years, for assistance with cannabis related problems including dependency.

The increasingly convincing body of research evidence about the relationships between cannabis use and mental health problems is also part of the context.

Establishing a national system for monitoring the potency of cannabis should be one of the priorities for filling the existing gaps in Australia's drug information system.

Drug use and drug-related harm among Indigenous people

Informants familiar with the AOD data relating to Indigenous peoples highlighted problems in this area. While the evidence is clear that the level of drug use among some sections of the Aboriginal and Torres Strait Islander population, and the levels of harm flowing from that use, are highly elevated, we have only limited epidemiological data on the levels of use and harm from which to develop intervention strategies and to monitor the implementation, outputs and outcomes. For example, recent research by NDRI into Indigenous drug related mortality had to rely upon data gathered in a one-off survey conducted in 1994.³⁰

Concerns about this gap led to AIHW being commissioned to investigate data on Indigenous drug use, to identify gaps and to propose remedies for these deficiencies. Their comprehensive report, including findings and recommendations, was published in 2006: *Drug use among Aboriginal and Torres Strait Islander peoples: an assessment of data sources* and *Drug use among Aboriginal and Torres Strait Islander peoples: an assessment of data sources; data collection summaries* (AIHW 2006). The report details the 'Priority information needs and the main information gaps', stating:

...there is some information that is fundamental to understanding the nature of substance use among Indigenous people. This is information that enables substance use and Indigenous status to be consistently recorded, and thus basic prevalence estimates of various types of substance use across locations and population groups to be developed. Limitations in this highest priority information reduce the usefulness of the remaining information about, for example, patterns of substance use, contextual factors and access to services (p. 74).

The report lists the priority areas under the headings:

- the nature or patterns of substance use among Indigenous peoples
- the characteristics of Indigenous substance users and their contextual factors
- the harms associated with substance use by Indigenous people

³⁰ Department of Health and Family Services (c. 1995). *National Drug Strategy Household Survey: Urban Aboriginal and Torres Strait Islander Peoples Supplement 199.4*. Canberra: DHFS

- the affordability, accessibility and appropriateness of current approaches for intervention and treatment of substance use in Indigenous persons
- what interventions are working well and why are they working and what extra measures/initiatives could make a difference
- expenditure relating to treatment and other intervention,
- general or overarching gaps in information availability.

We have reproduced this list to emphasise the extent of information deficiencies and the breadth and depth of the AIHW's report's recommendations. We concur with most of them and have not seen any published response to the report from DoHA or IGCD. In our judgment, the most strategic approach to these issues is that a system be put in place to systematically review the report's findings and recommendations and implement them as appropriate.

Questioning the validity of some core data collections

Our investigations into the use of particular data collections in the AOD sector have identified stakeholder concerns about two data collections: the NDSHS and the Australian Secondary Students' Alcohol and Drug Survey (ASSAD).

With regard to the NDSHS, informants pointed to what they see as a low response rate and the possibility that this introduces systematic biases into the findings. Falling survey response rates is an international experience, not confined to Australia, and present challenges to the validity of survey findings (Caetano 2001). Apparently no research has been published on the pattern of non-responses and their implications. It would be useful if future reports on the NDS Household Survey address this specifically so as to re-assure readers who hold these concerns.

With regard to ASSAD, concerns exist about undocumented variations in the methodology of the survey on a school-by-school basis. We heard claims about poor quality data collection activity within classrooms, the validity of which we were not able to evaluate. Some informants familiar with drug data collection among young people, including in schools, said that we should scrap ASSAD and develop in its stead a new schools-based national drug data collection of known validity and reliability. As with the NDS Household Survey, it would be useful to have published information confirming the reliability and validity of ASSAD.

Efficiency

Although relatively small amounts of funds are allocated to drug information systems in Australia, they are expended relatively efficiently. The resources available have enabled a more or less continuous flow of data in diverse areas, with the reports of many of the key data collections available free of charge online (eg AIHW's publications) and/or in printed format (eg IDRS/EDRS).

The Drug Strategy Branch of DoHA has commissioned various organisations to develop and implement key data collections. For example, AIHW is responsible for the NDS Household Survey and the national minimum data set covering episodes of drug treatment provided by government funded agencies. NDARC is responsible for the IDRS/EDRS. This an efficient way to operate that draws upon the strengths of the contacted organisations.

On the other hand, having to rely on individual researchers and research organisations (often funded from sources such as NHMRC and ARC that do not give priority to substance abuse) to undertake priority research and data collection is sometimes inefficient, with adverse consequences which can be readily foreseen. The example of mortality data, presented above, highlights this. No organisation is responsible for obtaining causes of death data from the source agencies and analysing them, on an annual or more frequent basis, to enable the NDS to monitor

drug-caused mortality. NDARC does so for certain illicit drugs among certain population groups, but considerable delays exist before ABS makes the mortality data available for analysis and publication by NDARC

The IDRS/EDRS program co-ordinated by NDARC is highly efficient, with State, Territory and local level value-adding activities undertaken by various team members.

This evaluation has highlighted the fact that Australia has a relatively large number and wide range of individual AOD data collections and that each is useful within the domain that it covers. However, the absence of a national drug research strategy and a national drug information strategy creates inefficiencies. There is no coherent planning to ensure that Australia has the most efficient mix of data collections, resource allocation for the analysis of the existing data collections and the dissemination of findings to stakeholders. This is despite the fact that recommendations have been made a number of times, over the years, for the establishment of a well resourced, coherent national drug information strategy and implementation plan.

Summary of findings

Australia is among the world's leaders in having available information that can be used for monitoring drug related issues and trends. This resource has been developed over a number of years, primarily within the NDS. It is one of the most significant outcomes and achievements of the NDS over the past two decades.

The NDS has not been as effective as it could be in either monitoring drug trends or evaluating the impact of the NDS.

The absence of a national drug information system and national drug research strategy means that the data collections are not used as effectively and efficiently as they could be for monitoring drug issues and trends, for evaluation, and for informing policy activity. Too much decision-making about data collections reflects the priorities of the organisations responsible for collecting and/or analysing the data, rather than the needs of the NDS for the purposes of monitoring and decision support. There is a large difference between having data available from separate data collections on the one hand, and using them strategically, in combination, as part of policy activity on the other. This latter area—the strategic, policy-focused use of data and information—is one that particularly requires more attention.

Differences of opinion exist among stakeholders as to the usefulness or otherwise of establishing a *centralised* process and set of resources for managing a national drug information system and converting its outputs into products that can be directly used in policy activity. Some take the view that a centralised body, perhaps something like the UK Home Office, is necessary. Others argue that centralisation (particularly in the public service) would produce inefficiencies, interfere with innovation and cause difficulties for the managers of data collection and data analysis activity in outside bodies, including universities. It has been suggested that the Commonwealth should fund the States and Territories, including their police services, to enhance their data collection and analysis capacities, as in the first and second phases of the National Drug Strategy, with highly successful outcomes.

Some important gaps in drug information still exist, and there are significant delays in producing policy relevant findings from some of the most important data collections.

Major components of the NDS have been developed and implemented with little or no attention from the outset to the need for monitoring and evaluation. Prominent examples are IDDI and NGOTGP. No strategy is in place for monitoring the implementation and the outcomes of key sub-strategies of the NDS, including the recently developed National Alcohol Strategy and National Cannabis Strategy.

Recommendations

Recommendation 11: Build monitoring and evaluation into the design of all NDS sub-strategies from the outset.

Recommendation 12: Fill key gaps in Australia's AOD data systems by undertaking a strategic review of AOD data collection systems to prioritise where resources should be applied, including but not confined to:

- developing and implement a process for reviewing, and implementing as appropriate, the findings and recommendations of the 2006 AIHW investigation into data on drug use, drug-related harm and drug interventions among Aboriginal and Torres Strait Islander peoples
- developing a data collection system that provides data on drug-related mortality covering all drugs, at least annually, with minimal delays
- developing a nationally consistent monitoring system regarding the purity of illicit drugs, which includes a national cannabis potency monitoring program

Recommendation 13: Establish an expert committee to develop a national drug information system, including recommendations on contents, structures, resourcing and processes. Its starting point would be this report, the report of the former National Drug Research Strategy Committee and the report of the NDS Data Analysis Project. It could include developing a system for converting the products of core data collections into policy and action within the framework of the NDS.

Recommendation 14: Establish an ongoing system for monitoring drug issues and trends in Australia, based on a further refinement of the Headline Indicators used in this report.

Recommendation 15: Review the validity and reliability of the NDSHS and the Australian School Student Alcohol and Drug Survey (ASSAD) as they are increasingly being questioned. Reviews are needed to assure users that these data collections are sound or, alternatively, to identify problems and suggest remedies.

Chapter 8: Enhancing Australia's drug strategy

In Chapters 4-7 we have discussed in detail each of the four components of the evaluation. Here we draw attention to some of the overarching issues that have emerged from the evaluation. We do so first in general terms and then for each component in turn, together with the suggestions for future processes and improvements developed in each component.

Overarching conclusions: opportunities for improvement

The 'harm minimisation' concept and terminology

'Harm minimisation' as a concept has worked well for the NDS over its life. It has facilitated engagement of diverse people and perspectives, drawn attention to the contributions of the health, law enforcement and education sectors both separately and in partnerships, helped keep the focus on all psychoactive drugs, and created space for initiatives focussing on drug use prevalence and reducing harm among people who continue to use drugs.

Throughout the components of the evaluation, however, we have noticed an underlying debate about the contemporary usefulness of 'harm minimisation' in facilitating sound policy activity, underpinning program development and implementation, and shaping the operation of the advisory structures. Managers and decision-makers close to the NDS are largely comfortable with the term, using it as a convenient shorthand representation of a complex concept. It is less successful, however, in communicating the essence - the strengths - of the NDS in contemporary society. It no longer facilitates communication, understanding and leadership.

The time has come, we have argued, to find a term that better captures and communicates to diverse audiences what the NDS seeks to achieve. That is why we have recommended that a new term be developed, preferably one that is more explicit about the fact that the Strategy addresses the causes and well as the consequences of problematic drug use, and reduces the prevalence of harmful drug use as well as assisting people who continue to use drugs to reduce the harm they experience and they cause to others.

Partnerships and engagement

Partnerships have featured in the core policy settings of the NCADA/NDS since its inception. Indeed, the 1985 ADCA *Drugs In Australia: National Action* workshop that developed the Strategy's central features was an exercise in developing and using partnerships. This was the first time this occurred in the arena of national policy on substance use.

In each of the five phases of the NCADA/NDS, partnerships have been prominent in the Australian approach to drugs policy. The power of this approach has been acknowledged internationally. We see it continuing to be crucial in the next phase of the NDS and beyond.

The nature of partnerships was a theme in component 1, where the NDS as a policy framework was evaluated. In component 2 we highlighted its contribution to developing and implement NDS programs and attaining their goals. Component 3's focus on advisory structures illuminated partnerships as reflected in governance arrangements - formal structures, codes of practice and informal networking. The component 4 evaluation showed that data and information on their own are of limited usefulness. Their real value emerges from structured processes that use the data and information, particularly where there is partnership between the producers and disseminators of data on the one hand and the users of data on the other.

Linked to partnerships is the process of engagement. Developing mutually respectful partnerships among people and organisations with different world views and different agendas facilitates genuine engagement - engagement between people, engagement with ideas, and engagement in program articulation and implementation.

Tensions inevitably arise in partnerships. Individuals experience difficulty in communicating, organisations find themselves in competition, and any number of other challenges arise from time-to-time. Nevertheless, all four components highlighted the achievement of partnerships and engagement in their respective domains, and all have pointed to its instrumental role in attaining the overarching goals of the NDS.

The allocation of resources to the various AOD sectors and drug types

One of the greatest challenges for the NDS has been getting the right mixture of interventions. The reality is that we do not have clear enough guidance from research evidence to be able to identify the optimal mix of interventions at the high level of generality expressed as supply reduction, demand reduction and harm reduction. We need to achieve an allocation of investments across different drug types and intervention sectors that maximises impact by investing in appropriate, effective and cost-effective interventions.

Priority-setting strategies such as the Basic Priority Rating Scale (Vilnius & Dandoy 1990) draw attention to the value of focusing on the extent and seriousness of drug-related problems and on the effectiveness and cost-effectiveness of the interventions available to address them. Although the NDS policy framework provides limited guidance for this, the NDS programs are the outcomes of resource allocation decisions that reflect policy (whether developed explicitly or implicitly) on what the optimal mix and emphases should be. The advisory structures are crucial in facilitating informed discussion and decision-making on the optimal mix of interventions. The NDS information systems should inform quality decision-making on the mixture of investments.

Tobacco stands out as an area within the NDS where we have clear evidence of the extent of the problems and their seriousness, and good evidence of the most cost-effective interventions. There are few major impediments to implementing them. Yet only 5% of governments' drug budgets go to tobacco, the drug which causes 56% of the social costs of all forms of drug use.

This highlights the fact the NDS still has a long way to go in attaining the optimal strategic allocation of resources within and between drug types, target population groups, and implementation sectors. The drug policy Modelling Project aims to develop decision support tools in this area, and the work of the National Preventative Health Taskforce, in response to the Commonwealth's commitment to prevention, is likely to drive a reconsideration of the role of prevention in the new NDS agenda.

Use of evidence

The effective use of evidence is another theme that emerged in the evaluation. The policy activity discussed in component 1 is informed by many different types of evidence. As one authority explains, 'Evidence is information that affects the existing beliefs of important people...about significant features of the problem you are studying and how it might be solved or mitigated' (Bardach 2005, 11). The challenge for the NDS is to maximise the proportion of valid *research* evidence that stakeholders find 'convincing', in contrast to other types of 'evidence' that often convinces stakeholders, such as lobby-group pressure, media stories, case studies, self-interest, and pre-judgment of issues.

Component 2 dealt with NDS programs, asking how far these interventions were systematically informed by the evidence. The answer was that most have made good use of the research evidence, but more attention should be given to what we know about the relative cost-effectiveness of different interventions.

The main function of the advisory structures that are the evaluated in component 3 is to facilitate development of sound, evidence-informed policy and implementation. Component 4 is directed at developing the evidence base, and converting it into products that can be readily used in developing policy and monitoring and evaluating its effectiveness.

Leadership

Leadership also arose as a theme in all four components of the evaluation, more subtly in some than others. Clearly the NDS as a policy framework has a leadership role: it sets directions, priorities and (to an extent) boundaries, while giving scope for flexible responses that reflect local factors. Developing programs and implementing them requires leadership.

Although characterised within the NDS as parts of the advisory structure, bodies such as IGCD, MCDS, ANCD and others also clearly have leadership roles. They help to shape policy and its implementation.

A key finding of the evaluation was some disquiet in the AOD sector about the lack of information on how this is carried out. There were calls for increased transparency in the advisory structure. Even though Australia 'punches above its weight' in drug research and continuing data collection in key areas, it still does not have a coherent, managed drug information system. This reflects and contributes to a lack of leadership in the nation's research, monitoring and evaluation capacity and achievements.

Social determinants

During the two decades of the NDS, research into social gradients in health has crystallised an understanding of the importance of the social determinants of health and well-being on the one hand, and of adverse outcomes like morbidity and mortality, crime, poor school attainment, unemployment, poor social and life skills on the other. The evidence about the causal pathways is clearer than about the interventions best able to address these social determinants. Small studies have been conducted, with promising results, but scaling-up (particularly to national and global levels) has been a challenge. This is especially the case with psychoactive drug abuse. Although we accept that in many (perhaps most) cases there are multiple interacting causes, appropriate, effective and cost-effective responses are unclear.

Contemporary drug policy (component 1) needs to address the up-stream social determinants of problematic drug use. The portfolio of NDS programs (component 2) needs to include multi-sectoral universal, indicated and targeted population-level interventions if it is to be effective. In the future, the advisory structures (component 3) will need to obtain insights from non-AOD specialists. Information systems (component 4) will need to be expanded to address wider and deeper elements of the causal paths that end in problematic drug use and harmful societal responses to drug use and drug users.

Monitoring and evaluation

The importance of monitoring and evaluation has emerged in all four components. The policy cycle heuristic (Althaus *et al* 2007) reminds us that these activities are integral parts of policy activity, contributing to identification of needs, analysis of policy and decision-making, and post-intervention assessment.

All phases of the NDS have included commitments to monitoring and evaluation. Each phase has been evaluated, and those evaluations have been important inputs into developing the subsequent phase. Developing and using targets and quantitative performance indicators has not been a common or consistent feature of the NDS in the past. We have identified eleven headline indicators for monitoring and suggest that their usefulness be assessed in the next phase of the NDS, along with other promising indicators. This should be as part of an explicitly managed and resourced national drug information system.

Component 1: NDS as a policy framework

Observations about efficiency and effectiveness

Contemporary public policy practice suggests that good public policy includes a clear understanding of the issue or problem; goals that can be evaluated; an inclusive and highly participatory consultation process; and the use of the best available evidence.

Over all, the NDS policy framework has effectively informed and facilitated development and implementation of congruent policies throughout jurisdictions, between sectors of government, and across public, private and non-government domains. The NDS has achieved these outcomes by promoting a consistent approach to harm minimisation, partnerships, and the use of evidence. It has done this over a considerable time.

Interpretation of the term ‘harm minimisation’ has focused the attention of community, policy makers and implementers on the consequences of harmful drug use, perhaps at the expense of addressing its causes. For the purposes of advancing leadership, community engagement, and a balanced approach to implementing the NDS, ‘harm minimisation’ no longer adequately supports a shared understanding of the need for prevention of drug use and the prevention of drug related harm. Nor does it adequately support the leadership and broader engagement needed to achieve a better balance between health and law enforcement perspectives in policy development, between licit and illicit drug interventions, and across supply, demand and harm reduction strategies.

The NDS has successfully facilitated a national program of effort through coordination and consistency in drug policy development and implementation. However, the efficiency and effectiveness of policy development and implementation has been limited by delays in addressing more challenging agenda issues. For example, development and implementation of a national prevention agenda has been on the IGCD and MCDS agenda in the past, but it remains a key area of the NDS that is yet to be turned into a formal strategy and action. There is disagreement about the amount of specification in delivery and accountability mechanisms, the identification of financial resources through the Strategy and whether this is necessarily a function of the NDS.

Promotion of an evidence-based approach has not always aligned with policy priorities, and investment decisions have not always been aligned with evidence. For example, the balance of investment between licit and illicit drug activities and across supply reduction, demand reduction and harm reduction strategies has not always been consistent. Without an adequate monitoring or early warning system, the NDS is limited in its capacity to be forward-looking and address emerging forms of drug use and drug-related harms in a timely manner. In so doing, there is a need to take into account the sound evidence of the relationship between drug-related harm and economic, social and cross-cultural circumstances. The NDS also needs to engage more broadly with experts and external stakeholders in policy development throughout the policy cycle.

Future processes and recommended improvements

Recommendation 1: Highlight and further develop a shared public understanding of the causes and consequences of drug-related harm and the need to retain the three pillars of supply reduction, demand reduction, and harm reduction, and consider replacing the term ‘harm minimisation’ with words which better communicate the need for prevention of drug use and drug-related harm.

Recommendation 2: Review investment among law enforcement, health and education sectors; supply, demand and harm reduction strategies; and illicit and licit drugs, and develop and apply funding mechanisms, jointly planned at Commonwealth and State and Territory levels, to make allocations that reflect the relative seriousness of the harms and costs addressed, and the availability of evidence-informed strategies and beneficial interventions for addressing

them, in order to ensure that allocations provide cost-effective interventions across drug types and sectors.

Recommendation 3: Progress the development and implementation of a national prevention agenda, for example by:

- 1) using NDRI's work in documenting the evidence base for a prevention agenda, including the roles of law enforcement in prevention (Loxley *et al* 2004), as a point of departure for developing a formal prevention strategy and action
- 2) developing links between NDS and related sectors and fields to address the social determinants of health
- 3) working to implement contemporary understandings of the social determinants of harmful drug use intersectorally, between drug strategies and other areas of social programming

Recommendation 4: Encourage broader stakeholder engagement in policy processes, in particular, engagement with consumer groups, service providers, and local government, for example by:

- 1) building stronger engagement of the NDS with the education and corrections sectors, and enhancing links with related national strategies and policies (welfare reforms, taxation policy) and sectors (mental health, employment, discrimination)
- 2) identifying and developing structured processes for assessing the views of the broader public through public consultations, providing greater transparency in public policy development and involving more people in shaping the next NDS
- 3) disseminating policy-relevant evidence to the public to bridge the gap in public understanding of the evidence, and ensure that community consultation involves a better informed public and is more likely to meet the ideals of deliberative democracy
- 4) establish mechanisms to provide feedback on continuing implementation and outcomes to stakeholders such as consumer groups, NGOs, and professional organisations

Component 2: NDS program outcomes

Observations about efficiency and effectiveness

In line with the principles, objectives, priorities and sub-strategies of the NDS Framework, the NDS programs were designed on the basis of evidence and sound planning. If implemented as planned, they are likely to produce the intended outcomes. These programs have contributed to Australia's capacity to reduce drug-related harm. They have formed part of a broader system involving partnerships among sectors and the complementary investments and activities of Government, non-government, private and community sectors. Investment in NDS programs has contributed to public understanding of drug issues and improved community knowledge, attitudes towards drug use and the acceptability of drug treatment.

The work of sectors responsible for policies and programs that address broader the social determinants of problematic drug use has contributed to the success of AOD specific investment. Attempts to develop 'whole-of-government' responses to complex problems have met with mixed success. This highlights the need for explicit, resourced structures and processes at the levels of research, policy activity, program implementation and evaluation to deal with the complex issues in an integrated way.

The program of effort under the NDS has contributed to increased availability of evidence-based programs (national and State and Territory-based drug-specific treatment programs, new legislation, published guidelines and research, industry/government partnerships, and new data

collections). Financial outlays by governments have gone predominantly to drug law enforcement and treatment interventions for illicit drugs. In 2008, investment in the National Binge Drinking Strategy and the National Drug Strategy Campaign: Tobacco suggested that there is now a rebalancing towards licit drugs and prevention strategies.

The NDS Programs contributed to the delivery of an evidence-based continuum of drug treatment and care (eg additional residential rehabilitation beds, increased counselling, outreach, care planning and follow-up). At the same time, positive changes have been observed in many drug use trends (for example, declining tobacco and cannabis use, heroin overdose deaths, and methamphetamine use).

The success of NDS programs, in terms of efficiency and effectiveness, has been constrained by external factors as well as those specific to the AOD sector. These broader factors include: the limited availability of a generalist and specialist labour force for the sector and AOD skill shortages. Also significant has been the limited data available to inform performance monitoring, review and evaluate programs, and disseminate the products of these activities.

Future processes and recommended improvements

Recommendation 5: Further integrate treatment services and pathways across the government, non-government and private sectors, and encourage increased investment in comprehensive models of evidence-based interventions, for example by:

- 1) working collaboratively across sectors to develop referral pathways and integration of care, through government and NGO provider co-location, coordinated referral pathways, and shared care arrangements to meet the clinical and non-clinical needs of clients
- 2) increasing capacity across State and Territory, non-government, and private sectors for more collaborative needs-based planning, funding allocation, performance monitoring, and review processes

Recommendation 6: Develop a strategic approach to AOD workforce development to meet current and future needs, for example by:

- 1) addressing structural issues of national concern such as more competitive employment conditions in the AOD sector, better clinical supervision and mentoring, and incentives, benefits, continuity of entitlements across government, non-government and private providers, and funding for medical, nursing and allied health specialist training in AOD-related conditions
- 2) identifying strategies to ensure a supply of appropriately skilled and qualified workers (such as enhancing their scope of practice, and providing MBS items for allied health professionals engaged in the AOD sector)
- 3) identifying strategies to ensure a supply of appropriately skilled and qualified Aboriginal and Torres Strait Islander and CALD AOD workforces
- 4) using NCETA's central role to focus on strategic workforce development and modelling to estimate future needs, in collaboration with other bodies, including some of the State AOD peaks and State and Territory AOD agencies

Recommendation 7: Acknowledging the significant volume and quality of Australian AOD research output, further enhance national drug research capacity, for example by:

- 1) developing a coherent national drug research strategy and implementation program (perhaps based on the report of the former National Drug Research Strategy Committee)

- 2) addressing the lack of NDS-supported infrastructure for drug law enforcement research (including dedicated researchers and research centres)
- 3) enhancing collaboration between NDS national research centres and other drug research groups and projects

Recommendation 8: Increase capacity for performance monitoring, review and evaluation to inform future investment, for example by:

- 1) developing an evaluation framework (literature review of existing evidence, program logic, contextual factors, performance indicators, data items and mechanisms for collecting them) as an integral part of the design of new programs
- 2) identifying and developing data collection mechanisms
- 3) training staff to collect and use data to monitor the performance of programs, to ensure that programs remain evidence-based and are in a position to improve the quality of their services
- 4) undertaking regular program review and improvement processes based on performance data

Component 3: NDS Advisory structure

Observations about efficiency and effectiveness

Advisory structures for large, complex programs such as the NDS work best when built on the principles of good governance. In the case of the NDS, good governance speaks to the 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 clear delineation of roles and responsibilities of the Commonwealth and State and Territory governments, and the private and non-government sectors.

The terms of reference of the NDS advisory structure reflect contemporary principles of good governance. Its activities are effective in providing evidence-based advice and progressing the development and implementation of drug-related policies that are nationally consistent and coordinated, integrated and balanced approach across supply reduction, demand reduction and harm reduction by establishing representation across jurisdictions and sectors.

MCDS functions as the top level of decision-making in the NDS. Unlike many other Ministerial Councils, it reaps the benefits of having cross-sectoral membership. IGCD, the committee of senior officers supporting MCDS, also has members from a number of sectors. These two bodies provide effective forums for discussion among policy makers and senior advisors across levels and sectors of government. Intergovernmental partnerships are highly valued by all stakeholders. Expert advice is highly regarded and used by IGCD and MCDS.

However, three key challenges exist in ensuring that the MCDS has the best available advice to make decisions in the best interests of Australian drug policy:

- The limited capacity of the IGCD to provide evidence-informed advice in a timely manner to the MCDS decision making processes
- The limited ability of the IGCD to engage with stakeholders outside the IGCD and the ANCD in activities to inform policy-making and implementation

- The limited capacity of the IGCD, ANCD and working groups to engender public debate and incorporate community views into decision-making

Improved relationships between IGCD and MCDS and other government stakeholders outside of the NDS advisory structure and COAG are needed to increase MCDS's capacity to address the social determinants of health.

Future processes and recommended improvements

Recommendation 9: Establish an integrative mechanism to address current limitations of the diverse relationships among the IGCD, ANCD, NEAP, the working groups, and relevant NGOs/peaks. Its functions could include:

- providing a channel of advice that places identified needs and emerging issues on appropriate agendas, and disseminates the responses
- defining the relationship of ANCD to the NGO sector in encouraging inputs from the non-government and private sectors into policy, program design, implementation, and evaluation
- enhancing the value of the NEAP by creating an accessible, stratified database of preferred suppliers of expertise for the use of all the advisory structures as needed

Recommendation 10: Expand the IGCD's access to expertise and streamline its operations by:

- providing a funding mechanism for IGCD activity
- ensuring a balance of discussion of health and law enforcement issues during meetings
- engaging with challenging agenda items in a timely way
- strategically commissioning research from experts inside and outside the IGCD
- ensuring that its recommendations to the MCDS are supported by evidence-based advice
- adopting decision-making processes that are fully documented and transparent to the field

Component 4: NDS performance in facilitating and guiding the monitoring of drug issues and trends and the outcomes of the Strategy

Observations about efficiency and effectiveness

Australia is among the world's leaders in the availability of data and information on the extent and nature of drug use and drug-related harm. This has been one of the major achievements of 25 years of developmental work within the NDS and in association with it, and one of the Strategy's most widely-acknowledged positive outcomes. Many individuals and organisations have contributed to these achievements, including Commonwealth agencies, the NDRCE, AIHW, ABS and the State-based drug centres.

As mentioned earlier in this chapter, the availability of data has not been readily transformed into structured arrangements for monitoring the implementation, outputs and outcomes of the NDS. Little attention has been paid to using targets and quantitative performance indicators tied to them in the NDS. We heard little enthusiasm for proceeding along this path.

On the other hand, the two-yearly AIHW publication *Statistics on Drug Use in Australia* provides comprehensive data that could form the basis of monitoring if the data and information provided there (and elsewhere) were routinely and systematically analysed to identify the policy-relevant lessons contained therein. This is done with the eleven headline indicators detailed in Volume 2. We suggest that the next phase of the NDS include assessment of the usefulness of these or other headline indicators.

The commitment to evaluating the NDS during each of its phases, dating back to the 1985 Special Premiers' Conference on Drugs, has been realised in each of the Strategy's five phases, and the products of the evaluations of each phase have been used in developing the next phase. This is another of the Strategy's achievements.

By contrast, evaluation of individual NDS components and programs has been inadequate. Large, important, and sometimes innovative programs have been established with little or no thought to monitoring and evaluation. This needs attention in the Strategy's next phase.

Previous evaluations of earlier phases of the NDS have recommended establishing sub-strategies to deal with drug research and drug information systems, but these recommendations have not been adopted, though other stakeholders have done studies and submitted recommendations on this issue. Soundly developed sub-strategies addressing research and information systems would contribute directly to sound NDS policy activity, and therefore we consider the matter warrants re-consideration.

Future processes and recommended improvements

Recommendation 11 Build monitoring and evaluation into the design of all NDS sub-strategies from the outset.

Recommendation 12: Fill key gaps in Australia's AOD data systems by undertaking a strategic review of AOD data collection systems to prioritise where resources should be applied, including but not confined to:

- developing and implement a process for reviewing, and implementing as appropriate, the findings and recommendations of the 2006 AIHW investigation into data on drug use, drug-related harm and drug interventions among Aboriginal and Torres Strait Islander peoples
- developing a data collection system that provides data on drug-related mortality covering all drugs, at least annually, with minimal delays
- developing a nationally consistent monitoring system regarding the purity of illicit drugs, which includes a national cannabis potency monitoring program

Recommendation 13: Establish an expert committee to develop a national drug information system, including recommendations on contents, structures, resourcing and processes. Its starting point would be this report, the report of the former National Drug Research Strategy Committee and the report of the NDS Data Analysis Project. It could include developing a system for converting the products of core data collections into policy and action within the framework of the NDS.

Recommendation 14: Establish an ongoing system for monitoring drug issues and trends in Australia, based on a further refinement of the Headline Indicators used in this report.

Recommendation 15: Review the validity and reliability of the NDSHS and the Australian School Student Alcohol and Drug Survey (ASSAD) as they are increasingly being questioned. Reviews are needed to assure users that these data collections are sound or, alternatively, to identify problems and suggest remedies.

Concluding remarks

The NDS has been operating under various names for over two decades. This justifies the prophetic words of the Commonwealth Minister for Health responsible for its initial development, Dr Neil Blewett MP, that ‘...a drug campaign is unlikely to yield many measurable short term achievements... A drug campaign’s success will be measured over a decade’ (Blewett 1987).

For many years the NDS has provided a model for other large, complex social interventions, embodying the fact that continuity of policy and effort is often required (along with other factors) for the attainment of sound outcomes.

The “Australian approach’, as it has come to be known, seeks to apply an effective and balanced combination of demand, supply and harm reduction, investments among alcohol, tobacco and other drugs, and among prevention, law enforcement and treatment. Its aims remain as valid today as they were in 1985.

The expanded availability of research-based evidence in recent years places the NDS in a better position to respond to current and emerging issues, and to anticipate new developments in an evidence-informed manner.

The context is changing, however. After a period of stability, new policies, structures, processes, resources and expectations are emerging in many domains. The work of the National Preventative Health Taskforce on a national prevention agenda that gives prominence to tobacco and alcohol, is likely to be important to a future NDS. Furthermore, the broadbanding of Special Purpose Payments by the Commonwealth to the States and Territories, and the introduction of National Partnership Payments under COAG, constitute new opportunities and challenges for developing the NDS policy framework, structures and processes. Australia may also be seeing a greater investment in demand reduction than has occurred to date.

Finally, we acknowledge the contributions that thousands of front-line workers in the policing, health, education, social welfare and allied sectors have made to changing individual, family, community and national well-being. Their contributions, and those of community activists, researchers, policy makers and managers, have been instrumental in maintaining the momentum and success of Australia’s National Drug Strategy.

