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.

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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 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 NCPI 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 NCPF, 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.\(^\text{18}\)

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,\(^\text{19}\) 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

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).  

**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.  

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.

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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. 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, the recent initiative of IGCD to commission a new national workforce development strategy has the potential for better outcomes.

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22 See the case study in Component 3.
Identification and response to emerging trends

The CSFM projects, NDRCE, NDLERF, NCI, and more recently NCPTIC 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 Heath 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 reinvigoration of the National Tobacco Strategy and Indigenous Control Initiative totalling $28.5 million. This rebalancing of investment across licits and illicits 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 that 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 - Illicitcs: 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 - Illicitcs: 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 illicits 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

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