

**INTERGOVERNMENTAL COMMITTEE  
ON DRUGS**

**National Drug Strategy  
2016-2025**

**Draft: For public consultation**

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# Contents

- FOREWORD ..... 3**
- 1 INTRODUCTION ..... 5**
  - 1.1 Aim .....6
  - 1.2 Harm Minimisation Approach.....6
    - 1.2.1 Three pillars of Harm Minimisation .....6
  - 1.3 Principles.....7
    - Partnerships .....7
    - Coordination and collaboration .....7
    - Evidence informed responses .....7
    - National direction, jurisdictional implementation.....7
- 2 PRIORITIES FOR THE NATIONAL DRUG STRATEGY ..... 9**
- 3 DEMAND REDUCTION ..... 11**
  - 3.1 What we know .....11
  - 3.2 Objectives of demand reduction.....13
    - Prevent uptake and delay first use .....13
    - Reduce harmful use .....13
    - Support people to recover from dependence and reintegrate with the community .....13
  - 3.3 What the evidence shows is Good Practice .....13
- 4 SUPPLY REDUCTION ..... 16**
  - 4.1 What we know .....17
  - 4.2 Objectives of supply reduction .....18
    - Control licit drug and precursor availability.....18
    - Reduce illicit drug availability and accessibility .....19
  - 4.3 What the evidence shows is Good Practice .....19
- 5 HARM REDUCTION ..... 22**
  - 5.1 What we know .....22
  - 5.2 Objectives of harm reduction .....23
    - Reduce risk behaviours .....23
    - Safer settings.....23
  - 5.3 What the evidence shows is Good Practice .....24
- 6 PRIORITY POPULATIONS.....26**
  - 6.1 Aboriginal and Torres Strait Islander People .....26

6.2	People with mental illness .....	27
6.3	Young people .....	27
6.4	Older people .....	28
6.5	People in contact with the criminal justice system .....	28
6.6	Culturally and Linguistically Diverse Populations.....	29
6.7	People identifying as gay, lesbian, bisexual, transgender or intersex .....	30
<b>7</b>	<b>PRIORITY DRUG TYPES .....</b>	<b>31</b>
7.1	Tobacco .....	31
7.2	Alcohol .....	31
7.3	Methamphetamines and other stimulants.....	32
7.4	Cannabis.....	33
7.5	Misused Pharmaceuticals .....	33
7.6	Opioids including heroin .....	33
7.7	New psychoactive substances.....	34
<b>8</b>	<b>MEASURES OF SUCCESS .....</b>	<b>35</b>
<b>9</b>	<b>GOVERNANCE .....</b>	<b>36</b>
9.1	Intergovernmental Committee on Drugs.....	36
	Stakeholder and community engagement.....	37
	Sub-Strategies .....	37

# FOREWORD

This is the seventh iteration of the National Drug Strategy. The first version, the National Campaign Against Drug Abuse, was launched in 1985. In 1993, it was renamed the National Drug Strategy. Throughout its history, the Strategy has focused on the important relationship between law enforcement and health, as well as the need to engage with other areas of government, the non-government sector and the community in minimising harms associated with alcohol, tobacco and other drug use. While much has been achieved, alcohol, tobacco and other drug use continues to impact individuals, families and entire communities through negative health, legal, social and economic outcomes. The National Drug Strategy 2016-2025 aims to:

*“contribute to ensuring safe, healthy and resilient Australian communities through minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities.”*

For the first time, this Strategy will have a ten year term. This reflects the consistent and ongoing commitment to the harm minimisation approach over the National Drug Strategy’s 30 year history. The flexible structure of the Strategy allows for responses to be developed to emerging issues and changing policy environments within this framework.

The overarching harm-minimisation approach that has proved so successful in previous iterations of the Strategy remains the direction for 2016-2025. The National Drug Strategy 2016-2025 continues to build on the successful collaboration of health and law enforcement agencies in leading the implementation of the three pillars of harm minimisation:

- **demand reduction** to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community
- **supply reduction** to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs
- **harm reduction** to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs.

Partnerships are not only important in implementation; they have also been essential in the development of the National Drug Strategy 2016-2025. The writing of the Strategy was informed by an extensive national consultation process, which included key informant interviews, online survey feedback and stakeholder forums.

This process identified priorities for the next ten years, which will be vital in reducing drug-related harm. These are detailed in the Strategy, but can be summarised as:

- increasing processes for community to identify and respond to key alcohol, tobacco and other drug issues
- improving national coordination
- developing and sharing data and research that supports evidence-informed approaches
- developing innovative responses to prevent uptake, delay the first use and reduce harmful levels of alcohol, tobacco and other drug use
- restricting or regulating the availability of alcohol, tobacco and other drugs
- enhancing harm reduction approaches.

Measures for improving stakeholder and community engagement have been identified in the Strategy as a result of the consultation feedback process. Opportunities for consumers and communities, service providers, peer organisations and other interested parties to be engaged in alcohol, tobacco and other drug strategies over the next ten years will increase. The health and law enforcement sectors demonstrate an excellent working relationship for managing alcohol, tobacco and other drug issues and initiatives, which can be used as a model for improving engagement with other parts of the sector.

During the period of the National Drug Strategy 2010-2015, evidence informed demand, supply and harm reduction strategies yielded positive results.

In 2011-12, police reported 76,083 drug seizures; the highest number of drug seizures in the last decade<sup>1</sup>. The same year, 809 clandestine laboratories were detected nationwide; the highest number ever detected in Australia<sup>2</sup>. In 2012-13, police made the second highest number of detections ever at 757<sup>3</sup>.

The significant decline in daily smoking rates between 2010 and 2013 from 15.1% to 12.8%<sup>4</sup> was a major achievement. There was also a decline in the proportion of people exceeding lifetime risk guidelines for consuming alcohol from 20% in 2010 to 18.2% in 2013. There were declines in the use of some illicit drugs between 2010 and 2013, including heroin and ecstasy and a decrease in the proportion of people injecting drugs during this period.

While those people with the lowest socio-economic status were more likely to smoke and consume alcohol at risky quantities, the proportion of daily smoking declined for this group from 22% in 2010 to 19.9% in 2013 and both lifetime and single occasion risky drinking declined slightly<sup>5</sup>.

The embedding of harm minimisation principles into the day-to-day operations of police, health services and other interested parties is also a worthy achievement.

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<sup>1</sup> Australian Crime Commission Annual Report 2011-12

<sup>2</sup> Australian Crime Commission Annual Report 2011-12

<sup>3</sup> Australian Crime Commission Annual Report 2012-13

<sup>4</sup> National Drug Strategy Household Survey detailed report 2013

<sup>5</sup> National Drug Strategy Household Survey detailed report 2013

# 1 INTRODUCTION

The National Drug Strategy 2016-2025 describes a nationally agreed harm minimisation approach to reducing the harm arising from alcohol, tobacco and other drug use. The Strategy takes Australia into the fourth decade with a consistent national drug policy framework, which has earned high international regard for its progressive, balanced and comprehensive approach and has made considerable achievements.

The term 'drug' in this document refers to a substance that produces a psychoactive effect when consumed by humans, including tobacco, alcohol, pharmaceutical drugs and illicit drugs. It also takes account of performance and image-enhancing drugs, and substances such as inhalants<sup>6</sup>.

Harms from drug use impacts on Australian communities, families and individuals. This includes health harms such as injury, lung and other cancers; cardiovascular disease; liver cirrhosis; mental health problems; road trauma; social harms including violence and other crime. It also includes economic harms from healthcare and law enforcement costs, decreased productivity, associated criminal activity, reinforcement of marginalisation and disadvantage, domestic and family violence and child protections issues. Harmful drug use is also associated with social and health determinants such as discrimination, unemployment, homelessness, poverty and family breakdown.

Since 1985, activities for the original National Campaign Against Drug Abuse and preceding National Drug Strategy iterations have demonstrated many of these harms can be minimised through coordinated, multi-agency approaches and community responses that address the harmful use of drugs and the underlying determinants of use. Cooperation between the law enforcement and health sectors is fundamental to drug harm responses and ongoing engagement with other key stakeholders is increasingly necessary for positive outcomes. Collaboration of this nature has facilitated referral pathways to alcohol and other drug treatment and supported less harmful substance use. The Strategy describes the national approach to prevent, minimise and address the drug harms to individuals, families and communities. It provides a national framework and guidance for action by Commonwealth, state and territory governments in partnership with service providers, local government and the community.

As well as outlining the national commitment to the harm minimisation approach, the Strategy describes priority actions, groups and drug types and summarises effective demand, supply and harm reduction strategies. The Strategy also includes headline indicators to monitor success.

Trends in alcohol, tobacco and other drug use change regularly and the evidence base for effective responses to drug-related harm is constantly evolving. As a consequence, priority populations and drug types, including forms and delivery, change over time. Interventions should change with them and be informed by the latest available evidence. The Strategy is informed by current evidence on drug use and effective strategies. However, priorities and responses are expected to change during the term of the Strategy. The Strategy provides a framework for flexible, proactive and nationally coordinated responses and is designed to adapt to changes based on the principles of harm minimisation.

Implementation of the approach presented in this Strategy, including funding, legislation and programs, is the responsibility of relevant agencies in Commonwealth, State and Territory

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<sup>6</sup> Ministerial Council on Drug Strategy (2004) The National Drug Strategy-Australia's Integrated Framework 2004-2009. [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/5EAED77A78166EB5CA2575B4001353A4/\\$File/framework0409.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/5EAED77A78166EB5CA2575B4001353A4/$File/framework0409.pdf)

jurisdictions. The mix of actions adopted in individual jurisdictions and the details of their implementation may vary to reflect local circumstances and priorities. Local innovation within the harm minimisation approach, responding to needs and emerging issues, leads to better outcomes.

## 1.1 Aim

The aim of the National Drug Strategy 2016-2025 is:

***To contribute to ensuring safe, healthy and resilient Australian communities through minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities.***

## 1.2 Harm Minimisation Approach

Australia's long standing harm minimisation approach has consistently addressed alcohol, tobacco and other drug issues to prevent or reduce the harmful effects of alcohol and other drug use. This approach considers the health, social and economic consequences of drug use on both the individual and the community as a whole and is based on the following considerations:

- Use of drugs, whether licit or illicit, is a part of society,
- Drug use occurs across a continuum, from occasional use to dependent use,
- A range of harms are associated with different types and patterns of drug use,
- Response to these harms can use a range of methodologies.

This approach reduces total harm due to alcohol, tobacco and other drug use through coordinated, multi-agency responses that address the three pillars of harm minimisation. These pillars are demand reduction, supply reduction and harm reduction. Strategies to minimise the harm from alcohol, tobacco and other drug use should be coordinated and balanced across the three pillars.

### 1.2.1 Three pillars of Harm Minimisation

#### **Demand Reduction**

Demand reduction includes strategies and actions that prevent the uptake of drug use, delay the first use of drugs, and reduce the harmful use of alcohol, tobacco and other drugs in the community. It also includes supporting people to recover from dependence and enhance their integration with the community.

#### **Supply Reduction**

Supply reduction includes strategies and actions that prevent, stop, disrupt or otherwise reduce the production and supply of illicit drugs; and control, manage or regulate the supply of alcohol, tobacco and other licit drugs.

#### **Harm Reduction**

Harm reduction strategies aim to reduce the negative outcomes from alcohol, tobacco and other drug use when it is occurring by encouraging safer behaviours, creating supportive environments and reducing preventable risk factors.

### **1.3 Principles**

The key principles of the National Drug Strategy 2016-2025 include the importance of partnerships; coordination and collaboration; implementation of evidence informed responses; and national direction, jurisdictional implementation. These principles underpin effective responses to alcohol, tobacco and other drug use.

#### **Partnerships**

The core partnership between health and law enforcement is central to the harm minimisation approach. This is reflected in membership of the Intergovernmental Committee on Drugs (IGCD), which has oversight of the Strategy on behalf of respective government ministers. However, a wide range of effective partnerships are critical components of the harm minimisation approach.

This includes partnerships between both government and non-government agencies in areas such as education, treatment and services, justice, child protection, social welfare, fiscal policy, trade, consumer policy, road safety and employment. It also includes partnerships with researchers and communities, affected communities such as drug user organisations, Aboriginal and Torres Strait Islander communities, and other priority populations.

#### **Coordination and collaboration**

Coordination and collaboration at the international level, nationally and within jurisdictions leads to improved outcomes, innovative responses and better use of resources. The Strategy coordinates the national response to alcohol, tobacco and other drugs by establishing the harm minimisation approach. The Strategy also facilitates collaboration by describing the wide variety of responsibilities within the harm minimisation approach and their interdependence, as well as through the Strategy's governance structure.

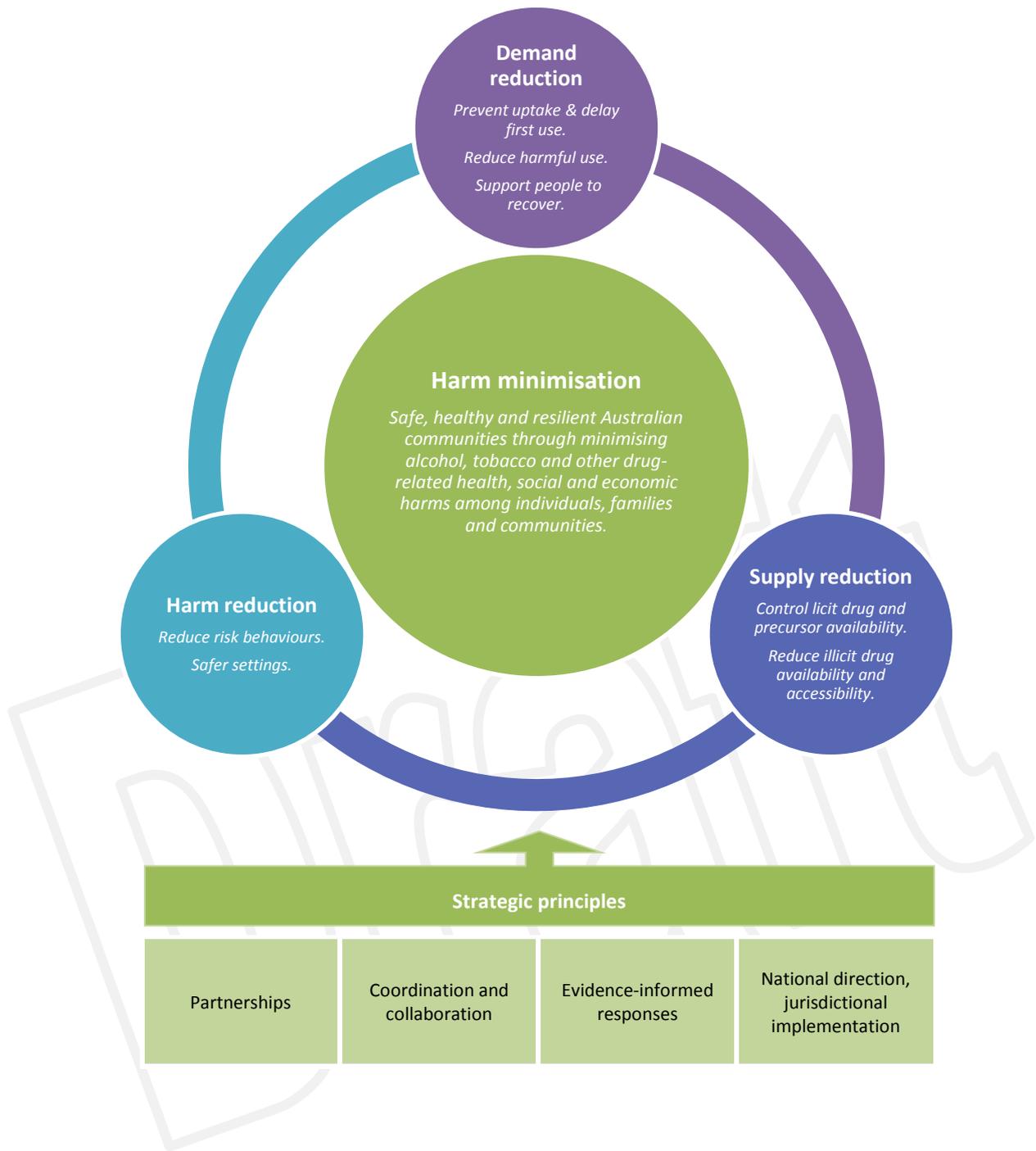
#### **Evidence informed responses**

Funding, resource allocation and implementation of strategies should be informed by evidence where possible. The Strategy is informed by current evidence. However, evidence is constantly improving and priorities and effective responses will develop during the term of the Strategy. Innovation and leadership in the development of new approaches is encouraged within the framework of harm minimisation. Supporting research and building and sharing evidence is a key mechanism that allows a national approach to leverage better outcomes from local implementation. Where evidence is not available or limited, effective policy should still be implemented, especially when this will expand the knowledge base.

#### **National direction, jurisdictional implementation**

The Strategy describes a nationally agreed harm minimisation approach to reducing the harm from alcohol, tobacco and other drug use. Examples of evidence informed approaches are described in the Strategy. However, funding and implementation occurs at all levels of government and the Commonwealth Government, state and territory governments and local governments are all responsible for regulation and the funding of programs that reduce the harms of drug use.

Jurisdictional implementation allows for governments to take action relevant to their jurisdiction within the national harm minimisation approach. Strategies should reflect local circumstances and address emerging issues and drug types. Coordination and collaboration supports jurisdictions to develop better responses and innovations within the national approach that can inform and benefit all jurisdictions by sharing practices and learning.



## 2 PRIORITIES FOR THE NATIONAL DRUG STRATEGY

Priorities for the National Drug Strategy are areas identified for specific coordinated action between jurisdictions. The Strategy describes an overall national commitment to the harm minimisation approach. In the implementation of harm minimisation, jurisdictions will have programs, initiatives and priorities reflecting local circumstances and areas of responsibility. Priorities for the National Drug Strategy are complementary to this approach. They have been identified through consultation, by incorporating available data and evidence, and by reviewing existing projects under the National Drug Strategy. The Priorities for the National Drug Strategy are:

- Increase participatory processes that facilitate community engagement and involvement in identifying and responding to the key national alcohol, tobacco and other drug issues.
- Improve national coordination for identifying and addressing drug use and its harms, sharing jurisdictional information on innovative approaches, and developing effective responses.
- Develop and share data and research that support evidence informed approaches.
- Develop new and innovative responses to prevent uptake, delay the first use and reduce harmful levels of alcohol, tobacco and other drug use, including:
  - Building community knowledge of alcohol, tobacco and other drug-related harms to encourage cessation and reduce harmful use
  - Increasing access to treatment services, including new approaches responding to emerging issues
  - Facilitating treatment service planning and responsibility for implementation between levels of government
  - Exploring effective price mechanisms shown to reduce uptake and use
  - Reducing exposure to licit drugs, particularly for young people and adolescents, through regulation of promotion and marketing.
- Develop responses that restrict or regulate the availability of alcohol, tobacco and other drugs, including:
  - Identifying and responding to challenges arising from new supply modes through the internet, postal services and other emerging technologies
  - Working with those at the point of supply for licit drugs, chemicals and equipment to minimise their misuse and opportunities for diversion to unlawful use
  - Identifying and responding to new methods for illicit drug production and supply
  - Supporting nationally consistent legislative and regulatory responses, particularly for international border control and challenges inhibiting inter-jurisdictional collaboration
  - Enhancing use and sharing of intelligence to identify and respond to emerging trends and issues.
- Reduce the adverse health, social and economic consequences associated with alcohol, tobacco and other drug use by enhancing harm reduction approaches, including:
  - Providing opportunities for intervention amongst high prevalence or high risk groups, including the implementation of settings based approaches to modify risk behaviours
  - Monitoring emerging drug issues to provide advice to the health, law enforcement, education and social services sectors for informing individuals and the community regarding risky behaviours
  - Continuing evidence based strategies shown to reduce the spread of blood borne virus, decrease road trauma, reduce passive smoking exposure, and decrease overdose risk, with translation of this evidence to address new and emerging issues

- Enhancing systems to facilitate greater diversion into health interventions from the criminal justice system, particularly for Aboriginal and Torres Strait Islander peoples, or other at risk populations who may be experiencing disproportionate harm
- Increasing access to pharmacotherapy demonstrated to reduce drug dependence, and encourage treatment engagement and compliance.

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## 3 DEMAND REDUCTION

Demand reduction strategies aim to prevent uptake, delay the first use, and reduce harmful levels of use of alcohol, tobacco and other drugs. There are many reasons that people use drugs, including socialising, experimentation, coping with stress or difficult life situations, peer pressure, increasing pleasure or to intensify feelings and behaviours. Demand reduction strategies influence these factors to delay, prevent or reduce use. An effective demand reduction approach includes strategies such as price mechanisms, building community knowledge and changing acceptability of use, regulation of advertising and promotional activities, early intervention and treatment, ongoing care and addressing underlying determinants of demand.

Demand reduction strategies also include building social inclusion and resilience. Resilient individuals can adapt to change and negative events more easily, reducing the impact of stressors and use of alcohol, tobacco or other drugs. Socially inclusive communities have strong social networks and work together to support individuals who need assistance. They promote safe and healthy lifestyles and can prevent the uptake of drug use, identify drug use in its early stages and help individuals access and maintain treatment.

For many people alcohol, tobacco or other drug use is one factor in complex social issues. Harmful drug use is associated with social and health concerns that have as common determinants factors such as discrimination, unemployment, homelessness, poverty and family breakdown. Strong protective factors that guard against harmful drug use and are important in preventing or overcoming drug-related problems include employment, income, participation in education, appropriate housing and supportive family and community.

As well as reducing use by the whole population, demand reduction strategies should target health and social inequalities that exist among specific population groups, including Aboriginal and Torres Strait Islander people; people living with a mental illness; people in contact with the criminal justice system; gay, lesbian, bisexual, transgender and intersex (GLBTI) people; and other marginalised or disadvantaged groups.

Along with strategies specifically aimed at drug use, many areas of government and the community can impact on demand reduction as part of activities to build stronger and healthier communities through addressing social, health and economic determinants of drug use. Specialist alcohol and other drug services can partner or collaborate with other service providers on providing education, employment, infrastructure, addressing stigma and discrimination and other factors influencing the social determinants of health.

### 3.1 What we know

The proportion of people that smoke daily has decreased from 19.4% in 2001 to 12.8% in 2013<sup>7</sup> and the proportion of daily drinkers has had a slight reduction from 2001 to 2013 (8.3% to 6.5%).<sup>8</sup> The proportion of Australians using any illicit drug in the preceding 12 months has also reduced slightly since 2001 (16.7% to 15%).<sup>9</sup>

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<sup>7</sup> Australian Institute of Health and Welfare (2014) National Drug Strategy Household Survey detailed report 2013, Drug statistics series no. 28. Cat no. PHE 183. Canberra: AIHW,

<sup>8</sup> Australian Institute of Health and Welfare (2014) National Drug Strategy Household Survey detailed report 2013, Drug statistics series no. 28. Cat no. PHE 183. Canberra: AIHW,

<sup>9</sup> Australian Institute of Health and Welfare (2014) National Drug Strategy Household Survey detailed report 2013, Drug statistics series no. 28. Cat no. PHE 183. Canberra: AIHW,

The proportion of school students 16 and 17 years old who smoked in the last seven days has decreased since 2005 (16.6% in 2005 and 12.9% in 2011)<sup>10</sup>. There has also been a moderate decline in the proportion of school students 16 to 17 years of age who had consumed alcohol in the last week (47% in 2005 and 33% in 2011).<sup>11</sup> Furthermore, the percentage of 16 and 17 year old students using any illicit drug in the past month has remained stable since 2005 (12.8% in 2005 and 13.2% in 2011).<sup>12</sup>

There has also been a delay in the first use of alcohol, tobacco and other drugs by young people in Australia<sup>13</sup>. The average age that young people smoked their first full cigarette increased from 14.3 years in 2001 to 15.9 years in 2013 and increased from 14.7 years to 15.7 years for the first full drink of alcohol in the same period<sup>14</sup>. Among Australians between 14 and 24 years, the age of initiation into illicit drug use increased from 15.2 years to 16.3 years between 2001 and 2013<sup>15</sup>.

However, challenges for demand reduction remain. More than 18% of Australians consume alcohol on a daily basis at levels that place them at risk of long-term harm<sup>16</sup> and 26% drink at levels on a monthly basis that pose a risk in terms of short-term harms, such as injury. While daily smoking prevalence for those aged 14 years or older declined to 12.8% in 2013<sup>17</sup>, the proportion is approximately 2.5 times higher among Aboriginal and Torres Strait Islander people.<sup>18</sup> Cannabis remains the most commonly used illicit drug with 10.2% of Australians 14 years and over using in the past 12 months<sup>19</sup>. While there has not been a rise in self-reported methamphetamine use overall, the proportion of users reporting the use of more potent crystal-methamphetamine form in the last 12 months, more than doubled between 2010 and 2013.<sup>20</sup>

In 2014, the Australian Institute of Health and Welfare reported that the number of alcohol and other drug treatment agencies and treatment episodes in Australia has been steadily increasing over the last decade, with 162,362 closed (completed) treatment episodes in 2012/13 (an increase of 6% from 2011/12).<sup>21</sup> The most common principal drug of concern for clients was alcohol (41%) and the proportion of clients reporting amphetamine (including methamphetamine) as their principal drug of concern has increased from 7% in 2009/2010 to 14% in 2012/2013.

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<sup>10</sup> Cancer Council Victoria. Tobacco, Alcohol, Over-the-counter and Illicit Substance Use Among Australian Secondary School Students.

<sup>11</sup> Cancer Council Victoria. Tobacco, Alcohol, Over-the-counter and Illicit Substance Use Among Australian Secondary School Students.

<sup>12</sup> Cancer Council Victoria. Tobacco, Alcohol, Over-the-counter and Illicit Substance Use Among Australian Secondary School Students.

<sup>13</sup> Australian Institute of Health and Welfare (2014) National Drug Strategy Household Survey detailed report 2013, Drug statistics series no. 28. Cat no. PHE 183. Canberra: AIHW.

<sup>14</sup> Australian Institute of Health and Welfare (2014) National Drug Strategy Household Survey detailed report 2013, Drug statistics series no. 28. Cat no. PHE 183. Canberra: AIHW. Available at <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129549848>

<sup>15</sup> Australian Institute of Health and Welfare (2014) National Drug Strategy Household Survey detailed report 2013, Drug statistics series no. 28. Cat no. PHE 183. Canberra: AIHW.

<sup>16</sup> Australian Institute of Health and Welfare (2014) *National Drug Strategy Household Survey: Detailed Report 2013*, Drug statistics series no. 28. Cat No. PHE 183. Canberra: AIHW.

<sup>17</sup> Australian Institute of Health and Welfare (2014) *National Drug Strategy Household Survey Detailed Report 2013*, Drug statistics series no. 28. Cat no. PHE 183. Canberra: AIHW.

<sup>18</sup> Australian Institute of Health and Welfare (2013). *National Drug Strategy Household Survey 2013, Specific Population Groups*. Available at: <http://www.aihw.gov.au/alcohol-Aboriginal-and-other-drugs/ndshs-2013/ch8/>. *Torres Strait Islander Health Performance Framework 2012: Detailed Analyses*. Cat. No. IHW 94. Canberra: AIHW.

<sup>19</sup> Australian Institute of Health and Welfare (2014) National Drug Strategy Household Survey detailed report 2013, Drug statistics series no. 28. Cat no. PHE 183. Canberra: AIHW,

<sup>20</sup> Australian Institute of Health and Welfare (2014) National Drug Strategy Household Survey detailed report 2013, Drug statistics series no. 28. Cat no. PHE 183. Canberra: AIHW,

<sup>21</sup> Australian Institute of Health and Welfare 2014. Alcohol and other drug treatment services in Australia 2012–13. Drug treatment series 24. Cat. no. HSE 150. Canberra: AIHW.

## **3.2 Objectives of demand reduction**

### **Prevent uptake and delay first use**

Prevention of uptake reduces personal, family and community harms, allows better use of health and law enforcement resources, generates substantial social and economic benefits and produces a healthier workforce. Demand reduction strategies that prevent drug use are more cost-effective than treating established drug-related problems.

Delaying first use can also lead to improved health and social outcomes. The earlier a person commences use, the greater their risk of harm, including mental and physical health problems, and the greater their risk of continued drug use. Strategies that delay the onset of use prevent longer term harms and costs to the community.

### **Reduce harmful use**

Many of the harms arising from the use of alcohol, tobacco and other drugs are associated with the volume consumed. Demand reduction strategies that reduce harmful consumption levels over time or the amount taken on one occasion, can reduce harm.

### **Support people to recover from dependence and reintegrate with the community**

Supporting people to recover from dependence and reintegrate with the community, can result in people ceasing or reducing their drug use. This can reduce levels of demand and harms from substance misuse in the community. Treatment services are highly effective in helping individuals reduce their drug use, its associated health and social harms, and recover from drug dependence. They help individuals to address their immediate physical and mental health needs and, through psychosocial interventions, assist in building resilience, problem solving and coping skills for longer term health outcomes. Specialist alcohol and other drug services can refer to, or collaborate with other government or non-government agencies to facilitate access to services that will address broader social, health and economic needs that are barriers to recovery from dependence.

Approaches that address social determinants of health can also enhance community health and wellbeing and reduce health inequalities among specific population groups. This includes social services and community groups collaborating to improve access to housing, education, vocational and employment support, as well as developing and enhancing family and social connectedness.

## **3.3 What the evidence shows is Good Practice**

Demand reduction requires a comprehensive approach involving a mixture of regulation, government initiatives, community services and treatment services. Strategies that affect demand include:

- Price mechanisms
- Building community knowledge and changing acceptability of use
- Restrictions on promotion
- Treatment services and brief intervention
- Targeted approaches to high prevalence population groups, including Aboriginal and Torres Strait Islander people.
- Addressing underlying social, health and economic determinants of use.

The relative effectiveness of each strategy varies for alcohol, tobacco and other drugs, due to differences in legality and regulation, prevalence of demand and usage behaviours. Strategies are also more effective in combination than separately. A comprehensive demand reduction approach

should use a mix of these strategies and be tailored to meet the varied needs of individuals, families, communities, and specific population groups.

Examples of evidence informed demand reduction approaches are described in the table below. This list is not exhaustive, but rather highlights or provides a guide to the key approaches to be considered. An effective demand reduction strategy must reflect evidence as it becomes available and address emerging issues, drug types and local circumstances.

Evidence informed approach	Strategies
<b>Tobacco</b>	
Price mechanisms	<ul style="list-style-type: none"> <li>Excise tax increases</li> </ul>
Build community knowledge and change acceptability of use	<ul style="list-style-type: none"> <li>Sustained, high volume social marketing campaigns that encourage tobacco cessation</li> <li>Labelling and health warnings</li> </ul>
Restrictions on promotion	<ul style="list-style-type: none"> <li>Plain packaging</li> <li>Advertising bans</li> <li>Retail display bans</li> </ul>
Treatment	<ul style="list-style-type: none"> <li>Cessation support counselling</li> <li>Subsidised medications, including nicotine replacement therapy</li> </ul>
<b>Alcohol</b>	
Price mechanisms	<ul style="list-style-type: none"> <li>Excise tax increases</li> <li>Volumetric excise tax</li> <li>Minimum floor price</li> <li>Regulate price discounting and bundling</li> </ul>
Build community knowledge and change acceptability of use	<ul style="list-style-type: none"> <li>Social marketing strategies, including campaigns, as part of a comprehensive response</li> <li>Promotion of National Health and Medical Research Council's <i>Australian Guidelines to Reduce Health Risks from Drinking Alcohol</i></li> </ul>
Restrictions on promotion	<ul style="list-style-type: none"> <li>Enforced advertising standards and restrictions</li> <li>Regulate price promotion</li> <li>Regulate promotion at point of sale</li> <li>Regulate promotions in key settings, such as those aimed at young people</li> </ul>
Treatment	<ul style="list-style-type: none"> <li>Outpatient and inpatient treatment services</li> <li>Medication assisted treatment for alcohol dependence</li> <li>Family-support programs that can positively impact on patterns of drug use (including intergenerational patterns)</li> <li>Post treatment support programs to reduce relapse</li> </ul>

Evidence informed approach	Strategies
<b>Illicit and illicitly used</b>	
Price mechanisms	<ul style="list-style-type: none"> <li>Influence the market price of illicit drugs by law enforcement and border control activities</li> </ul>
Build community knowledge and change acceptability of use	<ul style="list-style-type: none"> <li>Targeted social marketing campaigns as part of a comprehensive response</li> <li>Peer education networks</li> </ul>
Restrictions on promotion	<ul style="list-style-type: none"> <li>Regulate the promotion of and exposure to drug paraphernalia</li> </ul>
Treatment	<ul style="list-style-type: none"> <li>Outpatient and inpatient treatment services</li> <li>Medication assisted treatment of opioid and other drug dependence</li> <li>Access to community pharmacies and GPs for drug treatment to support both reintegration with the community and long term treatment outcomes.</li> <li>Family-support programs that can prevent patterns of drug use (including intergenerational patterns)</li> </ul>
Diversion	<ul style="list-style-type: none"> <li>Diversion from the criminal justice system to treatment services</li> </ul>
<b>All drugs</b>	
Build community knowledge and change acceptability of use	<ul style="list-style-type: none"> <li>School programs, policies and curriculum</li> <li>Support programs targeting life transition points</li> <li>Build parenting and family capacity to support the positive development of children</li> <li>Social competence training</li> <li>Increased engagement in community activity (education, employment, cultural, sporting)</li> </ul>
Treatment	<ul style="list-style-type: none"> <li>Assessment and brief intervention by GP's, allied health professionals and in other settings</li> <li>Treatment guidelines that support evidence based approaches</li> </ul>
Targeted approaches to priority populations, including Aboriginal and Torres Strait Islander people	<ul style="list-style-type: none"> <li>Supporting the Aboriginal Community Controlled sector to provide treatment services within and for Aboriginal communities</li> <li>Capacity building for health services and training for key workers</li> <li>Targeted social marketing strategies</li> </ul>
Social determinants of health	<ul style="list-style-type: none"> <li>Address underlying determinants of drug use for individuals, communities and priority populations</li> </ul>
Workforce	<ul style="list-style-type: none"> <li>Building the capacity of the workforce to deliver services and respond to emerging issues</li> </ul>

## 4 SUPPLY REDUCTION

Supply reduction strategies aim to restrict availability and access to alcohol, tobacco and other drugs in order to prevent or reduce their inappropriate and harmful use. Controlling who can use, as well as when, where and how use occurs reduces the harm experienced by both the consumer and the broader community.

Supply reduction is an important component of the National Drug Strategy. Where strategies have been effectively implemented limiting access to drugs through prohibitive pricing and/or by decreased availability reductions in harm have been realised. Perhaps the best and most contemporaneous example is the 'heroin shortage' that occurred in 2000 causing dramatic price increases at the time (for example, the New South Wales cost per gram of heroin rose from \$360 to \$1200<sup>22</sup>) and from which the market has not recovered. Although prices have returned to previous levels and are stable, it has resulted in reduced use with prevalence rates in 2013 of only 0.1% compared to 0.8%<sup>23</sup> in 1998. There has also been a corresponding decrease in fatal overdose incidents from 737<sup>24</sup> in 1998 to 208<sup>25</sup> in 2011. In addition, there were significant reductions in crime, particularly robbery and general theft, as evidenced by New South Wales crime statistics<sup>26</sup>.

Supply reduction strategies in relation to illicit drugs seek to remove drugs, their suppliers and manufacturers from the market. They do this through the detection and seizure of drugs and the disruption and dismantling of criminal enterprises by taking legal action against individuals, confiscating assets and introducing further regulation to restrict activity and practices. Where alcohol, tobacco, pharmaceuticals and other legitimate products, chemicals or equipment that can be diverted for the purpose of manufacturing illicit drugs is concerned, supply strategies involve working with industry and informing communities to prevent misuse; enforcing existing regulations; and introducing new restrictions or conditions where required.

While law enforcement agencies have primary carriage of supply reduction activities in the national response to drug misuse supply reduction is not the sole responsibility of law enforcement. Effective supply reduction involves a wide range of government agencies including local councils, State and Territory Governments, the Commonwealth and foreign governments and transnational organisations. Industry too, is and has always been, critical to supply reduction efforts concerning licit substances, for example, in ensuring responsible service of alcohol. They are, however, becoming an increasingly important partner for addressing the growth in the misuse of pharmaceuticals and the diversion of chemicals and equipment to the black market and illicit drug cultivation and manufacture.

Local communities can contribute to supply reduction efforts through participation in and support of community action plans and dry community declarations, input into liquor licensing applications, and the reporting of suspicious activity around the supply and manufacture of drugs. Parents and families also have a role to play, not only in shaping the culture of young people and their acceptance of alcohol and other drug misuse, but in reducing supply. Strategies like secondary supply legislation and public information activities that target the adverse consequences of substance misuse are aimed at reducing the availability of alcohol and tobacco to young people, particularly in the home.

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<sup>22</sup> Weatherburn et al 2003

<sup>23</sup> 2013 National Drug Strategy Household Survey

<sup>24</sup> NDARC Monograph No. 46, 2000

<sup>25</sup> Roxburgh, A. and Burns, L. (2015). Accidental drug-induced deaths due to opioids in Australia, 2011. Sydney: National Drug and Alcohol Research Centre. Heroin specific data supplied through personal communication.

<sup>26</sup> Weatherburn and Holmes, 2013

The effectiveness of strategies such as these is necessarily dependent on the extent to which they are implemented and supported.

#### 4.1 What we know

The affordability of tobacco has reduced markedly in recent decades. In 1984, it would take a 20-cigarette-per-day smoker approximately one hour to earn sufficient money to buy a week's supply of tobacco. By 2011 it took 3 hours and 36 minutes<sup>27</sup>. Access to tobacco products has also changed. In 2011, young smokers were less likely to purchase their own cigarettes than in previous years<sup>28</sup>. The proportion of 12 and 15 year old smokers buying their own cigarettes decreased from over 50% in 1987 to 10.2% in 2011<sup>29</sup>.

In contrast, alcohol has become more affordable and available in Australia with the number of liquor licences increasing around the country over the last 15 years.<sup>30</sup> Increases in the density of liquor outlets have been shown to elevate rates of violence and other alcohol-related harms.<sup>31,32,33</sup>

Compared to other commodities, alcohol in Australia has become increasingly affordable over the last decade.<sup>34</sup> The relative price of wine, in particular, has substantially reduced in recent years.<sup>35</sup> The evidence shows that the price of alcohol highly influences the rate of consumption and rates of alcohol-related harm, particularly amongst young people and heavy or problem drinkers<sup>36</sup>.

Unlike alcohol and tobacco, there are no records of production and sale available for illicit substances. Instead proxy measures such as police detections, price and purity, need to be used to determine questions of availability and accessibility. The four drugs most commonly detected by law enforcement agencies in Australia, in no particular order, are cannabis, MDMA, methamphetamine and pharmaceuticals, including steroids.

Cannabis detections continue to rise steadily and price remains relatively stable. There have, however, been fluctuations in the detection and purity of methamphetamine and MDMA influenced by both global and domestic strategies.

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<sup>27</sup> Scollo, MM and Winstanley, MH. Tobacco in Australia: Facts and issues. 4th edn. Melbourne: Cancer Council Victoria; 2012. Available from [www.TobaccoInAustralia.org.au](http://www.TobaccoInAustralia.org.au)

<sup>28</sup> Cancer Council Victoria. Tobacco, Alcohol, Over-the-counter and Illicit Substance Use Among Australian Secondary School Students.

<sup>29</sup> Cancer Council Victoria. Tobacco, Alcohol, Over-the-counter and Illicit Substance Use Among Australian Secondary School Students.

<sup>30</sup> Trifonoff, A., Andrew, R., Steenson, T., Nicholas, R. and Roche, A.M. (2011). Liquor Licensing Legislation in Australia: A Jurisdictional Breakdown. National Centre for Education and Training on Addiction (NCETA). Flinders University, Adelaide, SA. Available at [http://nceta.flinders.edu.au/files/2613/5226/7674/EN457\\_LLReport2.pdf](http://nceta.flinders.edu.au/files/2613/5226/7674/EN457_LLReport2.pdf)

<sup>31</sup> Livingston, M. (2008). A Longitudinal Analysis of Alcohol Outlet Density and Assault. *Alcoholism: Clinical and Experimental Research*, 32(6), 1074-1079. doi:10.1111/j.1530-0277.2008.00669.x

<sup>32</sup> McKinney, C. M., Caetano, R., Harris, T. R., & Ebama, M. S. (2009). Alcohol Availability and Intimate Partner Violence Among US Couples. *Alcoholism: Clinical and Experimental Research*, 33(1), 169-176.

<sup>33</sup> Burgess, M. & Moffatt, S. (2011) 'The association between alcohol outlet density and assaults on and around licensed premises', *Crime and Justice Bulletin*, No. 147, Sydney: NSW Bureau of Crime Statistics and Research.

<sup>34</sup> National Preventative Health Taskforce Alcohol Working Group, *Preventing Alcohol-related Harm in Australia: A Window of Opportunity (Australia: The Healthiest Country by 2020, Technical Report No 3)* (2009): <[http://www.health.gov.au/internet/preventativehealth/publishing.nsf/Content/09C94C0F1B9799F5CA2574DD0081E770/\\$File/alcohol-jul09.pdf](http://www.health.gov.au/internet/preventativehealth/publishing.nsf/Content/09C94C0F1B9799F5CA2574DD0081E770/$File/alcohol-jul09.pdf)> accessed 27 March 2015.

<sup>35</sup> New South Wales Bureau of Crime Statistics and Research, *What are the Options? Pricing and Taxation Policy Reforms to Redress Excessive Alcohol Consumption and Related Harms in Australia*. [web document] (2011) <<http://www.bocsar.nsw.gov.au/Documents/r59a.pdf>> accessed 16 March 2015.

<sup>36</sup> World Health Organization Regional Office for Europe. *Evidence for the Effectiveness and Cost-effectiveness of Interventions to Reduce Alcohol-related Harm*. [web document] (2009) <[http://www.euro.who.int/\\_data/assets/pdf\\_file/0020/43319/E92823.pdf](http://www.euro.who.int/_data/assets/pdf_file/0020/43319/E92823.pdf)> accessed 27 March 2015.

By far the most significant of these are the changes in relation to methamphetamine. Since 2009/2010 there has been an increase in the availability of methamphetamine as indicated by more domestic seizures, border detections and arrests. The average annual purity of domestically seized methamphetamine has risen from 19% in 2010/2011 to 62% in 2013/2014 and in 2013/2014 the price per gram fell<sup>37</sup> providing further support for the observation that methamphetamine is currently readily available in Australia. As a consequence, States and Territories are reporting an increase in the harms associated with its use including increased presentations to drug treatment services and admissions to Australian public hospitals.

In 2013, 4.8% of Australian adults used pharmaceuticals in the last 12 months for non-medical purposes<sup>38</sup>, which represented a significant increase from 2010. Not surprisingly, availability of these drugs is also increasing, particularly with respect to opioid analgesics. Between 1992 and 2007 the number of opioid prescriptions subsidised under the Pharmaceutical Benefits Scheme increased from 2.4 to 7 million. More specifically, there was a 22 and 46-fold increase between 1997 and 2012 in the provision of oxycodone and fentanyl respectively, such that in 2012 oxycodone is the seventh leading drug prescribed by general practitioners<sup>39</sup>.

There is increased availability of these and there are indications that there is a growing level of diversion and misuse of these pharmaceuticals. Analysis of trends in accidental drug-induced deaths due to opioids in Australia reveal that in 1998 only 20.5% were due to opioids other than heroin as compared to 66.3% in 2011<sup>40</sup>. Of particular concern have been the deaths associated with oxycodone and more recently fentanyl. While the largest proportion of fentanyl scripts are provided to women over the age of 80 years, a disproportionate number of the deaths involve young males (with an average age of 39) injecting diverted fentanyl<sup>41</sup>. Detecting pharmaceuticals that have been illicitly obtained or supplied, or are for illicit consumption is difficult for police and not easily monitored. In 2009, examination of police data undertaken in preparation for the *National Pharmaceutical Drug Misuse Framework for Action*, however, identified there had been an increase in pharmaceutical detections, particularly opioid analgesics and that an illicit trade in these drugs had emerged in some jurisdictions.

## 4.2 Objectives of supply reduction

### Control licit drug and precursor availability

Harm from drug use is associated with when, where, how it occurs and who is using it. The harm from products that are legally available, including tobacco, alcohol and pharmaceuticals, can be reduced by regulating supply. This can include who is allowed to sell these products, when and where they are available and who they can be sold to.

Regulating supply also includes ensuring that substances such as pharmaceuticals, precursors, and volatiles are available for legitimate uses, but not diverted for illicit uses.

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<sup>37</sup> National Ice Task Force – based on IDDR analysis

<sup>38</sup> Australian Institute of Health and Welfare (2014) National Drug Strategy Household Survey detailed report 2013, Drug statistics series no. 28. Cat no. PHE 183. Canberra: AIHW,

<sup>39</sup> Dobbin, M. (2014) Pharmaceutical drug misuse in Australia. *Australian Prescriber*, 37(3)

<sup>40</sup> Roxburgh, A., & Burns, L. (2015). Accidental drug-induced deaths due to opioids in Australia, 2011. National Drug and Alcohol Research Centre, UNSW, Sydney.

<sup>41</sup> Roxburgh, et al (2013) *Drug and Alcohol Review* (32) Trends in fentanyl prescriptions and fentanyl-related mortality in Australia.

**Reduce illicit drug availability and accessibility**

Preventing or disrupting illicit supply of drugs and precursors reduces availability, leading to a reduction of use and consequential harms. Illicit supply of drugs includes drugs that are prohibited, such as cannabis, heroin, cocaine and methamphetamine, and those diverted from legitimate use, such as pharmaceuticals. It also includes illicit supply of substances that are legitimately available, such as alcohol, tobacco, solvents and those precursors used in illicit drug manufacture.

Preventing illicit supply includes dismantling or disruption of distribution networks and manufacturing and cultivation facilities or locations. It can be closely associated with policing activities aimed at organised crime.

**4.3 What the evidence shows is Good Practice**

Supply reduction requires regulation, intelligence and coordination between enforcement agencies, within jurisdictions, across jurisdictions and internationally. Strategies that affect supply include:

- Regulating retail sale
- Age restrictions
- Border control
- Regulating or disrupting production and distribution.

The relative effectiveness of each strategy varies for alcohol, tobacco and other drugs, due to differences in legality and regulation, prevalence of demand and usage behaviours. Strategies are also more effective in combination than separately. A comprehensive supply reduction approach should use a mix of these strategies and be tailored to meet the varied needs of communities.

Examples of evidence informed supply reduction approaches are described in the table below. This list is not exhaustive, but rather highlights or provides a guide to the key approaches to be considered. An effective supply reduction strategy must reflect evidence as it becomes available and address, emerging issues, drug types and local circumstances.

Evidence informed approach	Strategies
<b>Tobacco</b>	
Regulating retail sale	<ul style="list-style-type: none"> <li>• Retail licensing schemes, supported by strong enforcement and retailer education.</li> <li>• Restrictions on temporary outlets and vending machines</li> <li>• Detect and disrupt sales of prohibited products</li> </ul>
Age restrictions	<ul style="list-style-type: none"> <li>• Ban sales to people under 18</li> </ul>
Border control	<ul style="list-style-type: none"> <li>• Interrupt illegal importation and enforce payment of excise tax</li> <li>• Duty free restrictions</li> </ul>
Regulating or disrupting production and distribution	<ul style="list-style-type: none"> <li>• Regulating production</li> <li>• Regulating wholesaler distribution</li> <li>• Detect and disrupt illegally grown or produced products</li> </ul>
<b>Alcohol</b>	

Evidence informed approach	Strategies
Regulating retail sale	<ul style="list-style-type: none"> <li>• Retail licensing schemes supported by strong enforcement and retailer education.</li> <li>• Restricting the type of retailers or venues that can sell</li> <li>• Limiting the density of licensed retailers and venues</li> <li>• Limiting trading hours</li> <li>• Responsible alcohol service schemes</li> <li>• Liquor licensing restrictions</li> <li>• Detect and disrupt sales of prohibited products</li> <li>• Declaration of dry communities</li> <li>• Lower strength alcohol sale requirements</li> </ul>
Age restrictions	<ul style="list-style-type: none"> <li>• Ban sales to people under 18</li> <li>• Secondary supply restrictions</li> </ul>
Border control	<ul style="list-style-type: none"> <li>• Interrupt illegal importation and enforce payment of excise tax</li> <li>• Duty free restrictions</li> </ul>
Regulating or disrupting production and distribution	<ul style="list-style-type: none"> <li>• Regulating production</li> <li>• Regulating wholesaler distribution</li> <li>• Detect and disrupt illegally produced products</li> </ul>
<b>Illicit and illicitly used</b>	
Regulating retail sale	<ul style="list-style-type: none"> <li>• Licensing schemes for pharmacists, veterinarians and other health professionals that sell pharmaceuticals</li> <li>• Coordinated medication management system</li> <li>• Electronic prescriptions to minimise the risk of dispensing errors and fraudulent alteration of prescriptions</li> <li>• Substitution of low aromatic fuel in vulnerable locations for volatile substance abuse</li> </ul>
Supporting workers at the point of supply	<ul style="list-style-type: none"> <li>• Supporting workers at the point of supply of licit drugs, chemicals and equipment to reduce their misuse or diversion</li> <li>• Real time reporting of prescribing and dispensing events</li> </ul>
Age restrictions	<ul style="list-style-type: none"> <li>• Restricting sale of volatiles to people under 18</li> </ul>
Supporting prescribers and dispensers	<ul style="list-style-type: none"> <li>• National guidelines for treatment of conditions commonly indicated in problematic use</li> <li>• Professional peer review mechanisms</li> <li>• Training in managing and responding to patients placing pressure on prescribers for medication</li> <li>• Provide and promote use of Medicare Benefits Schedule items that remunerate and target medication review and non-pharmacological management of certain conditions</li> <li>• Increase training and support for those at the point of supply of pharmaceutical drugs to reduce the inappropriate supply, misuse and</li> </ul>

Evidence informed approach	Strategies
	diversion
Border control	<ul style="list-style-type: none"> <li>Prevent or disrupt transnational supply of prohibited substances and precursors</li> </ul>
Regulating or disrupting production and distribution	<ul style="list-style-type: none"> <li>Prevent, stop, disrupt or reduce production and supply</li> <li>Disrupt and dismantle criminal groups involved in production, trafficking and supply of illicit drugs and precursors</li> <li>Target financial proceeds and the confiscation of assets arising from illicit supply activities</li> <li>Regulate the legitimate trade of pharmaceuticals, precursors and equipment used in the manufacture of illicit drugs</li> </ul>
Enforcing legislation	<ul style="list-style-type: none"> <li>Asset confiscation</li> <li>Search, seize and destruction powers</li> </ul>
<b>All drugs</b>	
Regulating or disrupting production and distribution	<ul style="list-style-type: none"> <li>Regularly review legislation and scheduling to capture emerging substances, production mechanisms, devices and distribution methods.</li> <li>Timely enforcement of legislation with meaningful penalties</li> <li>Implement Australia's obligations under international treaties</li> </ul>
Intelligence	<ul style="list-style-type: none"> <li>Cooperation and collaboration between law enforcement and forensic agencies, across jurisdictions</li> <li>Build and maintain strong relationships with international partner agencies and bodies</li> <li>Gather intelligence on all aspects of drug supply markets including identifying emerging drugs and manufacturing techniques</li> <li>Effectively utilising trend monitoring and data collection</li> </ul>
Workforce	<ul style="list-style-type: none"> <li>Building the capacity of the workforce to deliver services and respond to emerging issues</li> </ul>

## 5 HARM REDUCTION

Harm reduction strategies aim to reduce the negative outcomes from drug use when it is occurring. They address adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs on individuals, families and communities. Harm reduction strategies encourage safer behaviours, reduce preventable risk factors and can contribute to a reduction in health and social inequalities among specific population groups.

An effective harm reduction approach includes strategies such as drink and drug driving prohibitions, safer design of drinking venues, drug diversion programs, needle and syringe programs, smoke-free areas, safe transport options and sobering up facilities. It includes maintaining public safety and responding to critical incidents, including family and other interpersonal violence in which alcohol or other drugs are implicated.

By reducing death, disease (including blood borne viruses), injury, violence and crime, the benefits of harm reduction extend beyond the individual to families, workplaces and wider community.

Harm reduction also includes protecting the health and safety of children and other family members in environments affected by drug use. There is significant evidence that the substance misuse of individuals can impact on the lives of their friends and family<sup>42</sup>. For example, research consistently shows a strong association between domestic violence and substance misuse, particularly risky drinking<sup>43</sup>. However, the impact depends on a range of factors, including the type and frequency of substance used and the social environment<sup>44</sup>.

Marginalisation and disadvantage are associated with increased harms from drug use and priority populations face greater risks. A complex interplay of factors, including physical health, mental health, generational influences, social determinants and discrimination influence an individual or community's vulnerability to harmful drug use. Harm reduction can also be achieved by addressing historical, cultural, social, economic and other determinants of health.

### 5.1 What we know

The cost to Australian society of alcohol, tobacco and other drug use in 2004–05 was estimated at \$55.2 billion, including costs to the health and hospitals system, lost workplace productivity, road accidents and crime. Of this, tobacco accounted for \$31.5 billion (56.2 per cent), alcohol accounted for \$15.3 billion (27.3 per cent) and illegal drugs accounted for \$8.2 billion (14.6 per cent).<sup>45</sup>

In 2011, there were 683 accidental deaths in Australia attributed to opioids<sup>46</sup>. Many of these deaths were due to multiple drugs being taken, including prescription opioids. The most commonly injected drugs among respondents to the Australian Needle and Syringe Program Surveys between 2009 and

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<sup>42</sup> Bromfield, L, Lamont, A, Parker, R, & Horsfall, B 2010, in preparation. 'Parenting, child abuse and neglect in families with multiple and complex problems: The co-occurrence of domestic violence, parental substance misuse, and mental illness', *NCPC Issues*, 33. Australian Institute of Family Studies, Melbourne. Retrieved from <[www.aifs.gov.au/nch/pubs/issues/issues33/index.html](http://www.aifs.gov.au/nch/pubs/issues/issues33/index.html)>.

<sup>43</sup> Lipsky, S., & Caetano, R. (2008). Is intimate partner violence associated with the use of alcohol treatment services? Results from the National Survey on Drug Use and Health. *Journal of Studies on Alcohol and Drugs*, (January), 30–38.

<sup>44</sup> Spooner, C., & Hetherington, K. (2005). Social determinants of drug use. Technical Report No. 228. National Drug and Alcohol Research Centre

<sup>45</sup> Collins, D. & Lapsley, H. (2008). The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004-05. National Drug Strategy Monograph Series No 66. Canberra: Australian Government Department of Health and Ageing. Available, available at [http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/34F55AF632F67B70CA2573F60005D42B/\\$File/mono64.pdf](http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/34F55AF632F67B70CA2573F60005D42B/$File/mono64.pdf)

<sup>46</sup> Roxburgh, A., & Burns, L. (2015). Accidental opioid-induced deaths in Australia 2011, Sydney: National Drug and Alcohol Research Centre (NDARC). Available at [https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/Accidental%20drug-induced%20deaths%20due%20to%20opioids%20in%20Australia,%202011\\_0.pdf](https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/Accidental%20drug-induced%20deaths%20due%20to%20opioids%20in%20Australia,%202011_0.pdf)

2013 were heroin and methamphetamine.<sup>47</sup> Unsafe injecting drug use is a major route of transmission of blood borne virus infections like hepatitis B, hepatitis C and HIV. The proportion of respondents who reported reusing needles and syringes in the last month was stable at between 21% and 24% from 2009 to 2013.<sup>48</sup>

Although Australia has achieved significant reductions in drink driving since the 1980s, it continues to be one of the main causes of road accidents, responsible for approximately 30% of road fatalities in Australia<sup>49</sup>. Research shows between 20-30% of drink drivers reoffend and contribute disproportionately to road trauma<sup>50</sup>. Alcohol-attributable road accidents in Australia cost an estimated \$3.1 billion in 2004/05.<sup>51</sup>

Substance use during pregnancy poses a risk of fetal harm, including Fetal Alcohol Spectrum Disorders (FASD). Smoking occurs among approximately 15.5%<sup>52</sup> of pregnant women in Australia and some drinking occurs among approximately 20% of pregnant women after learning of their pregnancy<sup>53</sup>.

## 5.2 Objectives of harm reduction

### Reduce risk behaviours

Harms from alcohol, tobacco and other drugs can arise from risky behaviours associated with drug use in addition to directly from use. These behaviours can be positively influenced through public policy and programs. Strategies that encourage safer behaviours reduce harm to individuals, families and communities.

Effective public policy has included drink driving laws that have reduced the incidence of driving while intoxicated, smoke-free area laws that have reduced exposure to second hand smoke and needle and syringe programs that have reduced the incidence of people sharing injecting equipment.

### Safer settings

Environmental changes can reduce the impacts of alcohol, tobacco and other drug use. Examples include smoke-free areas, plastic glasses, chill out spaces, providing free water at licensed venues and the opportunity for the safe disposal of needles and syringes. Strategies that create safer settings reduce harm.

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<sup>47</sup> Chow, S. Iversen, J. and Maher. L. (Drug injection trends among participants in the Australian Needle and Syringe Program Survey, 2009-2013

<sup>48</sup> URL: <https://ncpic.org.au/professionals/publications/aic-bulletins/polydrug-use-among-cannabis-users/>

<sup>49</sup> Australian Transport Council (ATC) 2011. National Road Safety Strategy 2011–2020. Canberra: ATC.

<sup>50</sup> Freeman, James and Watson, Barry (2006) An application of Stafford and Warr's reconceptualization of deterrence to a group of recidivist drink drivers. *Accident Analysis and Prevention* 38(3):pp. 462-471.

<sup>51</sup> Collins D, Lapsley H, 2008, The Costs of Tobacco, Alcohol and Illicit Drug Abuse to Australian Society in 2004-2005. Canberra: Commonwealth of Australia, 2008.

<sup>52</sup> Hilder I, Shichao Z, Parker M, Johan S, Chambers GM, 2014. Australia's mothers and babies 2012. Perinatal statistics series no. 30. Cat. No. PER 59. Canberra: AIHW.

<sup>53</sup> Callinan, S and Room, R. Alcohol consumption during pregnancy: Results from the 2010 National Drug Strategy Household Survey. Foundation for Alcohol Research and Evaluation. February 2012.

### 5.3 What the evidence shows is Good Practice

Harm reduction requires commitment from government and non-government programs, industry regulation and standards, and targeted communication strategies. Strategies that affect harm reduction include:

- Creating safer settings
- Safe transport and sobering up services
- Blood borne virus prevention
- Reducing driving under the influence of alcohol or other drugs
- Diversion initiatives

The relative effectiveness of each strategy varies for alcohol, tobacco and other drugs, due to differences in legality and regulation, prevalence of demand and usage behaviours. Strategies are also more effective in combination than separately. A comprehensive harm reduction approach should use a mix of these strategies and be tailored to meet the varied needs of individuals, families and communities.

Examples of evidence informed harm reduction approaches are described in the table below. This list is not exhaustive, but rather highlights or provides a guide to the key approaches to be considered. An effective harm reduction strategy must reflect evidence as it becomes available and address, emerging issues, drug types and local circumstances.

Evidence informed approach	Strategies
<b>Tobacco</b>	
Safer settings	<ul style="list-style-type: none"> <li>• Smoke-free areas</li> </ul>
Replacement therapies	<ul style="list-style-type: none"> <li>• Nicotine Replacement Therapy</li> </ul>
<b>Alcohol</b>	
Safe transport and sobering up services	<ul style="list-style-type: none"> <li>• Sobering up facilities</li> <li>• Mobile assistance patrols</li> <li>• Access to public transport</li> </ul>
Safer settings	<ul style="list-style-type: none"> <li>• Promotion of responsible venue operations</li> <li>• Dry areas</li> <li>• Mandatory plastic glassware</li> <li>• Availability of free water at licensed venues</li> <li>• Lock out times</li> <li>• Emergency services responses to critical incidents</li> <li>• Maintenance of public safety</li> </ul>
<b>Illicit and illicitly used</b>	
Safer settings	<ul style="list-style-type: none"> <li>• Chill-out spaces</li> <li>• Availability of free water at licensed venues</li> <li>• Information and peer education</li> </ul>

Evidence informed approach	Strategies
	<ul style="list-style-type: none"> <li>• Emergency services responses to critical incidents</li> <li>• Maintenance of public safety</li> </ul>
Diversion	<ul style="list-style-type: none"> <li>• Diversion from the criminal justice system to treatment services</li> </ul>
Blood borne virus prevention	<ul style="list-style-type: none"> <li>• Hepatitis B vaccination</li> <li>• BBV and STI testing, prevention, counselling and treatment</li> </ul>
Safer injecting practices	<ul style="list-style-type: none"> <li>• Diversity and accessibility of needle and syringe programs</li> <li>• Medically supervised injection centres</li> <li>• Peer education</li> <li>• Overdose prevention and response</li> <li>• Police policy to exercise discretion when attending drug overdoses</li> <li>• Non-injecting routes of administration</li> </ul>
Replacement therapies	<ul style="list-style-type: none"> <li>• Pharmacotherapy for opioid maintenance and other drug use</li> </ul>
<b>All drugs</b>	
Periods of increased risk	<ul style="list-style-type: none"> <li>• Programs to reduce alcohol, tobacco and other drug use during pregnancy</li> </ul>
Reduce driving under the influence of alcohol or other drugs	<ul style="list-style-type: none"> <li>• Random drink and drug driver testing</li> <li>• Zero blood alcohol concentration requirements on novice drivers</li> <li>• Penalties and intervention programs for recidivist drink or drug drivers</li> </ul>
Workforce	<ul style="list-style-type: none"> <li>• Building the capacity of the workforce to deliver services and respond to emerging issues</li> </ul>

## 6 PRIORITY POPULATIONS

Whole of population strategies can be very effective at reducing total harm and social impact. However, there are specific priority population groups that are faced with a range of health inequalities and do not respond as well to whole of population strategies. Understanding and addressing the needs of priority populations reduces harm, marginalisation and disadvantage among these groups.

Current priority populations include Aboriginal and Torres Strait Islander people; people with a mental illness; young people; older people; people in contact with the criminal justice system; culturally and linguistically diverse populations; and people who identify as gay, lesbian, bisexual, transgender or intersex.

However, priority populations can change over time and differ due to local circumstances. Approaches to priority populations should be informed by evidence as it develops. Agencies implementing strategies to reduce the harms from alcohol, tobacco and other drugs should be aware of groups in their area of responsibility that do not respond as well to whole of population strategies, have high prevalence or face specific risks and challenges.

### 6.1 Aboriginal and Torres Strait Islander People

Prevalence of smoking, risky drinking and other drug use, is high among Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander people can be susceptible to the harms resulting from alcohol, tobacco and other drug use as a result of cultural deprivation and disconnection to cultural values, traditions, trauma, poverty, discrimination and adequate access to services.<sup>54</sup>

Best practice approaches to addressing the needs of Aboriginal and Torres Strait Islander people include:<sup>55</sup>

- Culturally responsive and appropriate mainstream programs
- Aboriginal and Torres Strait Islander community-controlled services leading the planning, implementation and delivery of programs
- Services delivered by specialist Aboriginal and Torres Strait Islander drug and alcohol services with an understanding of their physical, spiritual, cultural, emotional and social needs
- Screening and brief intervention in primary care, Aboriginal Medical Services and other relevant health services
- Services delivered in urban, regional and remote locations and in settings such as prisons, hospitals and mental health facilities
- Involvement of families and communities where appropriate
- Addressing the social determinants of alcohol, tobacco and other drugs use, including homelessness, education, unemployment, grief/loss/trauma and violence
- Interagency collaboration and data sharing.

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<sup>54</sup> National Indigenous Drug and Alcohol Committee (2014) Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples, Australian National Council on Drugs. Available at <http://www.nidac.org.au/images/PDFs/NIDACpublications/AOD-Treatment-report.pdf>

<sup>55</sup> Ibid.

## 6.2 People with mental illness

The use of alcohol, tobacco and other drugs can interact with a mental illness in ways that create serious adverse effects on many areas of functioning, including work, relationships, health and safety. People with mental illness use alcohol, tobacco and other drugs for the same reasons as other people. However, they may also use because the immediate effect can provide positive relief from symptoms.<sup>56</sup>

Comorbidity, or the co-occurrence of an alcohol and other drug use disorder with one or more mental health conditions, can complicate treatment and services for both conditions. They can also co-occur with physical health conditions (e.g., cirrhosis, hepatitis, heart disease, diabetes), intellectual and learning disabilities, cognitive impairment, and chronic pain.

Twenty-one percent (21%) of illicit drug users have been diagnosed with or treated for a mental illness (double the rate of diagnosis compared to non-illicit drug users). Illicit drug users are more likely to report high levels of psychological distress (17.5%) compared to non-illicit drug users (8.6%).<sup>57</sup>

People with mental illness smoke at a much higher rate than the general population. In 2012 around 32 per cent of people with a mental illness smoked<sup>58</sup> compared with a national smoking rate of 12.8 per cent of people without a mental illness in 2013<sup>59</sup>. This rate is even higher among people with serious mental illness, with data showing that 67.2 per cent of people with a psychotic disorder were smoking in 2010 (3). Unlike the declining smoking rate for people without a mental illness, smoking rates for people with mental illness have not substantially changed in the last 12 years<sup>60</sup>.

Best practice approaches to addressing the needs of people with mental illness include:

- Implement smoke-free policies in mental health services
- Routine assessment of alcohol, tobacco and other drug use when someone presents with a mental illness
- Routine inquiry around mental illness or psychological distress when someone presents with alcohol, tobacco and other drug use
- Management and treatment approach based around readiness for change
- Client management should aim to increase the awareness of the relationship and effect the alcohol, tobacco and other drug use and mental illness have on each other
- Approaches designed to address specific co-morbid mental illnesses and with specific cohorts where the evidence base is established.

## 6.3 Young people

Young people face specific risks in relation to alcohol, tobacco and other drug use. Rates of risky behaviours are generally higher among young people than the broader population<sup>61</sup>. Some drug use has higher prevalence among young people and associated harm can be reduced by delaying initiation.

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<sup>56</sup> Mental Illness Fellowship Victoria –Understanding dual diagnosis: mental illness and substance use, available at <http://www.mifellowship.org/sites/default/files/styles/Fact%20Sheets/Understanding%20Dual%20Diagnosis.pdf>

<sup>57</sup> Australian Institute of Health and Welfare (2014) National Drug Strategy Household Survey detailed report 2013. Drug statistics series no. 28. Cat. No. PHE 183. Canberra: AIHW..

<sup>58</sup> SANE Australia. 2012. *Smoking and mental illness. SANE Factsheet No. 16.* <https://www.sane.org/information/factsheets-podcasts/210-smoking-and-mental-illness>

<sup>59</sup> Australian Institute of Health and Welfare. 2014. *National Drugs Strategy Household Surveys (NDSHS). Highlights from the 2013 survey.* <http://www.aihw.gov.au/alcohol-and-other-drugs/ndshs>

<sup>60</sup> Morgan et al. 2011. People living with psychotic illness 2010. Report on the second Australian national survey. [http://www.health.gov.au/internet/main/publishing.nsf/Content/717137A2F9B9FCC2CA257BF0001C118F/\\$File/psych10.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/717137A2F9B9FCC2CA257BF0001C118F/$File/psych10.pdf)

<sup>61</sup> Australian Bureau of Statistics, Australian Social Trends, 2008, 'Risk taking by young people', (cat. no. 4102.0) ABS, <[www.abs.gov.au](http://www.abs.gov.au)>.

Best practice approaches to addressing the needs of young people include:

- Regulation of alcohol and tobacco retailers
- Zero blood alcohol concentration requirements on novice drivers
- Family interventions
- Tailored services
- Connections to services
- School programs and curriculum
- Restrictions on access
- Price
- Promotional restrictions
- Tailored public education

## 6.4 Older people

Harmful use of prescription medications and alcohol is increasing in older people (ages 60 or over) in Australia. Older people can be more susceptible to the harms arising from alcohol, tobacco and other drug use as a result of pain and medication management, isolation, poor health, grief/loss/life events and loss of independent living.

Best practice approaches to addressing the needs of older people include:

- Early identification of issues in primary care settings
- Maintenance of social connections
- Promotion of community inclusion, positive environments and full and active lives
- Age appropriate treatment components
- Longer treatments
- Physically accessible services (hand rails, appropriate seating, transport etc)
- Outreach and home visits
- Workforce development to enable care for more complex co-morbidities.

## 6.5 People in contact with the criminal justice system

People in contact with the criminal justice system in Australia have high underlying rates of alcohol, tobacco and other drug use. In 2012 half of all prison entrants reported using cannabis prior to entering prison and more than one-third (37%) reported using methamphetamines. Between 50-90% of people who inject drugs have spent time in prison and 34% continue to inject while incarcerated. For those injecting drugs in prison, 90% report sharing needles/injecting equipment.<sup>62</sup> Blood borne virus rates among the prison population, who report injecting drug use in 2010 were for hepatitis C (51%); hepatitis B (1%); HIV (<1%).<sup>63</sup> In 2012, 80% of prison discharges reported that they smoked tobacco.<sup>64</sup>

Best practice approaches to addressing the needs of people in contact with the criminal justice system include:

- Implement smoke-free policies in correctional facilities.

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<sup>62</sup> Australian Institute of Health and Welfare 2013. The health of Australia's prisoners 2012. Cat. no. PHE 170. Canberra: AIHW, available at <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129543945>

<sup>63</sup> NDARC/Kirby Institute: National Prison Entrants BBV and risk behaviour survey report 2004, 2007, 2010

<sup>64</sup> Australian Institute of Health and Welfare 2013. The health of Australia's prisoners 2012. Cat. no. PHE 170. Canberra: AIHW.

- Improve the capability, capacity and confidence of the workforce to work with people who have a range of complex needs
- Access to education, health promotion, treatment and support services while in prison and during their transition back into the community
- Provision of a range of treatments, including detoxification and withdrawal management, pharmacotherapy, drug free units or therapeutic communities
- Testing, education and treatment for blood borne viruses
- Restorative justice conferencing
- Strengthen existing harm reduction efforts in prison settings, such as opioid substitution therapy, and to support inmates to adopt safe behaviours and assist inmates connect with health and social services post-release
- Aftercare and support post release
- Drug detection units and searching of offenders, staff, visitors, vehicles.

## 6.6 Culturally and Linguistically Diverse Populations

Some culturally and linguistically diverse (CALD) populations have higher rates of, or are at higher risk of, drug use. For example, some members of new migrant populations from countries where alcohol is not commonly used may be at greater risk when they come into contact with Australia's more liberal drinking culture. Some types of drugs specific to cultural groups, such as kava and khat, can also contribute to problems in the Australian setting and some individuals may have experienced torture, trauma, grief and loss, making them vulnerable to harmful use of drugs. Other factors that may make CALD groups susceptible to harmful use of alcohol, tobacco and other drugs include family stressors, unemployment, language barriers and a lack of understanding of available services.<sup>65</sup>

Best practice approaches to addressing the needs of CALD communities include:<sup>66 67</sup>

- Using trained interpreters
- Ensuring male or female clinicians are available and determine the client's preference
- Ensuring services are welcoming for CALD clients by displaying signage and images that reflect culturally diverse clients, and recruiting a culturally diverse workforce
- Providing care that is trauma-informed and client centred (this can be done by making efforts to understand each client's cultural background, family, migration and settlement experiences (including refugee experiences)
- Providing resources and service information in major community languages or in formats which are easier for CALD clients to understand
- Providing education and resources at CALD festivals/events
- Addressing social determinants of alcohol, tobacco and other drug use for CALD such as a lack of connectedness to their community and strained family relationships
- Providing a culturally sensitive service which is familiar with the different needs, norms and experiences of different CALD groups
- Ensuring appropriate training for frontline responders working with CALD communities.

<sup>65</sup> Drug Info Clearinghouse – Australian Drug Foundation (2007) Culturally and Linguistically Diverse Communities and Drug Prevention, *Prevention Research Quarterly: Current Evidence Evaluated*, available at [http://www.druginfoclearinghouse.org.au/attachments/349\\_PRQ01Jun07\\_FINAL.pdf](http://www.druginfoclearinghouse.org.au/attachments/349_PRQ01Jun07_FINAL.pdf)

<sup>66</sup> Ibid.

<sup>67</sup> Network of Alcohol and Other Drug Agencies (n.d.) Working with Diversity in Alcohol and Other Drug Settings, available at [http://www.nada.org.au/media/59706/nada\\_working\\_with\\_diversity\\_sept14.pdf](http://www.nada.org.au/media/59706/nada_working_with_diversity_sept14.pdf)

## 6.7 People identifying as gay, lesbian, bisexual, transgender or intersex

Those who identify as gay, lesbian, bisexual, transgender or intersex (GLBTI) can be at an increased risk of alcohol, tobacco and other drug use and harm from use. In 2013, use of licit and illicit drugs was more common in people who identified as homosexual or bisexual in Australia than for those identifying as heterosexual.<sup>68</sup> These risks can be increased by stigma and discrimination, familial issues, marginalisation within their own community as a result of sexually transmitted infections (STIs) and blood borne viruses (BBVs), fear of identification or visibility of GLBTI and a lack of support.<sup>69</sup>

Best practice approaches are not well defined for this particular group and further research is required to determine what works for the GLBTI community and the extent to which already established approaches for other groups may be effective. However, the literature does indicate the following approaches may be effective:<sup>70</sup>

- Involve GLBTI students or local GLBTI-friendly health clinics in health education and prevention programs
- Review how consumer data can be collected by providers to collect baseline data on health needs and services usage by GLBTI consumers
- Address homophobia and bullying in school education as well as provide comprehensive education around sexuality
- Workforce development and training in appropriate supports for GLBTI people
- Provide support groups specifically for GLBTI people
- Provide relevant educational materials at GLBTI social events
- Build capacity within GLBTI communities.

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<sup>68</sup> Australian Institute of Health and Welfare (2014). National Drug Strategy Household Survey detailed report 2013. Drug Statistics series no. 28. Cat. No. PHE 183. Canberra: AIHW.

<sup>69</sup> Gay and Lesbian Medical Association (2010) Healthy People 2010: Companion Document for Lesbian, Gay, Bisexual and Transgender Health, available at <https://www.med.umich.edu/diversity/pdffiles/healthpeople.pdf>

<sup>70</sup> Gay and Lesbian Medical Association (2010) Healthy People 2010: Companion Document for Lesbian, Gay, Bisexual and Transgender Health, available at <https://www.med.umich.edu/diversity/pdffiles/healthpeople.pdf>

## 7 PRIORITY DRUG TYPES

Current priority drug types include alcohol; tobacco; cannabis; methamphetamines and other stimulants; new psychoactive substances; opioids including heroin; and misused pharmaceuticals. These are the drug types associated with the most harm in Australia.

However, priority drug types change over time and differ due to local circumstances. Priority drug types should be informed by evidence as it develops.

In addition to these priority drug types, jurisdictions should be aware of emerging trends or drugs with concentrated use in specific communities. These include image enhancing drugs (steroids) and volatiles (fuel, paint and aerosols). Poly-drug use is also a significant concern and strategies that address this can be very effective at reducing harm.

### 7.1 Tobacco

Tobacco remains a significant cause of death and disability in Australia. Around 2.8 million Australians smoke<sup>71</sup> and an estimated 15,000 people die each year of smoking-related illness<sup>72</sup>. Tobacco smoking also carries the highest burden of drug-related costs on the Australian community<sup>73</sup>.

Australia's implementation of a range of multifaceted tobacco control measures has been effective in reducing smoking rates over recent decades, with daily smoking for those aged 14 years or older declining in Australia from 24.3% in 1991 to 12.8% in 2013. Smokers are also having fewer cigarettes per week (96 in 2013 compared to 111 in 2010).<sup>74</sup> However, tobacco smoking among disadvantaged populations remains high. Aboriginal and Torres Strait Islander people were 2.5 times more likely to smoke daily (32% compared to 12.4% for non-Aboriginal and Torres Strait Islander Australians)<sup>75</sup> and approximately 32% of people reporting a common mental illness smoked daily<sup>76</sup>, more than double the rate in the total Australian population.

Challenges remain for tobacco, including addressing the inequality in smoking rates between some disadvantaged populations and the broader community. In addition, it is important to maintain low smoking rates and expand smoke-free areas to protect people from second hand smoke. Responding to the introduction of e-cigarettes is also a matter currently faced by Australian jurisdictions.

### 7.2 Alcohol

Alcohol consumption has resulted in significant fiscal and health costs in Australia. In 2010, the cost of alcohol-related harm (including harm to others) was reported to be \$36 billion. Alcohol is also associated with 3,000 deaths and 65,000 hospitalisations every year.<sup>77</sup>

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<sup>71</sup> Australian Institute of Health and Welfare 2014. National Drug Strategy Household Survey detailed report 2013. Drug statistics series no. 28. Cat. No. PHE 183. Canberra: AIHW.

<sup>72</sup> Collins DJDj and lapsley HM. The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05. 2008, Canberra: Commonwealth Department of Health and Ageing.

<sup>73</sup> Scollo, MM and Winstanley, MH. Tobacco in Australia: Facts and issues. 4th edn. Melbourne: Cancer Council Victoria; 2012. Available from [www.TobaccoInAustralia.org.au](http://www.TobaccoInAustralia.org.au)

<sup>74</sup> Australian Institute of Health and Welfare 2014. National Drug Strategy Household Survey detailed report 2013. Drug statistics series no. 28. Cat. No. PHE 183. Canberra: AIHW.

<sup>75</sup> Scollo, MM and Winstanley, MH. Tobacco in Australia: Facts and issues. 4th edn. Melbourne: Cancer Council Victoria; 2012. Available from [www.TobaccoInAustralia.org.au](http://www.TobaccoInAustralia.org.au) Ibid.

<sup>76</sup> SANE AUSTRALIA. 2012. *Smoking and mental illness. SANE factsheet No. 16.* Available from [http://www.sane.org/images/stories/information/factsheets/fs16\\_smoking.pdf](http://www.sane.org/images/stories/information/factsheets/fs16_smoking.pdf)

<sup>77</sup> Miller, P., Curtis, A., Chikritzhs, T. & Toumbourou, J. (2015) Interventions for reducing alcohol supply, alcohol demand and alcohol-related harm. National Drug Law Enforcement Research Fund, Monograph Series No. 57.

While the burden of alcohol harms in the community remains high, some gains have been made. The proportion of people aged 14 or older who consumed alcohol daily declined between 2004 (8.9%) and 2013 (6.5%)<sup>78</sup>. The proportion of people exceeding the lifetime risk guidelines has reduced from 20.8% in 2004 to 18.2% in 2013, and those drinking more than four drinks on an occasion in the last month decreased from 29.5% in 2004 to 26.4% in 2013.

In the 2013 National Drug Strategy Household Survey, respondents were asked if anyone under the influence of or affected by alcohol had perpetrated verbal abuse, physical abuse or put them in fear in the preceding 12 months. 22.3% reported verbal abuse, 12.6% reported being put in fear and 8.7% reported being physically abused.

The ABS Crime Victimization Survey 2013-2014 identified that over 258,000 Australians aged 15 years and above report being the victim of an alcohol-related assault with only 51.5% reporting any assault to police<sup>79</sup>. Research suggests that there were 90 'one-punch' deaths in Australia between the years 2000 to 2012<sup>80</sup>. Alcohol was involved in 73% of those deaths.

### 7.3 Methamphetamines and other stimulants

Methamphetamine comes in a range of forms, including powder, paste, liquid, tablets and crystalline. Methamphetamines are part of a broader category of stimulants that also includes cocaine, and MDMA (ecstasy). Stimulants can be taken orally, smoked, snorted/inhaled and dissolved in water and injected. Some of the harms that can arise from the use of methamphetamines and other stimulants include mental illness, cognitive impairment, cardiovascular problems and overdose.<sup>81</sup>

According to the 2013 National Drug Strategy Household Survey, 2.1% of Australians had used methamphetamine in the past 12 months<sup>82</sup>. This figure has remained stable since 2007, but is lower than the prevalence recorded between 1998 and 2004.<sup>83</sup> However, among those who use amphetamine, the use of the powder form of the drug decreased significantly from 51% in 2010 to 29% in 2013, while the use of crystal-methamphetamine more than doubled since 2010 (from 22% to 50% in 2013) amongst methamphetamine users. There was also a significant increase in the proportion of users consuming methamphetamine daily or weekly (from 9% in 2010 to 16% in 2013). In addition, 16% of Australians identified methamphetamine as the illicit drug of most concern to the community (an increase from 10% in 2012). Violent behaviour is also more than six times as likely to occur among methamphetamine dependent people when they are using the drug, compared to when they are not using the drug<sup>84</sup>.

There was a reduction in the use of ecstasy 'in the last 12 months' from 3.0% in 2010 to 2.5% in 2013; while the proportion of Australians who used cocaine 'in the last 12 months' remained stable over the same period (2.1% in 2010 and 2013).

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<sup>78</sup> Australian Institute of Health and Welfare (2014) National Drug Strategy Household Survey detailed report 2013, Drug statistics series no. 28. Cat no. PHE 183. Canberra: AIHW.

<sup>79</sup> ABS Crime Victimization Australia 2012-13. Available at [www.abs.gov.au](http://www.abs.gov.au)

<sup>80</sup> Pilgrim et al. "King hit" fatalities in Australia, 2000-2012: The role of alcohol and other drugs. *Drug and Alcohol Dependence* 135 (2014) p119-132.

<sup>81</sup> Ministerial Council on Drug Strategy (n.d) National Amphetamine-Type Stimulant Strategy 2008-2011, Commonwealth of Australia

<sup>82</sup> Australian Institute of Health and Welfare (2014) National Drug Strategy Household Survey detailed report 2013, Drug statistics series no. 28. Cat no. PHE 183. Canberra: AIHW, available at <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129549848>

<sup>83</sup> Australian Institute of Health and Welfare (2014) National Drug Strategy Household Survey detailed report 2013, Drug statistics series no. 28. Cat no. PHE 183. Canberra: AIHW.

<sup>84</sup> McKetin et al. (2014) Does methamphetamine use increase violent behaviour? Evidence from a prospective longitudinal study. *Addiction* 109(5): 798-806.

## 7.4 Cannabis

The use of cannabis can result in various health impacts, including mental illness, respiratory illness, and cognitive defects<sup>85</sup>. In 2013, 10.2% of Australians over the age of 14 years had used cannabis in the last 12 months and 35% had used cannabis in their lifetime<sup>86</sup>. This figure has remained relatively stable since 2004.

As the most widely used of the illicit drugs in Australia, cannabis carries a significant burden of disease<sup>87</sup>. In particular, cannabis dependence among young adults is correlated with, and probably contributes to, mental disorders such as psychosis<sup>88</sup>.

## 7.5 Misused Pharmaceuticals

The range of pharmaceutical drugs commonly misused include opioids (such as oxycodone, fentanyl, morphine, methadone, pethidine and codeine), benzodiazepines (such as diazepam, temazepam and alprazolam), and other analgesics (such as paracetamol and ibuprofen in preparations combined with codeine) and performance and image enhancing drugs (such as anabolic steroids, phentermine and human growth hormones)<sup>89</sup>. The harms that can arise as a result of the use of pharmaceutical drugs depend on the drug used, but can include fatal and non-fatal overdose<sup>90</sup>. Harms also include infection and blood vessel occlusion from problematic routes of administration, memory lapses, coordination impairments and aggression.

There has been a significant increase in the misuse of pharmaceutical drugs in Australia. In 2013, 4.7% of people had misused a pharmaceutical in the last 12 months, an increase from 3.8% in 2004<sup>91</sup>. Analgesics were the most commonly misused pharmaceutical (3.3% in 2013), followed by tranquillisers/sleeping pills (at 1.6%).

## 7.6 Opioids including heroin

The negative health consequences of heroin use include physiological dependence, infectious disease transmission through risky injecting practice and death from overdose<sup>92</sup>.

Heroin use 'in the last 12 months' has declined from 0.8% in 1998 to 0.1% in 2013.<sup>93</sup> However, Australia has seen an increase in the prescription and use of licit opioids. In particular, the supply of

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<sup>85</sup> Ministerial Council on Drug Strategy (2006) National Cannabis Strategy 2006-2009, Commonwealth of Australia, Publications Approval No. 3875, available at [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/FC2EF9E5D3AE9DDCA2571B6001C96B8/\\$File/cannabis-strategy.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/FC2EF9E5D3AE9DDCA2571B6001C96B8/$File/cannabis-strategy.pdf)

<sup>86</sup> Australian Institute of Health and Welfare (2014) National Drug Strategy Household Survey detailed report 2013, Drug statistics series no. 28. Cat no. PHE 183. Canberra: AIHW.

<sup>87</sup> Degenhardt, L. & Hall, W. (2012). Extent of illicit drug use, dependence, and their contribution to global burden of disease. *The Lancet*, 379(9810)

<sup>88</sup> Degenhardt, L. & Hall, W. (2012). Extent of illicit drug use, dependence, and their contribution to global burden of disease. *The Lancet*, 379(9810)

<sup>89</sup> Nicholas, R., Lee, N., & Roche, A. (2011). *Pharmaceutical Drug Misuse in Australia: Complex Problems, Balanced Responses*, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide.

<sup>90</sup> Nicholas, R., Lee, N., & Roche, A. (2011). *Pharmaceutical Drug Misuse in Australia: Complex Problems, Balanced Responses*, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide.

<sup>91</sup> Australian Institute of Health and Welfare (2014) National Drug Strategy Household Survey detailed report 2013, Drug statistics series no. 28. Cat no. PHE 183. Canberra: AIHW.

<sup>92</sup> Hall, W. Lynskey, M. and Degenhardt, L. *Heroin use in Australia: Its impact on public health & public order*. National Drug and Alcohol Research Centre. Monograph No. 42

<sup>93</sup> Australian Institute of Health and Welfare (2014) National Drug Strategy Household Survey detailed report 2013, Drug statistics series no. 28. Cat no. PHE 183. Canberra: AIHW.

oxycodone and fentanyl increased 22 fold and 46-fold respectively between 1997 and 2012 and the number of prescriptions for opioid prescriptions subsidised by the Pharmaceutical Benefits Scheme increased from 2.4 million to 7 million between 1992 and 2007.<sup>94</sup> Consistent with these trends, hospital separations associated with prescription opioid poisoning have increased substantially while those for heroin have decreased.<sup>95</sup>

## 7.7 New psychoactive substances

New psychoactive substances (NPS) are a range of drugs that have been manufactured to mimic other illicit drugs such as cannabis, cocaine, ecstasy and LSD. They include, but are not limited to, synthetic cannabis, mephedrone and methylenedioxypropylvalerone (MDPV). While the effect of the drugs may be similar to other illicit drugs, their chemical structure is different and the effects are not always well known.

One of the principal concerns with the use of new psychoactive substances is that the products, and their chemical compounds or makeup, are constantly evolving. The toxicity of each drug is also not often well understood.<sup>96</sup> The use of NPS is often linked to health problems. NPS users have frequently been hospitalized with severe intoxications. There have also been a number of unexplained suicides associated with preceding use of synthetic cannabinoids (spice). In addition, substances like 4-methylmethcathinone (mephedrone), methylenedioxypropylvalerone (MDPV), 4-methylamphetamine (4-MA) have been associated with fatalities.

Data around the use of new psychoactive substances in Australia obtained through the National Drug Strategy Household Survey indicate that in 2013, 1.3% of Australians had used synthetic cannabinoids 'in the last 12' months and 0.4% had used another new psychoactive substance.

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<sup>94</sup> Dobbin, M. (2014) Pharmaceutical drug misuse in Australia, *Australian Prescriber*, 37:3.

<sup>95</sup> Nicholas, R., Lee, N., & Roche, A. (2011). *Pharmaceutical Drug Misuse in Australia: Complex Problems, Balanced Responses*, National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide.

## 8 MEASURES OF SUCCESS

In order to measure the success of the National Drug Strategy 2016-2025 the following headline indicators will be monitored to illustrate progress.

These measures are taken from the *Evaluation and Monitoring of the National Drug Strategy 2004-2009 Final Report*<sup>97</sup>. The proposed measures use existing published data sources to help ensure continuity.

The performance measures are high-level as data are not always comprehensive enough to provide robust national measures of activity and progress. It is not possible to directly match the objectives of the strategy, or each drug type, to a performance measure.

### 1. Average age of uptake of drugs, by drug type

Source: National Drug Strategy Household Survey, Australian Institute of Health and Welfare

### 2. Recent use of any drug, people living in households

Source: National Drug Strategy Household Survey, Australian Institute of Health and Welfare

### 3. Arrestees' illicit drug use in the month before committing an offence for which charged

Source: Drug Use Monitoring Australia, Australian Institute of Criminology

### 4. Victims of drug-related incidents

Source: National Drug Strategy Household Survey, Australian Institute of Health and Welfare

### 5. Drug-related burden of disease, including mortality

Source: The Australian Burden of Disease Study, Australian Institute of Health and Welfare and School of Population Health, University of Queensland

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<sup>97</sup> *Evaluation and Monitoring of the National Drug Strategy 2004-2009 Final Report*. Siggins Miller. 2009

# 9 GOVERNANCE

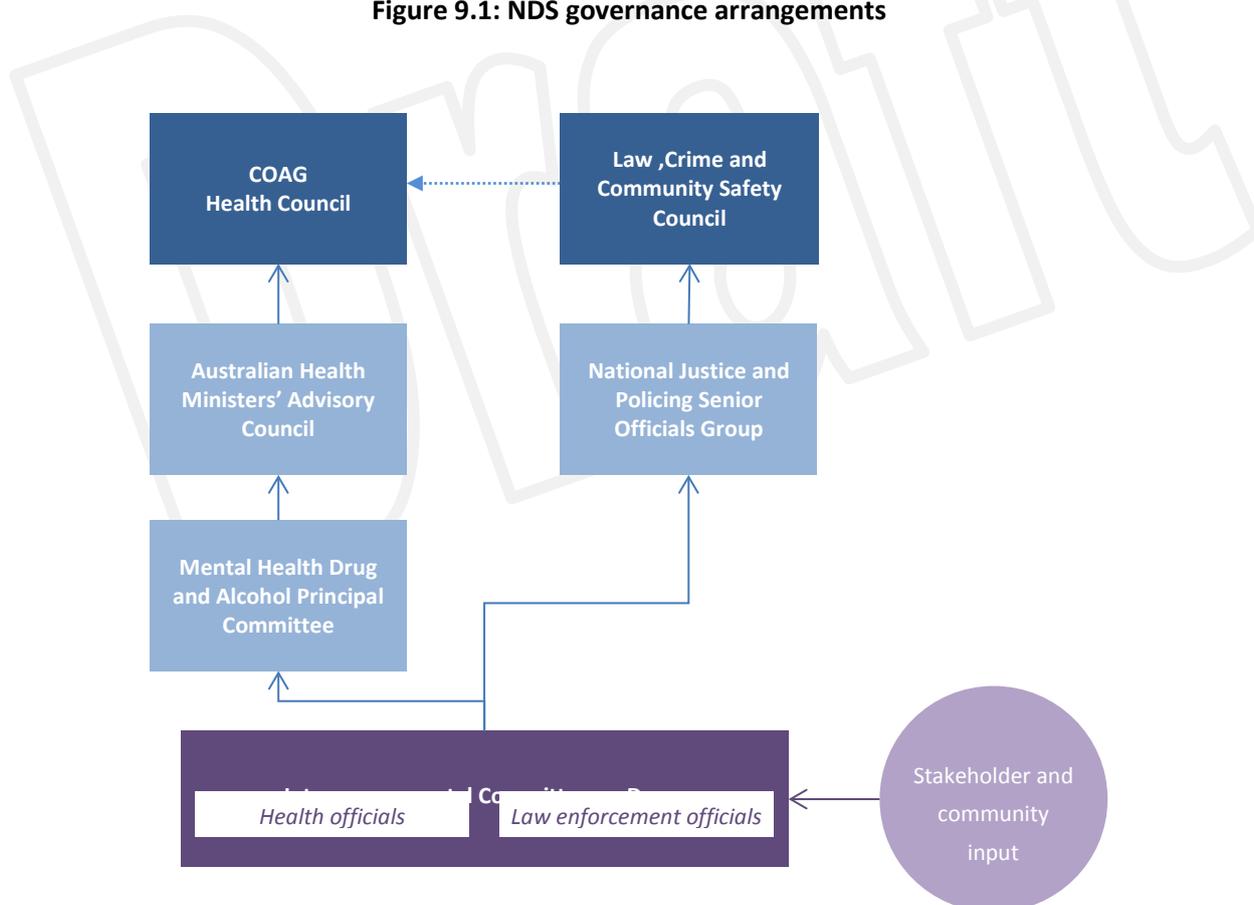
## 9.1 Intergovernmental Committee on Drugs

The National Drug Strategy is the joint responsibility of the Council of Australian Governments (COAG) Health Council (CHC) and the COAG Law, Crime and Community Safety Council (LCCSC). The Intergovernmental Committee on Drugs (IGCD) provides advice to the CHC and the LCCSC through the Australian Health Ministers' Advisory Council (AHMAC) and the National Justice and Policing Senior Officials Group (NJPSOG). IGCD advice to AHMAC is provided through the Mental Health Drug and Alcohol Principal Committee (MHDAPC).

Oversight of the National Drug Strategy is undertaken by the IGCD, which is a Commonwealth, state and territory government forum of senior officers who represent health and law enforcement agencies in each Australian jurisdiction. The IGCD provides policy advice to relevant ministers on drug-related matters.

To expand consultation and engagement with government agencies during the term of this Strategy, IGCD is exploring options for participation by representatives from Ministerial advisory councils from Attorneys General, education, Aboriginal and Torres Strait Islander people, human services and local government.

**Figure 9.1: NDS governance arrangements**



## **Stakeholder and community engagement**

Increasing engagement of stakeholders and the community is a priority for the Strategy. This includes consumers and communities, service providers, peaks, peer organisations and other alcohol, tobacco and other drug organisations.

During the term of the Strategy, the annual stakeholder forum will be replaced with half day stakeholder forums convened immediately preceding IGCD meetings. As IGCD meetings occur three times a year and follow a jurisdictional rotation, this will create new opportunities for stakeholder consultation and increase engagement with IGCD's agenda.

IGCD also intends to improve communication with stakeholders following meetings, including communicating the outcomes from stakeholder forums and IGCD meetings. IGCD will also report annually on the progress of its agenda.

## **Sub-Strategies**

Sub-strategies sit under the *National Drug Strategy 2016-2025*. These sub-strategies provide direction and context for specific issues, while maintaining the consistent and coordinated approach to addressing drug use, as set out in this strategy. During the life of the *National Drug Strategy 2016-2025*, the sub-strategies listed below will be updated or developed to address specific priorities. These are focussed on priority populations, drug type and the development of the workforce which is critical to implementation of the Strategy.

- National Aboriginal and Torres Strait Islander Peoples Drug Strategy
- National Alcohol Strategy
- National Tobacco Strategy
- National Illicit Drugs Strategy

Standing committees and working groups of the Intergovernmental Committee on Drugs will be responsible for the development of these sub-strategies. Best efforts will be made to synchronise the timing of these sub-strategies.