



# *National Drug Strategic Framework 1998-99 to 2002-03*

## *Building Partnerships*

A strategy to reduce the harm  
caused by drugs in our community

November 1998

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Ministerial Council on Drug Strategy

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This document was endorsed by the Ministerial Council on Drug Strategy at its meeting in Sydney on 19 November 1998. The document was prepared for the Ministerial Council by a joint steering committee of the Intergovernmental Committee on Drugs and the Australian National Council on Drugs.

Information on the National Drug Strategy  
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# 1 Introduction

This document presents a shared vision, a framework for cooperation, and a basis for coordinated action to reduce the harm caused by drugs in Australia.

The National Drug Strategic Framework 1998–99 to 2002–03 maintains the policy principles of the previous phases of the National Drug Strategy and adopts the recommendations of *Mapping the Future: an evaluation of the National Drug Strategy 1993–97* (Single & Rohl 1997).

The Framework has been prepared under the direction of the Ministerial Council on Drug Strategy, which brings together Commonwealth, State and Territory Ministers responsible for health and law enforcement to collectively determine national policies and programs designed to reduce the harm caused by drugs to individuals, families and communities in Australia. In *Mapping the Future* Single and Rohl identified the Ministerial Council on Drug Strategy as one of the great strengths of the National Drug Strategy: under the National Drug Strategic Framework the Ministerial Council on Drug Strategy will continue to function as the peak policy- and decision-making body in relation to licit and illicit drugs in Australia.

The principle of harm minimisation has formed the basis of Australia's Drug Strategy since 1985; Single and Rohl saw it as fundamental to the Strategy's success. Harm minimisation refers to policies and programs designed to reduce drug-related harm. Harm minimisation aims to improve health, social and economic outcomes for both the community and the individual and encompasses a wide range of approaches, including

- supply-reduction strategies designed to disrupt the production and supply of illicit drugs;
- demand-reduction strategies designed to prevent the uptake of harmful drug use, including abstinence-oriented strategies to reduce drug use;
- a range of targeted harm-reduction strategies designed to reduce drug-related harm for individuals and communities.

Another important element of the National Drug Strategy has been research into and evaluation of Australian approaches to reducing drug-related harm. Improving the evidence base to better inform policy development is a priority for 1998–99 to 2002–03.

This next phase of the National Drug Strategy places emphasis on extending the successful partnership between health and law-enforcement agencies to take in a broader range of partners:

- expanding the body supporting the Ministerial Council on Drug Strategy—the Intergovernmental Committee on Drugs, consisting of health and law-enforcement officers from each Australian jurisdiction—to include officers from the portfolios of customs and education;
- encouraging closer working relationships between government and the community—the Ministerial Council on Drug Strategy will also be supported by the Australian National Council on Drugs, consisting of people with relevant expertise from the government, non-government and community-based sectors to provide policy advice;
- promoting partnerships between individuals, families, communities, police, service providers, business and industry, local government, and researchers in developing strategies to reduce the harm caused by drugs in local settings.



## 2 The harm caused by drugs in Australia

This chapter briefly describes the extent of drug use, factors underlying drug use, and indicators of drug-related harm in Australia. The information provided is not comprehensive: it is a summary. A detailed analysis of national indicators and the currency and availability of data was done for the evaluation of the National Drug Strategy 1993–1997 and published as *Progress of the National Drug Strategy: key national indicators* (Williams 1997).

The National Drug Strategy Household Survey series has been the principal data-collection vehicle used to monitor trends and evaluate progress under the Strategy. Surveys have been conducted nationally in 1985, 1988, 1991, 1993, 1995 and 1998; they provide data on behaviour, knowledge and attitudes relating to drug use among people aged 14 years and over. Data have also been obtained from the Australian Bureau of Statistics, the Australian Institute of Health and Welfare, and other sources.

Despite this range of data on current drug use in Australia, no data are available for some areas and there remain gaps in the total picture of drug use and drug-related harm in Australia.

### 2.1 The extent of drug use

Preliminary data from the National Drug Strategy 1998 Household Survey have been used to develop estimates of the extent of drug use by people aged 14 years and over in Australia. Data are provided for tobacco, alcohol, pharmaceutical drugs, performance- and image-enhancing drugs, illicit drugs, inhalants and kava, and polydrug use.

#### 2.1.1 Tobacco

- Twenty-one per cent of Australians reported that they are regular tobacco smokers (smoke at least one cigarette a day) and a further 4 per cent are occasional smokers (smoke less than daily).
- Twenty-two per cent of men and 20 per cent of women were regular smokers. Sixteen per cent of young people aged 14 to 19 years were regular smokers; the proportion was roughly the same for males and females.
- Forty-four per cent of Indigenous Australians were regular smokers compared with 20 per cent of non-Indigenous Australians.

#### 2.1.2 Alcohol

- Seventy-seven per cent of Australians consumed alcohol and, of these, 36 per cent usually consumed at hazardous or harmful rates (more than four standard drinks a day for males and more than two standard drinks a day for females) at least once in the 12 months preceding the survey.
- Thirty-three per cent of males and 39 per cent of females who consume alcohol usually do so at hazardous or harmful rates.
- Sixty-seven per cent of young people aged 14 to 19 years consumed alcohol; of these, 57 per cent of males and 74 per cent of females did so at hazardous or harmful rates at least once in the 12 months preceding the survey.

- Seventy-four per cent of Indigenous Australians consumed alcohol; of these, 56 per cent of males and 73 per cent of females usually did so at hazardous or harmful rates.

### 2.1.3 Pharmaceutical drugs

Pharmaceutical drugs are used by many Australians and, although they contribute greatly to improved general health and increased life expectancy, they can also cause harm if used inappropriately. Some people obtain analgesics, tranquillisers and sedatives, particularly benzodiazepines, from medical practitioners and then use these for non-medical purposes; these pharmaceutical drugs are also diverted for illicit trade.

- Six per cent of Australians used analgesics, tranquillisers or sedatives for non-medical purposes at least once in the 12 months preceding the survey.
- In the same period 11 per cent used these medications for medical purposes without consulting a health practitioner.
- Six per cent of males and 6 per cent of females used analgesics, tranquillisers or sedatives for non-medical purposes in the 12 months preceding the survey.
- Nine per cent of young people aged 14 to 19 years used these medications for non-medical purposes in the 12 months preceding the survey; females were 53 per cent more likely to have done so than males.
- Nine per cent of Indigenous Australians used analgesics, tranquillisers or sedatives for non-medical purposes in the 12 months preceding the survey; females were 94 per cent more likely to have done so than males.

### 2.1.4 Performance- and image-enhancing drugs

The use of anabolic steroids and other drugs to improve performance is more likely to occur at the elite sporting level than among people involved in sports at other levels. Anecdotal evidence suggests that bodybuilders and young people are the population groups most likely to use these drugs.

- Steroids were used for performance- or image-enhancement purposes by 0.2 per cent of Australians in the 12 months preceding the survey.
- Steroids were used for performance- or image-enhancement purposes by 0.2 per cent of males and 0.1 per cent of females.
- Less than 0.1 per cent of young people aged 14 to 19 years had used steroids for these purposes in the 12 months preceding the survey.
- The proportion of Indigenous Australians who used steroids for performance- or image-enhancement purposes in the 12 months preceding the survey could not be reliably estimated.

### 2.1.5 Illicit drugs

Illicit drugs include cannabis, heroin, cocaine, hallucinogens, amphetamines, and designer drugs such as ecstasy.

- Twenty-two per cent of Australians aged 14 years or older used illicit drugs in the 12 months preceding the survey. Cannabis was the most used illicit drug, followed by amphetamines and ecstasy, then hallucinogens. Less than 1 per cent of Australians injected illicit substances in the 12 months preceding the survey.

#### Cannabis

- Twenty-one per cent of males and 15 per cent of females aged 14 years or older used cannabis in the 12 months preceding the survey.
- Thirty-four per cent of young people aged 14 to 19 years used cannabis in the 12 months preceding the survey; females were 6 per cent more likely than males to have done so.
- Twenty-eight per cent of Indigenous Australians used cannabis in the 12 months preceding the survey; males were 1.9 times more likely than females to have done so.

#### Injecting drug use

- One per cent of males and 0.6 per cent of females aged 14 years or older injected illicit drugs in the 12 months preceding the survey. Of these, 28 per cent reported overdosing at least once after injecting heroin in that period.
- One per cent of young people aged 14 to 19 years injected illicit drugs in the 12 months preceding the survey. Of these, 25 per cent reported overdosing at least once after injecting heroin in that period.
- The proportion of Indigenous Australians who injected illicit drugs in the 12 months preceding the survey could not be reliably estimated.

### 2.1.6 Inhalant and kava use

Some substances are inhaled for psychoactive effects. Many domestic and industrial products are used for this purpose—glues, aerosol sprays, paints, industrial solvents, thinners, petrol, cleaning fluids, and so on. Young people are the most frequent users of inhalants. In some remote Indigenous communities, petrol sniffing by boys and young men is the most common kind of inhalant use.

Kava—a drug extracted from the roots of the plant *Piper methysticum* that has long been used by Pacific Islanders—has also been used periodically in some Aboriginal communities in the Arnhem Land region of the Northern Territory.

- In the 12 months preceding the survey 0.9 per cent of Australians aged 14 years or older had used inhalants.
- In the 12 months preceding the survey 1.1 per cent of males and 0.8 per cent of females had used inhalants.
- Three per cent of young people aged 14 to 19 years had used inhalants in the 12 months preceding the survey; females were 60 per cent more likely than males to have done so.
- The proportion of Indigenous Australians who had used inhalants or kava in the 12 months preceding the survey could not be reliably estimated.

### 2.1.7 Polydrug use

There is considerable evidence to suggest that many drugs, licit and illicit, are used in combination. For example, alcohol is frequently used in combination with illicit drugs or pharmaceutical drugs. Post-mortem analyses of people who have died from a drug overdose often reveal a variety of drugs.

- Illicit drug users aged 14 years or over used an average of 1.7 substances in the 12 months preceding the survey.
- On average, male illicit drug users used more drugs (1.8) than females (1.7).
- The average number of substances used by young people aged 14 to 19 years who had used at least one illicit substance was 1.8 in the 12 months preceding the survey; the average number for males was 1.7 and the average for females 1.9.
- The average number of substances used by Indigenous Australians who used illicit drugs was 2.5 in the 12 months preceding the survey; the average number for males was 2.7 and the average for females was 2.3.

## 2.2 Factors underlying drug use

### 2.2.1 Social and cultural factors

The available evidence suggests that a broad and complex range of personal and social factors underlie harmful drug use. It also appears that the factors related to the initiation of drug use may not be the same as those associated with continued or harmful use (Miller & Ware 1989).

An earlier age of initiation into drug use is associated with a range of adverse outcomes (Lynskey & Hall 1998). Preliminary data from the National Drug Strategy 1998 Household Survey show the mean age of initiation for tobacco is 15.9 years; for alcohol, 17.2 years; for cannabis, 18.9 years; for steroids, 25.4 years; for hallucinogens, 19.4 years; for ecstasy, 23.2 years; for heroin, 22.0 years; and for inhalants, 17.6 years.

Some evidence suggests that the onset of alcohol use by adolescents is more likely to be a result of the influence of parents and peers rather than the personal characteristics of the individual (Miller & Ware 1989). Drinking behaviour is usually learnt within the family environment, so the individual may imitate or adopt the drinking behaviour or attitudes of parents. This behaviour is then supported within the peer group context. Family conflict, parental drug use and isolation from family support, particularly for older people, are other factors that may contribute to harmful drug use.

Social and cultural norms relating to drug use also influence individuals. Although the legal drinking age is 18 years there is widespread under-age drinking, and harmful alcohol use among young people is sometimes viewed as a rite of passage (Makkai & McAllister 1998). The norms for drug use change with time and may vary between population groups, between men and women, and between localities.

In the Aboriginal and Torres Strait Islander community the continuing high rates of mortality and morbidity from cardiovascular disease, respiratory diseases, circulatory diseases and cancer show a strong correlation with harmful drug and substance use. The broader social effects of

harmful drug and substance use are also evidenced in higher rates of hospitalisation and injury and the impact of crime on the emotional and social wellbeing of individuals, their families and their communities (Department of Health and Family Services 1998). Specific, culturally responsive strategies aimed at dealing with the complex social, economic and health impacts that harmful drug and substance use has in Indigenous communities will be an important element of the National Drug Action Plans.

### 2.2.2 Psychological factors

Mental health and wellbeing can influence drug use. The Australian Bureau of Statistics' *Mental Health and Wellbeing: profile of adults* (1997a) shows that at least 20 per cent of people with mental disorders also engage in harmful drug use, with increased risks of suicide, hospitalisation, violence and homelessness. For example, mental health problems appear to be very common among people who use amphetamines regularly: studies report depression, anxiety, hallucinations, paranoia, mood swings, aggression and violence, panic attacks, and suicidal thoughts (Kamieniecki et al. 1998). Research suggests that drug use in young people is often associated with risk-taking or self-harming behaviours. Specific strategies to meet the needs of individuals with co-existing mental health and drug problems—through the coordination of drug treatment services, mental health services and mainstream health services—will be another important element of the National Drug Action Plans.

### 2.2.3 Health factors

Chronic pain, including that induced by injury, can lead to harmful use of pharmaceutical drugs. Lack of access to mainstream health services, pain clinics and specialist drug treatment services in some areas and for certain population groups reduces the opportunity for early intervention and specialist treatment of harmful drug use.

### 2.2.4 Market factors

The promotion, availability and cost of drugs influence patterns of drug use. Miller and Ware (1989), for example, found a consistent association between levels of advertising of spirits, wine and wine coolers and the consumption of these products among young people. Drugs are promoted and marketed through advertising—at the point of sale, by product placement in films and on television, through sponsorship of events, through product packaging, and so on. The cost of licit drugs can be influenced by taxation and pricing policy, which has the potential to affect the level of harmful use in the community. The demand for illicit drugs influences availability, and demand and availability influence price. Patterns of illicit drug use vary according to availability, price and purity.

### 2.2.5 Economic and geographic factors

Income and levels of employment, for both individuals and communities, also affect patterns of harmful drug use: low income and homelessness are considered to be risk factors. Increased workplace stress may also contribute to increased drug use. In rural and remote communities lack of access to recreational and cultural facilities may also influence drug use.

## 2.3 Indicators of drug-related harm in Australia

Harmful drug use has many social, health and economic impacts on Australian society. The following are the major areas of drug-related harm:

- illness and disease
- injury
- economic costs and workplace concerns
- violence and crime
- families and relationships.

### 2.3.1 Illness and disease

Nearly one in five deaths in Australia is drug-related. It was estimated that in 1998 approximately 22 500 Australians would die either directly or indirectly as a result of harmful drug use and over 175 000 Australians would be hospitalised for conditions that are the result of harmful drug use (Single & Rohl 1997).

#### **Tobacco**

Tobacco smoking is the primary cause of premature and preventable death and disease in Australia. It has been estimated that 18 580 Australians died from tobacco-related causes in 1996; of these 13 343, or 72 per cent, were male (Australian Institute of Health and Welfare 1998). The short-term health effects of tobacco use can include shortness of breath and increased susceptibility to colds and influenza; the longer term health effects can include numerous types of cancer, atherosclerosis, ischaemic heart disease, heart failure, stroke, pneumonia, chronic obstructive pulmonary disease, peptic ulcer, and Crohn's disease (English et al. 1995).

There is ever-mounting evidence linking environmental tobacco smoke with ill-health among adults and children. The National Health and Medical Research Council's information paper on the health effects of passive smoking notes clear links between passive smoking and a number of serious illnesses: asthma in children, lower respiratory illness, lung cancer, major coronary conditions, and so on (NHMRC 1997a). The evidence also suggests an association with other health effects but further research is needed to confirm this.

Environmental tobacco smoke is an important contaminant of indoor air and exposure can occur in a variety of settings, such as workplaces, public places and domestic environments. There is strong and consistent evidence that passive smoking increases non-smokers' risk of lung cancer by around 30 per cent and their risk of ischaemic heart disease by 23 per cent (NHMRC 1997a). Passive smoking is associated with a 25 per cent increased risk of chronic respiratory disease in adults (Hackshaw et al. 1996). Children are particularly susceptible to the effects of environmental tobacco smoke and around 547 000 children under the age of 4 years live with one or more smokers (Australian Bureau of Statistics 1997). These children have an increased risk of respiratory disease: for those under 18 months the risk is 60 per cent and they are more likely to suffer symptoms of asthma (NHMRC 1997a).

#### **Alcohol**

Alcohol is second only to tobacco as a preventable cause of death and hospitalisation in Australia (Holman et al. 1990; English et al. 1995). It is estimated that 3656 Australians died in 1996 from alcohol-related causes and that the 96 111 hospital attendances attributed to alcohol-

related conditions accounted for 714 889 hospital bed-days (Australian Institute of Health and Welfare 1998). Alcohol consumed at harmful or hazardous levels or in a dangerous manner (such as binge drinking) can produce short-term effects such as headaches, nausea, sleeping difficulties and depression. Among the longer term problems are severe impairment of the brain, liver, intestines and pancreas.

Alcohol is a significant risk factor for cancers of the oral cavity, pharynx, larynx, oesophagus and liver; English et al. estimated that 18 per cent of liver cancer deaths, both male and female, were due to alcohol. There is increasing evidence that some women are at risk of breast cancer from even moderate doses of alcohol: mortality from breast cancer has been found to be 30 per cent higher among women reporting at least one drink daily than among non-drinking women.

Other causes of disease and death that may be related to the use of alcohol are respiratory tuberculosis, alcoholic gastritis, pancreatitis, diabetes, pneumonia and influenza, peptic ulcer and epilepsy.

### **Pharmaceutical drugs**

The harms associated with pharmaceutical drug use can include short-term mild side-effects, longer term dependency, and overdose. It is estimated that about 80 000 people are hospitalised every year as a result of problems related to the use of pharmaceutical drugs (Roughead et al. 1998). In 1994–95, the proportion of hospital drug-poisoning admissions related to the use of tranquillisers, antidepressants, analgesics, hypnotics and sedatives was 4.87 per cent for males and 12.67 per cent for females (Williams 1997).

The use of benzodiazepines among people who inject drugs is a serious clinical problem: it is linked to a higher risk of HIV infection, anxiety and depression, poorer health, poorer social functioning, and greater risk of heroin overdose. Darke et al. (1995) reported that more than one-third of injecting drug users use benzodiazepines.

### **Illicit drugs**

It is estimated that 739 Australians died from conditions associated with illicit drug use in 1996 and that there were four times as many deaths among males than among females (Australian Institute of Health and Welfare 1998). Since 1988 there has been a steady increase in the number of opioid-overdose fatalities among people aged 15 to 54 years (Lysnkey & Hall 1998).

The immediate harmful health effects of cannabis use can include anxiety, panic, paranoia, difficulty concentrating, memory loss, and impairment of motor skills. The long-term harmful health effects can include an increased risk of experiencing psychotic symptoms for some people, an inability to abstain from or to control cannabis use, and subtle forms of cognitive impairment, particularly difficulty concentrating and memory loss, which may continue after use stops (Hall et al. 1994).

The immediate harmful health effects of amphetamine use can include abdominal cramps, nausea, headaches, anxiety, muscle pain, abnormally fast heartbeat, difficulty concentrating, memory loss, and dehydration. Long-term harmful health effects can include increased risk of weight loss, sleep problems, skin problems, reduced immunity to infections, and mental health problems such as depression, anxiety, hallucinations, paranoia, panic and aggression (Kamieniecki et al. 1998).

The immediate harmful health effects of heroin can include difficulty concentrating and the risk of overdose. Long-term harmful health effects can include the build-up of tolerance (which increases the risk of overdose) and withdrawal symptoms associated with stopping or reducing use.

The immediate harmful health effects of ecstasy can include loss of appetite, abnormally fast heartbeat, difficulty concentrating, increased jaw tension and grinding of teeth, insomnia, hot and cold flushes, fluid retention and dehydration. Ecstasy use combined with increased body temperature (for example, from vigorous exercise such as dancing) can lead to death. The long-term harmful health effects of ecstasy are not quantifiable at this stage, but long-term heavy use may lead to nerve or brain cell damage.

In addition to these harmful health effects, the frequent injection of pharmaceutical and illicit drugs also has serious adverse health effects. It can result in bacterial infections, abscesses, bacterial endocarditis, inflamed veins, and thrombosis and occlusion of arteries, which may lead to limb gangrene (Prescription Drug Abuse Working Party 1997).

### **Inhalants and kava**

Petrol sniffing is one of the most dangerous forms of inhalant use and prolonged sniffing can lead to long-term disability. The behaviours associated with inhalant use and the long-term care of people who use inhalants can be extremely distressing, disruptive and debilitating for the families and communities involved.

Research has revealed links between chronic excessive kava use and increased susceptibility to serious infectious disease, the development of neurological abnormalities, pulmonary hypertension, blood in the urine (suggesting effects on the kidneys and renal system), ischaemic heart disease, and sudden cardiac deaths (d'Abbs & Burns 1997). There have also been reports about kava's effects on the skin and vision, its thrombotic effects, and kava-induced liver damage.

### **Polydrug use**

Polydrug use is a growing trend among some population groups, especially people who use heroin. The drugs involved are principally alcohol, amphetamines, ecstasy, heroin, cannabis, cocaine, tranquillisers and other pharmaceuticals. In a recent survey of people who use ecstasy, 93 per cent of respondents said they used other drugs in conjunction with ecstasy (Topp et al. 1998). People who use amphetamines also reported high levels of polydrug use involving alcohol, cannabis, heroin, ecstasy and tranquillisers (Darke et al. 1998).

Taking combinations of drugs can lead to additional health complications. For example, alcohol can exacerbate the dehydration that is commonly associated with ecstasy. There are also indications that alcohol intoxication is a factor in a significant proportion of deaths linked to heroin overdose.

### **Blood-borne viruses and sexually transmissible diseases**

There is particular concern about the injection of illicit drugs, mainly heroin, cocaine and amphetamines, because of the high potential for spreading HIV/AIDS, hepatitis and other infectious diseases. Australia has had notable success in controlling the prevalence of HIV among injecting drug users: less than 5 per cent of this group is HIV positive (National Centre in HIV Epidemiology and Clinical Research 1998). The social impacts and health care costs of HIV/AIDS are enormous, and it is important that this low rate of prevalence is maintained and continues to reduce. It is estimated, however, that 50 to 60 per cent of injecting drug users are hepatitis C positive and that about 13 per cent of uninfected users become infected each year (ANCARD Hepatitis C Sub-committee 1998). This has important implications both for the individuals involved and for long-term social and health costs to the community.

Some drugs, among them alcohol and amphetamines, can have disinhibiting effects and may lead people to engage in high-risk behaviours such as sharing needles and unsafe sexual activity (NSW Department of Health 1998; Klee 1992).

### **Pregnancy**

Drug use during pregnancy can harm babies and infants. Smoking during pregnancy is responsible for around 7 per cent of spontaneous abortions (English et al. 1995) and can have serious adverse effects on a baby's birth weight and lung function (Winstanley et al. 1995). It has also been found to be a significant indicator of health status in children (Hanna et al. 1997). Excessive alcohol consumption during pregnancy can cause problems such as bleeding, miscarriage, stillbirth and premature birth (Holmes 1998); heavy prenatal alcohol exposure can also lead to a distinct pattern of birth defects termed 'foetal alcohol syndrome' (Roebuck et al. 1998).

Preliminary data from the National Drug Strategy 1998 Household Survey show that in the 12 months preceding the survey 24 per cent of pregnant women smoked, 81 per cent consumed alcohol, 19 per cent used cannabis, 22 per cent used other illicit drugs, and 2 per cent injected illicit drugs.

### **2.3.2 Injury**

Alcohol is considered one of the most important risk factors in injury among adults and adolescents (Meyers et al. 1990; Paulson 1988; Friedman 1985). Individuals affected by alcohol are more likely to engage in riskier behaviours (Hingson & Howland 1993a), place themselves in more hazardous circumstances, or be at risk from a direct biological effect of reduced perception and response to hazards (Li & Baker 1994). Alcohol affects body stability by lowering visual acuity, impairing judgment, attention and alertness, and decreasing coordination and balance (Hingson & Howland 1993b; Cherpitel 1994; White et al. 1993). In addition to the harmful health effects of alcohol, it has been estimated that approximately 39 per cent of alcohol-related deaths were attributable to either injury or violence (English et al. 1995). The research indicates that alcohol-related injury is indeed a potent source of harm in the population (McLeod et al. 1998).

Alcohol consumed at harmful or hazardous levels or in a dangerous manner—for example, in combination with driving or operating machinery—can have far-reaching effects. There is sufficient evidence that alcohol causes road injuries (English et al. 1995), particularly fatal ones (Holubowycz 1994). In 1995 post-mortem results showed that 30 per cent of all fatally injured drivers or motorcyclists registered a blood alcohol concentration of 0.05 per cent or more; of these, 70 per cent registered 0.15 per cent or higher (Single & Rohl 1997). In the same year 28.5 per cent of fatal road accidents involved at least one of the drivers having a blood alcohol concentration of more than 0.05 per cent; of these, 67 per cent involved deaths of people aged 15 to 34 years (Williams 1997). It has been estimated that 490 motor vehicle fatalities in 1996 were attributable to alcohol (Australian Institute of Health and Welfare 1998).

The link between alcohol and injury is also well established for falls, drowning, burns, assault and suicide (Hingson & Howland 1993a; English et al. 1995). In the elderly, one of the consequences of heavy and long-term drinking is an increased risk of hip fractures from falls (*Australian Doctor* 11 September 1998, p. 65).

### 2.3.3 Economic costs and workplace concerns

The economic costs associated with harmful drug use, including prevention, treatment, loss of productivity in the workplace, property crime, theft, accidents and law-enforcement activities, amount to over \$18 billion annually (Collins & Lapsley 1996).

In 1992 the estimated economic cost to Australia of tobacco use was \$12.7 billion, or 67.3 per cent of all costs associated with harmful drug use (Collins & Lapsley 1996). Australian data show that workers who smoke record around 27 per cent more absenteeism than non-smokers. Smokers also have more accidents at home and in the workplace (Smith 1992): a US study found that smokers suffer around 30 per cent more industrial accidents and 40 per cent more occupational injuries than non-smokers (Ryan 1992). It has been estimated that smoking cost Australian industry around \$6.8 billion in 1992 (Collins & Lapsley 1996). In the National Drug Strategy 1998 Household Survey, 10 per cent of workers reported that there were no restrictions on smoking in their workplace.

In 1992 the estimated economic cost to Australia of harmful alcohol use was \$4.49 billion, (Collins & Lapsley 1996). Studies have shown that certain industries and occupations are more prone to alcohol consumption in the workplace than others. Use of alcohol in the workplace may be linked to a number of factors at work or at home (NSW Department of Health 1998). There is evidence that the effects of alcohol—such as impaired balance and reflexes, lack of coordination, and lack of a sense of danger—contribute to work injuries (NHMRC 1996). Studies of the blood alcohol levels of fatally injured workers have revealed that alcohol may have contributed to between 3 per cent and 11 per cent of workplace fatalities (NHMRC 1997b).

The economic cost to Australia of harmful pharmaceutical drug use (in terms of, for example, medical services and lost productivity) are not quantifiable at present (Collins & Lapsley 1996). It has been estimated that in 1997–98 there were approximately 9500 ‘doctor shoppers’; that is, individuals who each attended 15 or more general practitioners and were seeking either benzodiazepines, pethidine, methadone or codeine-compound analgesics (Health Insurance Commission 1998). The Health Insurance Commission estimates that the direct cost of doctor shopping in 1997–98 through Medicare and the Pharmaceutical Benefits Scheme was \$30 million.

The total production loss caused by alcohol, tobacco and illicit drugs is estimated to have been over \$9.2 billion in 1992. For the same year, the economic cost of illicit drug use—including lost productivity, drug treatment and law enforcement—was estimated to be \$1.68 billion (Collins & Lapsley 1996).

The National Drug Strategy 1998 Household Survey found that 3 per cent of respondents aged 14 years and over had missed at least one day’s work or study for alcohol-related reasons in the three months preceding the survey.

There is increasing concern about drug use in the workplace. Drug use in this setting places both the user and others in the workplace at risk of illness and injury and increases the associated economic costs of medical and sickness payments, compensation, and staff turnover. In some cases, such as the long-distance road transport industry, drug use in the workplace can also threaten public safety, even though the drugs may be used in an effort to enhance performance. It also imposes direct and indirect costs associated with loss of productivity and efficiency, increased absenteeism, and ill-health.

### 2.3.4 Violence and crime

A relatively large proportion of the funds spent on dealing with harmful drug use are spent on law enforcement, the courts and correctional systems.

Of all the drugs, alcohol presents the most serious threat to public safety (Holman et al. 1990; English et al. 1995). It is implicated in many incidents of violence and property loss or damage. Preliminary data from the National Drug Strategy Household Survey show that in 1998 at least 8 per cent of Australians suffered property loss or damage in alcohol-related incidents, 6 per cent suffered alcohol-related physical assault, and 28 per cent suffered alcohol-related verbal assault.

Research by the Australian Institute of Criminology shows that alcohol is an important factor in homicide, with 34 per cent of all offenders and 31 per cent of all victims being under the influence of alcohol at the time of the incident (Carach 1997; James & Carach 1997).

In 1996 prison inmates whose primary offence was drug-related—possession, trafficking or manufacturing drugs—constituted 10 per cent of all prisoners (Australian Bureau of Statistics 1997b). This statistic does not account for inmates who committed some other more serious crime in connection with a drug-related offence or to support a drug habit. There is also a substantial, although unquantifiable, cost from drug-related crime and associated activities such as burglary, robbery and money laundering. In 1996, 1638 people were imprisoned for drug offences: 160 for possession of an illicit drug, 1277 for dealing or trafficking and 201 for manufacturing or growing illicit drugs (Australian Bureau of Statistics 1996).

Violent behaviour and aggression by prison inmates using benzodiazepines, such as rohypnol or rivotril, have been identified in South Australia, New South Wales and Victoria. Rohypnol is seen as the most serious drug problem in South Australian prisons. Prison officers in most States nominated the use of prescription drugs as the most serious drug issue in Australian prisons (Prescription Drug Abuse Working Party 1997).

### 2.3.5 Families and relationships

In addition to the economic and health costs of harmful drug use are the intangible social costs, such as damage to family and other relationships. Apart from disruption to relationships, other family members may have to take on the role of carer for someone affected by harmful drug use. Families may have reduced disposable income because the money is being spent on drugs, or people may engage in criminal activity to finance their drug use. Both the individual engaged in a pattern of harmful drug use and other family members may be stigmatised, which may lead to loss of relationships with extended family members and friends.

The generational transmission of values, attitudes and behaviours contributes to higher rates of drug use in families where parents use drugs. Preliminary data from the National Drug Strategy Household Survey show that in 1998 children aged over 14 year in families where a parent used the same drug were no more likely to smoke tobacco or consume alcohol. They were, however, 27 per cent more likely to use cannabis and 55 per cent more likely to use other illicit drugs than young people whose parents did not use those drugs.



# 3 The Australian approach to reducing the harm caused by drugs

## 3.1 Evaluation of the National Drug Strategy 1993 to 1997

The National Drug Strategy, formerly the National Campaign Against Drug Abuse, was initiated in 1985 following a Special Premiers Conference. From its inception the Strategy recognised the importance of a comprehensive, integrated approach to the harmful use of licit and illicit drugs and other substances. The aim is to achieve a balance between demand-reduction and supply-reduction measures to minimise the harmful effects of drugs in Australian society (Blewett 1987).

Professors Single and Rohl, authors of *Mapping the Future: an evaluation of the National Drug Strategy 1993–1997*, found that Australia’s National Drug Strategy is widely recognised as one of the most progressive and respected drug strategies in the world. They considered that the success of Australia’s drug policy was based on four main features:

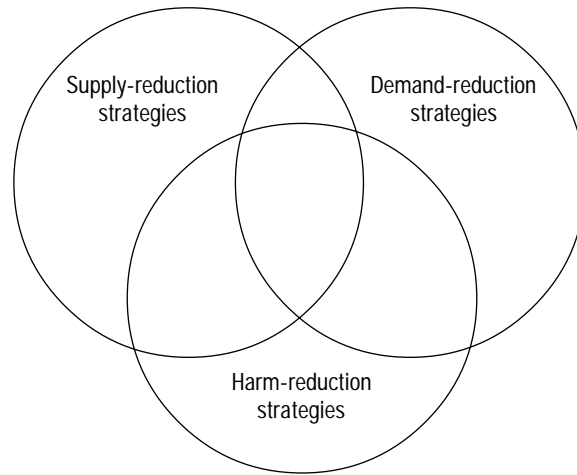
- the principle of harm minimisation, which recognises the need to take a wide range of approaches in dealing with drug-related harm—for example, supply-reduction, demand-reduction (including abstinence-oriented interventions) and harm-reduction strategies;
- the comprehensiveness of the approach, encompassing the harmful use of licit drugs (such as tobacco, alcohol and pharmaceutical drugs), illicit drugs, and other substances (such as inhalants and kava);
- the promotion of partnerships between health, law-enforcement, and education agencies, community-based organisations and industry in tackling drug-related harm;
- a balanced approach—between supply-reduction, demand-reduction and harm-reduction strategies, between preventing use and harm, facilitating access to treatment, and encouraging research, and between the Commonwealth and the States and Territories.

## 3.2 Harm minimisation

Harm minimisation has been the key principle underpinning Australia’s Drug Strategy since 1985 and was identified by Professors Single and Rohl as one of the features contributing to the success of the National Drug Strategy.

Harm minimisation refers to policies and programs aimed at reducing drug-related harm. Harm minimisation aims to improve health, social and economic outcomes for both the community and the individual and encompasses a wide range of integrated approaches, including

- supply-reduction strategies designed to disrupt the production and supply of illicit drugs;
- demand-reduction strategies designed to prevent the uptake of harmful drug use, including abstinence-oriented strategies to reduce drug use;
- a range of targeted harm-reduction strategies designed to reduce drug-related harm for particular individuals and communities.

**Figure 1: The harm-minimisation approach**

Both licit and illicit drugs are the focus of Australia's harm-minimisation strategy. Harm minimisation includes preventing anticipated harm as well as reducing actual harm. Harm minimisation is therefore consistent with a comprehensive approach to drug-related harm, involving a balance between demand-reduction, supply-reduction and harm-reduction strategies.

A comprehensive harm-minimisation approach must take into account three interacting components: the individuals and communities involved; their social, cultural, physical and economic environment; and the drug itself. Approaches will vary according to population group, time and locality. For example, strategies for reducing harm to under-age drinkers will be entirely different from strategies targeting older smokers. Similarly, different strategies may be required for people who inject drugs in rural Queensland and people who inject drugs in metropolitan Sydney.

Governments do not condone illegal risk behaviours such as injecting drug use, but they do acknowledge that these behaviours occur. They have a responsibility to develop and implement public health and law-enforcement measures designed to reduce the harm that such behaviours can cause, both to individuals and to the community. In these circumstances harm-reduction strategies specifically target the individual using drugs and promote initiatives that benefit the wider community. For example, drink-driving was identified as a serious drug-related harm and changes to legislation and law-enforcement practices were introduced. These harm-reduction strategies aimed to reduce harm associated with drink-driving. Similarly, while the practice of injecting drug use continues, the provision of sterile injecting equipment through needle and syringe exchange programs is an important harm-reduction strategy for preventing the spread of blood-borne viruses such as HIV and hepatitis C.

### 3.3 A coordinated, integrated approach

The National Drug Strategy provides a framework for a coordinated, integrated response to reducing drug-related harm in Australia. Responsibility for action under the Framework and in related areas of law enforcement, criminal justice, health, and education, rests with government agencies at all levels, the community-based sector, business and industry, research institutions, local communities and individuals.

Single and Rohl (1997) identified coordination of an integrated harm-minimisation approach as an important policy principle for the National Drug Strategy. Coordination and fostering of approaches consistent with the National Drug Strategic Framework will occur through a number of mechanisms:

- developing National Drug Action Plans;
- promoting community understanding of drug-related harm;
- building partnerships;
- establishing links with other strategies;
- National Drug Strategy advisory structures;
- continued coordination by the Commonwealth and State and Territory governments through the Ministerial Council on Drug Strategy.

### 3.4 A partnership approach

A partnership approach is another principle underpinning the National Drug Strategy. In national public policy terms, a partnership approach for the Strategy can be defined as a close working relationship between the Commonwealth, State and Territory, and local governments, affected communities (including drug users and those affected by drug-related harm), business and industry, professional workers, and research institutions.

Single and Rohl found that the National Drug Strategy has been successful in developing an increasingly strong partnership between health and law enforcement and recommended that attention now be given to enhancing partnerships with other sectors of government, community-based organisations and industry bodies.

‘Building partnerships’ has therefore been identified as a priority for the next phase of the National Drug Strategy. The National Drug Strategic Framework recognises the need for a cooperative effort between all levels of government, community-based organisations, researchers, health professionals, educators, law-enforcement authorities, drug users, and the wider community in working together to reduce the harmful social, health and economic effects of drug use.

### 3.5 A balanced approach

Pursuing a balanced approach to reducing drug-related harm is one of the primary principles underlying the National Drug Strategy.

The National Drug Strategic Framework continues to seek a balance between supply-reduction, demand-reduction and harm-reduction strategies, emphasising the need for integration of drug law enforcement and crime prevention into all health and other strategies aimed at reducing drug-related harm. It is important to recognise that policing initiatives do have an impact on the success of public health initiatives and the health of individuals who use drugs, just as public health initiatives have an impact on criminal activity.

The National Drug Strategic Framework also seeks a balance between strategies to reduce the harm caused by licit and illicit drugs. Illicit drugs are of increasing concern to many communities, but licit drugs are much more widely used and continue to be a source of substantial harm to individuals, their families and the wider community.

Achieving a balance between other components of the National Drug Strategy is more difficult and complex. It involves, among other things, allocating resources between prevention, treatment, training and research or meeting the needs of special populations and other groups. The increased emphasis on coordination of research, monitoring, evaluation and reporting in the National Drug Strategic Framework should facilitate better allocation of resources to areas of significant drug-related harm.

### 3.6 Evidence-based practice

To ensure that effective and efficient strategies are used to reduce harmful drug use and drug-related harm, one important policy principle of the National Drug Strategy is the emphasis on evidence-based practice. All supply-reduction, demand-reduction and harm-reduction strategies should reflect evidence-based practice, which is based on rigorous research and evaluation, including assessment of the cost-effectiveness of interventions. Best practice takes account of the preferences of individual clients, their families and the wider community. It is important that the National Drug Strategic Framework continue to encourage innovation and the development of new approaches.

Priority areas for action under the Framework will be determined on the basis of assessment of current areas of significant drug-related harm. Experts in the field will be consulted, national expert advisory committees will be established, approaches will be coordinated through a National Drug Research Strategy, and interested parties will be consulted.

### 3.7 Social justice

The principle of social justice is also fundamental to the National Drug Strategy. Although drug-related harm can affect any individual, family or community, patterns of such harm show that particular communities and population groups are more affected than others. Strategies for tackling drug-related harm not only must target the particular drug or drugs causing problems but must also be developed with regard to the broader context of the needs of and problems facing the affected community. Levels of employment, health status (including mental health status), homelessness, remoteness, recreation opportunities, cultural considerations, family support, community development and access to services must all be taken into account.

The National Drug Strategic Framework seeks to develop strategies that recognise the unique settings of local communities, are culturally responsive, meet the needs of marginalised population groups, and improve access to services. Local communities will be partners in the development of local strategies, and client groups should be involved in the continuing design and evaluation of service models.

# 4 The National Drug Strategic Framework 1998–99 to 2002–03

## 4.1 Mission

The mission for the National Drug Strategic Framework 1998–99 to 2002–03 is

*to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society.*

## 4.2 Objectives

The following are the objectives of the National Drug Strategic Framework 1998–99 to 2002–03:

1. *to increase community understanding of drug-related harm;*
2. *to strengthen existing partnerships and build new partnerships to reduce drug-related harm;*
3. *to develop and strengthen links with other related strategies;*
4. *to reduce the supply and use of illicit drugs in the community;*
5. *to prevent the uptake of harmful drug use;*
6. *to reduce drug-related harm for individuals, families and communities;*
7. *to reduce the level of risk behaviour associated with drug use;*
8. *to reduce the risks to the community of criminal drug offences and other drug-related crime, violence and anti-social behaviour;*
9. *to reduce the personal and social disruption, loss of quality of life, loss of productivity and other economic costs associated with the harmful use of drugs;*
10. *to increase access to a greater range of high-quality prevention and treatment services;*
11. *to promote evidence-based practice through research and professional education and training;*
12. *to develop mechanisms for the cooperative development, transfer and use of research among interested parties.*

### 4.3 National Drug Action Plans

The National Drug Strategic Framework outlines policy principles and priority areas; it will be accompanied by a series of National Drug Action Plans. These Plans will specify priorities for reducing the harm arising from the use of licit and illicit drugs, strategies for taking action on these priorities, and performance indicators. Harm arising from the use of substances such as inhalants and kava will be part of this.

The Action Plans will be developed by the Intergovernmental Committee on Drugs together with the Australian National Council on Drugs; they will be reviewed and reported on annually. The Intergovernmental Committee on Drugs will develop priorities for and coordinate the development, implementation and evaluation of the Plans, with the assistance of the national expert advisory committees and the national research centres. Interested parties will be consulted in the development of each Action Plan.

The National Drug Action Plans will provide a focus for determining resourcing priorities under the National Drug Strategic Framework and will reflect the agreement of the Council of Australian Governments that the National Illicit Drug Strategy, launched by the Prime Minister on 2 November 1997, will be a major component of the next phase of the National Drug Strategy. The Action Plans will also take account of the priorities identified in the National Heroin Supply Reduction Strategy and the National Supply Reduction Strategy for Illicit Drugs Other than Heroin.

Development and implementation of the National Drug Strategic Framework and the National Drug Action Plans require the collaborative effort of all jurisdictions. Such collaboration should aim for a high degree of national consistency in approaches to policy and program development while allowing flexibility for individual jurisdictions to pursue priorities specific to them.

### 4.4 Priority areas

Seven priority areas for future action were identified during Single and Rohl's (1997) consultations for the evaluation of the National Drug Strategy 1993–1997. An eighth priority area—increasing the community's understanding of drug-related harm—was identified during consultations on the draft National Drug Strategic Framework document. The priority areas are as follows:

- increasing the community's understanding of drug-related harm
- building partnerships
- links with other strategies
- supply reduction
- preventing use and harm
- access to treatment
- professional education and training
- research and data development.

#### 4.4.1 Increasing the community's understanding of drug-related harm

Consultations on the draft National Drug Strategic Framework document identified the need to increase community understanding of drug-related harm as a priority for the next phase of the National Drug Strategy. Single and Rohl also noted confusion in the wider community about the meaning of 'harm minimisation'.

In the National Drug Strategy 1998 Household Survey, the majority of respondents saw licit drug use as the most serious concern for the community, with alcohol use being highest on the list but with significant numbers seeing smoking as the primary concern. After these two, the most frequently mentioned concern was the risks associated with needle sharing. The survey results show considerable inaccuracies in identifying the drug responsible for the greatest number of deaths—tobacco. There are, however, indications that the public is becoming better informed, although only four in every 10 adults surveyed identified tobacco as the principal cause of drug-related death in Australia.

During the next phase of the National Drug Strategy health education campaigns will be used to continue the emphasis on increasing the public's awareness of the health impacts of drug use. Emphasis will also be given to increasing the public's understanding of drug-related harm and the wider impacts of drug use on individuals, families and communities; this includes increasing the community's understanding and acceptance of the broad range of prevention, treatment and harm-reduction programs and services and of evidence-based approaches to new treatment options.

The Australian Drug Information Network and the Community Partnerships Initiative, announced as part of the first phase of the National Illicit Drug Strategy, are important national initiatives. They will facilitate the dissemination of information on drug-related harm to the wider community.

#### 4.4.2 Building partnerships

The partnerships between the Commonwealth and the States and Territories and between health and law-enforcement agencies have been a hallmark of Australia's National Drug Strategy to date and are widely recognised as contributing to its success. Single and Rohl recommended that, in addition to maintaining current partnerships, during this phase of the Strategy attention should be given to enhancing partnerships with other sectors of government, community-based organisations and industry bodies.

The development of a closer working relationship between the three tiers of government and affected communities (including drug users, their families and those affected by drug-related harm), community-based organisations, business and industry, the medical profession, and research institutions has therefore been identified as a priority. In recognition of this, and acknowledging that a partnership approach is still evolving, 'building partnerships' is the theme for this next phase of the National Drug Strategy.

The effectiveness of the National Drug Strategic Framework depends on cooperation between and within a wide range of sectors of Australian society. The Framework seeks to strengthen existing partnerships and expand them to other areas in the following ways:

- through a commitment to consultation and collaboration on all aspects of Australia's response to drug-related harm, emphasising community involvement. For example, interested parties will be consulted on the development of the National Drug Action Plans;

- through the establishment of the Australian National Council on Drugs in 1998, to enhance the partnership between government and the community;
- by allowing for representation of individuals from community-based organisations, business and industry, affected communities (including drug users, their families and those affected by drug-related harm), the medical profession and research institutions on the Australian National Council on Drugs and other bodies that provide advice to the Ministerial Council on Drug Strategy;
- by developing mechanisms at the State and Territory and local government levels to encourage organisations and individuals outside government to become involved in the development of policies and programs;
- by disseminating information about successful models of community action, to help communities develop local responses to drug-related harm. This will be facilitated by the Community Partnerships Initiative announced as part of the National Illicit Drug Strategy.

#### 4.4.3 Links with other strategies

Single and Rohl support the continuation of an integrated approach, whereby the harms associated with use of tobacco, alcohol, pharmaceutical drugs, illicit drugs and other substances are all dealt with in a united national strategy. However, a great deal of activity occurs outside the National Drug Strategy and there are a number of other strategies targeting drug-related harm. Single and Rohl emphasise that the multiplicity of national strategies involving drug-related harm should be clearly linked and coordinated, in order to avoid duplication and to ensure integration and consistency.

The National Drug Strategy Unit within the Commonwealth Department of Health and Aged Care is the central point for coordinating the National Drug Strategy with other relevant strategies and programs. Coordination will also be achieved through the establishment of formal links between National Drug Strategy advisory bodies and advisory bodies in other program areas. The Intergovernmental Committee on Drugs and the Australian National Council on Drugs will work together to develop links with other relevant strategies and programs.

#### **Links with the National Public Health Partnership**

The National Public Health Partnership provides a mechanism for the development, implementation and evaluation of national public health programs, promoting and facilitating evidence-based planning and practice. The Partnership Group aims to support national public health interventions and to strengthen public health capacity generally through the development of national frameworks for public health regulation, planning and practice, information and workforce development and through determining national directions for public health research and development. Formal links exist through the National Strategies Coordination Working Group and the meetings of the Chairs of National Public Health Strategies, which are attended by the Chairs of the Australian National Council on Drugs and the Intergovernmental Committee on Drugs.

The National Public Health Partnership Group is a sub-committee of the Australian Health Ministers Advisory Council, which is the senior officers advisory group to the Australian Health Ministers Conference. The Conference is made up of the Commonwealth, State, Territory and New Zealand Ministers responsible for health.

**Links with Directions in Australasian Policing, the National Heroin Supply Reduction Strategy and the National Supply Reduction Strategy for Illicit Drugs Other than Heroin**

The National Drug Action Plans will be developed in such a way as to be consistent with the National Heroin Supply Reduction Strategy and the National Supply Reduction Strategy for Illicit Drugs Other than Heroin. These Strategies have been developed by the Australasian Police Ministers Council, which is made up of the Commonwealth, State, Territory and New Zealand Ministers responsible for police services. Formal links will be maintained with the Council and its advisory body, the Senior Officers Group.

**Links with the Lead Ministers National Anti-crime Strategy and the National Campaign Against Violence and Crime**

The Lead Ministers National Anti-crime Strategy has been developed by all jurisdictions, which are represented by either their Minister responsible for police services or their Attorney-General; it is a national mechanism for crime-prevention planning and research. The National Campaign Against Violence and Crime aims to prevent violence and crime and reduce fear of violence and crime. The Commonwealth Attorney-General's Department will maintain links between these initiatives and the National Drug Strategy.

**Links with the Aboriginal and Torres Strait Islander Substance Misuse Program**

A review of the Aboriginal and Torres Strait Islander Substance Misuse Program, administered by the Office for Aboriginal and Torres Strait Islander Health, was completed in 1998. OATSIH is responsible for implementing the recommendations arising from the review and, in collaboration with the National Drug Strategy Unit, will ensure that the National Drug Strategy is responsive to Indigenous issues.

**Links with the National HIV/AIDS Strategy and the National Hepatitis C Action Plan**

The National HIV/AIDS Strategy and the National Hepatitis C Action Plan are the responsibility of the Australian National Council on AIDS and Related Diseases, with support from the Intergovernmental Committee on AIDS and Related Diseases. Links will be established between these two organisations, the Australian National Council on Drugs and the Intergovernmental Committee on Drugs to ensure consistency in and coordination of harm-reduction strategies to prevent the spread of blood-borne viruses, including HIV and hepatitis C.

**Links with the National Medicinal Drug Policy**

The continuing development and implementation of the National Medicinal Drug Policy is coordinated by the Australian Pharmaceutical Advisory Committee. The Quality Use of Medicines policy is coordinated by PHARM—the Pharmaceutical Health and Rational Use of Medicines Committee. Both Committees are supported by the Pharmaceutical Benefits Branch of the Commonwealth Department of Health and Aged Care. Links between the Pharmaceutical Benefits Branch and the National Drug Strategy Unit will be maintained.

**Links with the National Mental Health Strategy and the National Youth Suicide Prevention Strategy**

The National Mental Health Strategy is coordinated by the National Mental Health Working Group. The National Mental Health Council and the National Advisory Council on Youth Suicide Prevention advise the Commonwealth Minister for Health and Aged Care; the latter Council advises on development and implementation of the National Youth Suicide Prevention Strategy. Links will be established with these bodies so that a broad range of overlapping matters can be considered, among them coordination between drug treatment services and mental health services to improve service provision in both sectors and in mainstream health services. This will lead to improved management of clients with co-existing mental health and drug problems; it will also help prevent self-harm.

### **Links with the National Health and Medical Research Council**

The National Health and Medical Research Council is responsible for the management of research funding under the National Illicit Drug Strategy. The NHRMC has established a National Illicit Drug Strategy Research Committee to undertake this task; the Committee is made up of representatives of the NHMRC's research committees and the Australian National Council on Drugs and other people with expertise in the prevention and treatment of illicit drug use.

### **Links with the education sector**

The National Expert Advisory Committee on School Drug Education will be supported by the Department of Education, Training and Youth Affairs. In addition to reporting to the Ministerial Council on Drug Strategy, this Committee will report to the Ministerial Council on Employment, Education, Training and Youth Affairs.

### **Links with the National Drugs in Sport Framework**

The National Drugs in Sport Framework was agreed to and developed by the Sport and Recreation Ministers Council in 1995. The Australian Sports Drug Agency is responsible for monitoring the Framework.

### **Links with international drug treaties**

Australia is a signatory to several international conventions and agreements that have implications for domestic policy formulation. The purpose of Australia's participation in international drug cooperation is to contribute to global stability and regional cooperation, drawing on our extensive expertise and experience in effective law-enforcement strategies, regulatory mechanisms and demand- and harm-reduction initiatives. Australia will continue to participate in the international drug policy arena.

Australia's efforts in international drug cooperation are coordinated by the Standing Interdepartmental Committee on International Narcotics Issues, which is made up of representatives of all Commonwealth agencies with an interest in international drug matters. The National Drug Strategy Unit coordinates links between the Committee's activities and the National Drug Strategic Framework.

## **4.4.4 Supply reduction**

Supply-reduction strategies aim to disrupt both the supply of illicit drugs entering Australia and the production and distribution of illicit drugs within Australia.

The Australian Customs Service and the Australian Federal Police are key agencies in implementing strategies to reduce the supply of illicit drugs entering Australia. They work in partnership: Customs has primary responsibility for the detection of illicit drugs at Australia's border and the AFP has primary responsibility for the conduct of investigations arising from the detection and seizure of illicit drugs. Funding through the National Illicit Drug Strategy has provided additional resources to these agencies for supply-reduction initiatives such as strike teams, an increased presence in Torres Strait, and improved technology and communications capabilities.

Within each jurisdiction, State and Territory police services are the lead agencies in implementation of supply-reduction strategies. The National Crime Authority and the Australian Bureau of Criminal Intelligence also have roles in reducing the supply and the production of illicit drugs in Australia.

Supply reduction involves national and cross-jurisdictional information sharing. Additional funding has been provided through the National Illicit Drug Strategy to help the National Crime Authority pursue money laundering and tax evasion related to crime, especially drug trafficking, and to enhance the capacity of AUSTRAC (the Australian Transaction Reports and Analysis Centre) to monitor suspicious transactions.

Law-enforcement agencies are developing innovative approaches to the illicit drug trade, including coordinating intelligence on drug use. Among other things, at the local level this coordinated approach involves establishing a network of people in the community to report on changing patterns of drug use in local settings. This information is combined with demographic data on such factors as drug-related crime, motor vehicle accidents, deaths and arrests. The information is then analysed by using geographic information systems to provide police with an assessment of the illicit drug market in a local area.

Supply-reduction strategies may also apply to limits on access to and the availability of licit drugs in particular contexts. An example is legislation regulating the sale of alcohol and tobacco to people under the age of 18 years. State and Territory government agencies (including health, law-enforcement and licensing authorities), local government, industry bodies and retail outlets all have roles in developing, implementing, complying with and enforcing supply-reduction strategies for licit drugs.

Law-enforcement agencies have been developing partnership approaches in a range of areas. The Australian Customs Service runs two participation schemes—Frontline and Customs Watch—that seek the assistance of the business community and the broader community in providing information about suspicious activity that may indicate drug importation. State and Territory police services have been establishing local networks through community policing initiatives and through other initiatives connected with community safety and crime prevention. All jurisdictions run operations such as phone-ins targeting specific issues or have dedicated telephone lines to encourage the reporting of crime.

The Australasian Police Ministers Council has set strategic directions for police services to fully explore their role in supporting community wellbeing through taking responsibility for a broader concept of service. The Council's 1997 document entitled *Directions in Australasian Policing 1996–1999* outlines directions for providing leadership in critical matters affecting socio-economic wellbeing, adopting a partnership approach to problem solving, engaging stakeholders, and aiding the progress of reform in criminal justice. The Council has also emphasised the importance of law-enforcement agencies working cooperatively with each other in relation to the National Heroin Supply Reduction Strategy and the National Supply Reduction Strategy for Illicit Drugs Other than Heroin. These Strategies have six common objectives:

- improving the coordination of investigations;
- enhancing interdiction at the international border;
- increasing the accuracy and timeliness of information and intelligence;
- improving technology and best practice;
- a review of legislation to ensure a complementary approach to drug law enforcement;
- development of performance indicators.

#### 4.4.5 Preventing use and harm

Single and Rohl's *Mapping the Future* (1997) was strongly supportive of the continuation and expansion of prevention programs under the National Drug Strategic Framework, including school-based drug education. Such programs are designed to prevent harmful drug use and prevent drug-related harm.

Community ownership and participation are central to the development and implementation of effective prevention programs. Communities are able to develop local responses to harmful drug use; they are not simply a target audience for public health campaigns. Individuals, families and a variety of community-based organisations need to participate in efforts to reduce drug-related harm—this is particularly important for Indigenous and culturally and linguistically diverse communities.

Preventing use is achieved through demand-reduction strategies designed to deter people from taking up harmful drug use; among these strategies are abstinence-oriented ones aimed at preventing and reducing drug use. The National Illicit Drug Strategy emphasises the importance of school-based drug education. The Ministerial Council on Drug Strategy will work closely with the Ministerial Council on Employment, Education, Training and Youth Affairs in developing future approaches to drug-related education in schools.

Preventing harm is achieved through a range of targeted harm-reduction strategies designed to reduce the impact of drug-related harm for particular individuals and communities. Levels of drug use among individuals and communities can vary greatly—from no use at all to consumption at harmful levels. Prevention programs that are sensitive to individual and community levels of use are necessary.

For any drug issue there may be a variety of prevention programs that can be introduced to reduce harms for particular population groups—targeted media campaigns, development programs for professionals, distribution of information products, community development projects, peer education, skills building, and employment programs are examples. Effective prevention programs are often based in settings such as youth centres, prisons, places of employment, gyms and liquor outlets.

In State and Territory police services there has been increasing emphasis on the development of a truly intersectoral, collaborative approach to harmful drug use. Law-enforcement agencies work closely with liquor-licensing authorities and the hospitality industry to develop and implement harm-reduction initiatives, including responsible serving practices. Health and law-enforcement agencies also work together; for example, police and ambulance services have developed protocols relating to police attendance at overdoses, and police services have developed guidelines to prevent their duties impinging on the operation of needle and syringe exchange programs. Initiatives such as these continue to be an important element of harm-reduction strategies to reduce the spread of blood-borne viruses such as HIV and hepatitis C.

Prevention programs may also be supported by legislative measures such as those pertaining to tobacco advertising and drink-driving. The National Drug Action Plans will nominate priorities for preventing use and harm: programs will be developed according to evidence-based research and in consultation with interested parties and the wider community.

#### 4.4.6 Access to treatment

The availability of treatment services for users of both licit and illicit drugs remains integral to the National Drug Strategic Framework. Preventing the uptake of harmful drug use is vital, but it is also important to provide treatment services for people who are drug dependent to reduce drug use and prevent drug-related harm.

Extensive research conducted for the National Drug Strategy demonstrates that drug treatment services are effective in reducing harmful drug use, hospital costs, drug-related crime, violence and welfare costs (Mattick & Hall 1993). In *Mapping the Future* Single and Rohl noted the cost-effectiveness of treatment services and that early and brief interventions offer substantial benefits if conducted by suitably trained and resourced workers.

There is an expectation—in the community and among drug users and their families—that a range of treatment services will be accessible, regardless of age, race, gender, sexual preference and location. Such services are provided through partnerships involving government, community-based organisations and the private sector in a variety of settings. It is important that clients are matched to the treatment option that best meets their needs.

Treatment services range from early, brief intervention to long-term residential treatment. Early intervention is designed to prevent someone progressing to harmful drug use—general practitioners, hospital nurses, and community workers are ideally placed to provide early intervention for a range of clients. The main models for drug treatment services involve detoxification, therapeutic communities, residential facilities, outpatient treatment, day programs and self-help groups.

Substitution therapies are one of a range of options used for managing opioid dependence; of these, methadone-maintenance treatment has been the most widely used in Australia to date. Research is being conducted into a range of new substitution therapies, both for opioid dependence and for psychostimulant dependence. Within the treatment sector, increasing emphasis is being given to relapse prevention.

The goals of drug treatment services can be complete abstinence or reduced or controlled use. In addition to helping people become drug free, such services focus on other health benefits through drug substitution and reducing harmful drug use and associated risk behaviour. The services also collaborate with other service providers to try to resolve a range of other health and social problems confronting individuals and families affected by harmful drug use.

There are a number of areas for future development of treatment services:

- improving the range of services available—for example, by developing a range of effective alternative pharmacotherapies for the treatment of opioid dependence to better tailor treatment to individual needs;
- improving the effectiveness and quality of services—for example, by ensuring that service provision is evidence-based and provided by experienced and appropriately qualified staff;
- improving access to services and ensuring community acceptance of services—this includes the development of services for specific population groups (young people, Indigenous people, women with children, people who live in rural and remote areas, people from culturally and linguistically diverse backgrounds) and improving the delivery of culturally responsive services from mainstream treatment facilities;
- increasing the involvement of mainstream service providers such as general practitioners and hospitals in early intervention and relapse prevention;

- building stronger links between drug treatment services and mental health services, to improve service provision in both sectors and in mainstream health services for the management of clients with co-existing mental health and drug problems;
- improving access to treatment for people in the criminal justice and juvenile justice systems—this includes expanding the use of diversion programs to enable those apprehended for minor drug-related offences to be diverted to a range of appropriate drug treatment services.

A continuing partnership between government, community-based organisations and the private sector forms the basis of progress in these areas. The National Illicit Drug Strategy has recognised the need to target unmet demand across a broad geographic range and population groups. Further research will examine the effectiveness of existing interventions and identify new treatment options, with a particular emphasis on quality outcomes and cost-effectiveness. Priorities for access to treatment will form part of the National Drug Action Plans.

#### 4.4.7 Professional education and training

It is estimated that during 1998 over 175 000 Australians would be hospitalised for drug-related conditions (Single & Rohl 1997). Many more individuals and family members will consult their local doctor, community nurse, pharmacist, counsellor or youth worker in connection with harms arising from the use of tobacco, alcohol, pharmaceutical drugs, illicit drugs or other substances. Others will come into contact with the police, ambulance officers, or the criminal justice and juvenile justice systems as a result of harmful drug use.

A wide range of criminal justice, health, welfare and education workers are exposed to people who experience drug-related harm. But many of these professionals do not consider they have the skills, training and confidence, or see it as their responsibility, to respond directly to health, social and psychological harms caused by drug use. Another important initiative will be improving access to knowledge and skills development through professional education and training.

An overview of drug education and training for professionals in Australia suggests that its nature, delivery, content and quality is diverse and varied. There is a marked difference between education and training programs that are systematic, well planned and adequately resourced and those that are ad hoc. The National Centre for Education and Training on Addiction found that the extent of training also varies according to jurisdiction, professional group and organisation (Allsop et al. 1998). The poor quality of evaluation in drug education and training was highlighted by this research, which identified as priority areas: responding to the needs of young people, providing enhanced access to quality and integrated care, enhancing collaboration across services, and responding to areas of significant harm.

There may also be structural or organisational barriers to preventing drug-related harm that need to be redressed. Priorities for professional education and training will form part of the National Drug Action Plans.

#### 4.4.8 Research and information development

Research will continue to have high priority under the National Drug Strategic Framework. In order to maximise outcomes, action by health, police and education services to redress drug-related harm should reflect evidence-based practice, which in turn is based on quality research and evaluation, including assessment of the cost-effectiveness of interventions.

The National Drug Strategy benefits from dedicated national research centres that provide the opportunity for a core research program. The two national research centres—the National Drug and Alcohol Research Centre and the National Centre for Research into the Prevention of Drug Abuse—were established in 1986. Under the National Drug Strategy funding has been provided to these Centres to support and facilitate research into matters identified as priorities in the Strategy. The Centres engage in a broad range of research, which is published widely, and have an international reputation for excellence.

These two Centres and other research institutions have much to contribute to the development of the National Drug Action Plans and in supporting the work of the national expert advisory committees. It is essential that research results continue to be disseminated and that practice is linked to research evidence.

The rigour applied to development of the National Drug Action Plans should provide for nationally agreed research priorities accompanied by a commitment to and process for disseminating research results. The research priorities should have regard to the proposed principles for public health research and development—in particular, the need for a balance of investment between fundamental, strategic and multi-disciplinary research—and the development and evaluation of interventions.

A mechanism for coordinating research is needed, so that the policy principles underlying the National Drug Strategy are based on the best available evidence and information. A National Drug Research Strategy, with the same status as the National Drug Action Plans, will be developed to

- identify research principles under the National Drug Strategy;
- provide a systematic process for identifying research gaps and priorities;
- assess the appropriateness of the information systems used for dissemination of research findings to those involved with the National Drug Strategy and to the wider community;
- assess and develop priorities for research resources, including the research workforce;
- find a balance between commissioned and investigator-determined research;
- develop mechanisms for the cooperative development, transfer and use of research among those involved with the National Drug Strategy.



## 5 Evaluation, monitoring and reporting

Monitoring and evaluation strategies are required to determine whether the objectives and priorities of the National Drug Strategic Framework are being met and whether specific strategies identified in National Drug Action Plans are effective. A comprehensive National Drug Monitoring and Evaluation Strategy will be developed by the National Drug Strategy Unit, under the direction of the Intergovernmental Committee on Drugs and the Australian National Council on Drugs, and in collaboration with representatives of Commonwealth, State and Territory government agencies, community-based organisations and research institutions.

The National Drug Monitoring and Evaluation Strategy will have four primary objectives:

- to measure the National Drug Strategic Framework's performance against its objectives and priorities, using the best available medical, social and epidemiological data;
- to provide timely and accurate information on National Drug Strategy program performance for program management and Commonwealth, State and Territory annual reporting purposes;
- to identify emerging challenges and changing trends in harmful drug use, including the emergence of new drug-related harms;
- to communicate to all levels of government and the wider community the successes, problems and challenges of the National Drug Strategy.

The National Drug Monitoring and Evaluation Strategy will operate through four mechanisms:

- review and refinement of performance indicators for regular monitoring of the effectiveness (including cost-effectiveness) of the National Drug Strategic Framework and the National Drug Action Plans in meeting their objectives;
- coordination of existing data sources and early development of additional appropriate databases and information systems to allow for monitoring against agreed performance indicators;
- a requirement that Commonwealth, State and Territory governments agree on a reporting framework for implementation of the National Drug Strategy within their jurisdictions;
- an annual monitoring report to the Ministerial Council on Drug Strategy dealing with implementation of the National Drug Strategic Framework.



## 6 National Drug Strategy structures

### 6.1 The Ministerial Council on Drug Strategy

The Ministerial Council on Drug Strategy will continue to bring together Commonwealth, State and Territory Ministers responsible for health and law enforcement to collectively determine national policies and programs to reduce the harm caused by drugs. In *Mapping the Future* Single and Rohl (1997) identified the Ministerial Council as one of the major strengths of Australia's National Drug Strategy. Under the National Drug Strategic Framework, the Council will continue to function as the peak policy- and decision-making body in relation to licit and illicit drugs in Australia.

The Ministerial Council will ensure that Australia has a nationally coordinated and integrated approach to reducing the harm arising from the use of drugs. The Ministerial Council's collaborative approach is designed to achieve national consistency in policy principles, program development and service delivery.

The Council of Australian Governments has asked the Ministerial Council on Drug Strategy to report on the development and implementation of the National Illicit Drug Strategy announced by the Prime Minister on 2 November 1997. The Ministerial Council will also continue to liaise with and provide reports to the Australasian Police Ministers Council, the Australian Health Ministers Council, the Ministerial Council on Employment, Education, Training and Youth Affairs, and other ministerial councils on matters of joint responsibility and priority in relation to the National Drug Strategy.

### 6.2 The Intergovernmental Committee on Drugs

The Ministerial Council on Drug Strategy will be supported by a Commonwealth–State–Territory government forum—the Intergovernmental Committee on Drugs (formerly known as the National Drug Strategy Committee). The IGCD will consist of senior officers representing health and law enforcement in each Australian jurisdiction (appointed by their respective health and law-enforcement Ministers) and people with expertise in identified priority areas (for example, representatives of the Australian Customs Service and the Department of Education, Training and Youth Affairs).

The IGCD will provide policy advice to Ministers on the full range of drug-related matters and will be responsible for implementing National Drug Strategy policies and programs, as directed by the Ministerial Council on Drug Strategy.

The Ministerial Council has endorsed the IGCD as the appropriate body to develop priorities for and coordinate the activities of the national expert advisory committees, to ensure that policies, strategies and directions are consistent with the National Drug Strategic Framework. The IGCD will also coordinate the development, implementation and evaluation of National Drug Action Plans. The Framework and the Action Plans will provide the basis on which the IGCD can develop priorities for and coordinate the activities of the national expert advisory committees on behalf of the Ministerial Council.

### 6.3 Australian National Council on Drugs

The Australian National Council on Drugs, consisting of people with relevant expertise from the government, non-government and community sectors, will support the Ministerial Council on Drug Strategy. The ANCD will ensure that the expert voice of non-government organisations and individuals working in the drug field reaches all levels of government and influences policy development. It will have broad representation from volunteer and community organisations and law-enforcement, education, health and social welfare interests.

The ANCD will provide Ministers with independent, expert advice on matters connected with licit and illicit drugs. It will facilitate an enhanced partnership between governments and the non-government and community sectors in the development and implementation of policies and programs to redress drug-related harms. It will also be central to the National Drug Strategic Framework's efforts to extend the partnership approach of the National Drug Strategy to the community sector.

In consultation with interested parties, the ANCD will develop a workplan. It will report annually to the Prime Minister and the Ministerial Council on Drug Strategy on progress with its workplan and provide independent advice on drug-related matters.

### 6.4 The national expert advisory committees

The national expert advisory committees will provide a range of advice to the Ministerial Council on Drug Strategy. Committee members will be selected on the basis of their expertise in health, law enforcement, community-based service provision, education, research, government and industry.

Initially, national expert advisory committees will be established for tobacco, alcohol, illicit drugs, and school-based drug education. Additional committees may be established as other priorities are identified. The committees will have clearly defined tasks, specified in the National Drug Action Plans. Among their tasks will be the following:

- identifying emerging trends relating to the harmful use of specific drugs or other substances and providing expert advice on strategies to ensure a timely response;
- providing expert advice to the Ministerial Council on Drug Strategy, the ANCD and the IGCD on priorities and strategies for dealing with specific drug-related harm, including priorities and strategies for supply reduction, demand reduction and harm reduction;
- providing advice on current legal, medical, scientific, ethical, social and public health approaches to reducing drug-related harm;
- providing advice and direction to ensure the development and application of strategies that are culturally responsive to specific population groups, including Indigenous communities;
- contributing to the development of National Drug Action Plans under the National Drug Strategic Framework by identifying national priorities and strategies for addressing them;
- contributing to annual reports to the Ministerial Council on Drug Strategy on the progress of the National Drug Action Plans;
- providing expert advice on other nationally significant matters, as referred to them by the Ministerial Council on Drug Strategy, the ANCD or the IGCD.

## 6.5 Review of advisory structures

The Ministerial Council on Drug Strategy will review the advisory structures supporting the National Drug Strategic Framework at the end of 1999–2000.



# 7 Roles and responsibilities

The effectiveness of the National Drug Strategic Framework depends on cooperation between and within a wide range of sectors of Australian society—across the three tiers of government; between governments, community-based organisations and industry; between unions and employers; between health and welfare, law-enforcement and education professionals; with families and communities; and with all those affected by harmful drug use.

## 7.1 Families and communities

Responsibility for reducing the harm caused by drugs rests with all Australians. Families and communities have a vital role in the development of attitudes to and values concerning drug use. Communities and community members must take individual and collective responsibility for their own health and wellbeing. The harms caused by drugs extend beyond the individual: they affect families, friends, local communities, schools, workplaces, public places and the wider community.

Individuals have a responsibility to be aware of the harms that may arise from their drug use and the impact it may have on their family and community. As noted, there are many such harms—crimes of violence against people; property crimes; the causing of injury and death through impaired reactions while driving and operating machinery; loss of productivity; the transmission of blood-borne viruses, including HIV and hepatitis C; the effects of environmental tobacco smoke; and a range of harms to individuals' physical and mental health and wellbeing.

Families are often the first to be affected by drug-related harm. Harmful drug use may impair parents' ability to care for their children. Parents can be affected by their child's use of drugs. Harmful drug use affects relationships between family members. Families can be affected by loss of and grief for the relationship they enjoyed before the harmful drug use set in. Families and friends are traumatised when drug use results in illness, disability or death. In some cases families are stigmatised because one of their members engages in harmful drug use. Families and friends are also an important source of support for people seeking to deal with their drug use by obtaining treatment.

Particular communities experience changing patterns of drug use and drug-related harm. The National Drug Strategic Framework seeks to enhance families' and communities' ability to respond to drug-related harm. It will do this in four main ways:

- by providing accurate and accessible information about drug use and drug-related harm;
- by providing access to a range of treatment options;
- by encouraging parents and communities to be involved in local initiatives;
- by promoting and providing information about successful partnership approaches to dealing with drug-related harm in local settings.

## 7.2 Community-based organisations

In *Mapping the Future* Single and Rohl (1997) note that the success of the National Drug Strategy to date has been largely a result of the commitment of individuals and community-based organisations that have carried out the prevention, treatment and research initiatives under the Strategy.

Community-based organisations have a role in four important areas:

- the provision of counselling, support, and treatment and care—for people who experience or are at risk of experiencing harm as a result of their drug use and for their families, friends and other affected parties. The National Drug Strategic Framework recognises that investment in community-based organisations is essential to the delivery of many services and the attainment of National Drug Strategy objectives;
- the provision of education, information and support to prevent and reduce drug-related harm. Community-based organisations represent a source of expertise and knowledge in relation to the needs and circumstances of specific groups in the community. Some organisations are able to target and provide services to particular population groups and to establish continuing relationships with local communities. This enables the organisations to gain an understanding of the particular needs of and problems facing their local communities;
- contributing to the development, delivery and evaluation of policies and programs. Community-based organisations are uniquely placed to assess and advise government on appropriate responses and to provide feedback on the effects of policy and programs on specific groups in the community;
- advocating for specific policies or programs.

The integral role of the community-based sector is acknowledged by the inclusion of experts from this sector in the membership of the Australian National Council on Drugs and the national expert advisory committees.

Within the National Drug Strategy, community-based organisations will continue to be fundamental to building a partnership approach to taking action on the priorities identified in the National Drug Strategic Framework.

### 7.3 Business and industry

Both employers and employees are responsible for occupational health and safety. Chapter 2 discusses drug-related harm in relation to workplace injury and loss of productivity. Many employers help their employees deal with harmful drug use through access to Employee Assistance Programs and incentives to quit smoking.

The pharmaceutical, alcohol beverage and hospitality industries have a responsibility to promote safe and responsible use of their products. Industry bodies have been active partners with government and the community in developing and implementing strategies to reduce drug-related harm. Professional associations provide training for general practitioners and community pharmacists on the appropriate use of pharmaceutical drugs. Community pharmacists are an important point of information and advice for health consumers, and some have been active in harm reduction through providing needle and syringe exchange programs. The alcohol beverage and hospitality industries have encouraged responsible serving practices in licensed premises and provide information at the point of purchase on reducing the harm associated with alcohol use.

## 7.4 Local government

Local government is in an ideal position to respond to the needs of local communities and to facilitate the development of local responses. Many local governments are involved in developing partnerships with local communities to respond to drug-related harms. Such community-development approaches include links with community safety initiatives and public place management strategies, support for ‘accords’ between police and health services, and the development of local drug and alcohol action plans.

Local government is an active partner in and facilitator of many local cooperative initiatives aimed at reducing drug-related harm. These initiatives may involve business owners, police, community representatives, community-based service providers, and State or Territory government agencies. Local government also has the opportunity to develop policies that support the appropriate location of treatment services and the operation of needle and syringe exchange programs. In relation to waste disposal, an important adjunct to the operation of needle and syringe exchange programs is the provision of safe disposal chutes for used syringes and the operation of services to collect discarded syringes.

Models of best practice could be developed and promoted within the local government sector, with the encouragement and support of local government associations and the States and Territories.

## 7.5 State and Territory governments

Under the National Drug Strategy State and Territory governments are responsible for providing leadership within their respective jurisdictions. They are responsible for policy development, implementation and evaluation and for the delivery of police, health and education services to reduce drug-related harm.

Among the functions State and Territory governments may perform under the National Drug Strategic Framework are the following:

- ensuring the establishment of a comprehensive strategy enabling community and specialist involvement in policy and program development, including advisory structures;
- developing and implementing their own drug strategies from the perspectives of law enforcement and population health and based on local priorities;
- collaborating in national policy and strategy development;
- controlling the supply of illicit drugs through both specialist drug law enforcement units and ‘general duties’ police officers;
- enforcing the regulation of pharmaceutical drugs;
- enforcing laws regulating the consumption and availability of alcohol and developing and enforcing legislation relating to tobacco;
- implementing harm-reduction strategies to prevent drink-driving;
- designing, developing and implementing public information and education programs aimed at discouraging the uptake and reducing the level of harmful drug use and reducing drug-related harm;

- ensuring that drug treatment services are provided in a manner consistent with the philosophy of the National Drug Strategic Framework and taking account of priorities within their jurisdiction;
- assessing measures that allow police to exercise discretion in diverting drug users away from the criminal justice system into appropriate treatment options;
- encouraging police and health services to develop joint guidelines that prevent police duties from coming into conflict with health services designed to reduce drug-related harm—for example, needle and syringe exchange programs;
- providing public sector health services or funding community-based organisations to provide drug prevention and treatment programs;
- developing effective and comprehensive professional education and training, research and evaluation strategies, in close cooperation with other jurisdictions so as to achieve consistency;
- establishing an appropriate public policy framework to deal with drug use and drug-related harm in areas such as housing, school-based drug education, criminal justice and juvenile justice, and liquor licensing;
- analysing and monitoring patterns of drug use and drug-related harm;
- monitoring outcomes, reporting on performance at the jurisdictional level, and contributing to cross-jurisdictional and national surveys and research.

Many of these functions are also carried out by Commonwealth agencies; in many cases, they are cooperative exercises between the Commonwealth and the States and Territories.

## 7.6 The Commonwealth Government

The Commonwealth Government is responsible for providing leadership in Australia's response to reducing drug-related harm. The Department of Health and Aged Care will continue to be the Commonwealth agency with overall responsibility for coordination of the National Drug Strategy and related programs.

The National Drug Strategy Unit, within the Department's Population Health Division, has primary carriage at the Commonwealth level of activities under the National Drug Strategic Framework. The Unit's activities and priorities will be determined by the Ministerial Council on Drug Strategy and its advisory structures. In relation to the National Drug Strategic Framework, the Unit has five primary responsibilities:

- ensuring national policy development, coordination and management, in conjunction with the Ministerial Council on Drug Strategy, the Australian National Council on Drugs, the Intergovernmental Committee on Drugs, the national expert advisory committees and the community-based sector;
- managing the workplans of and providing policy assistance and executive support for the Ministerial Council on Drug Strategy, the Australian National Council on Drugs, the Intergovernmental Committee on Drugs and the national expert advisory committees;
- monitoring and evaluating the impact of the National Drug Strategy and any changing trends in order to provide timely advice to the Ministerial Council on Drug Strategy, the Australian National Council on Drugs and the Intergovernmental Committee on Drugs;

- responding to identified areas of need by commissioning work that is best done at the national level;
- providing advice on the policy-related aspects of Australia's international treaty obligations.

The National Drug Strategy operates in the context of other national public health initiatives under the National Public Health Partnership.

The Department of Health and Aged Care administers programs for medical and hospital treatment through Medicare, for pharmaceutical products through the Pharmaceutical Benefits Scheme, and for methadone under section 100 of the *National Health Act 1953*.

The Office for Aboriginal and Torres Strait Islander Health provides funding for community-controlled health services and administers the Aboriginal and Torres Strait Islander Substance Misuse Program.

The Therapeutic Goods Administration regulates the quality, safety, efficacy and availability of therapeutic goods for use in Australia and for export, including medicines and medical devices. It also issues licences and permits for the import and export of narcotic and psychotropic drugs and other controlled substances and monitors the movement of narcotic drugs throughout Australia. This helps Australia meet its obligations under international drug treaties, including the *Single Convention on Narcotic Drugs 1961*, the *Convention on Psychotropic Substances 1971* and the *United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988*.

The Commonwealth Department of Education, Training and Youth Affairs is responsible for developing a National School Drug Education Strategy, which will build on and enhance existing State and Territory initiatives.

The Commonwealth Attorney-General's Department contributes to the development of national drug policy (principally in the area of illicit drugs and supply reduction), monitors adherence to international drug treaties, and develops and implements policy in the areas of crime prevention, money laundering, extradition and mutual assistance. It also coordinates the National Campaign Against Violence and Crime, which supports research into links between illicit drug use and crime, and strategies relating to prevention of domestic violence, crime prevention, and the relationship between young people and crime.

At Australia's border the Australian Customs Service enforces the Government's controls on illicit drugs and controlled substances.

The Australian Federal Police has primary responsibility for investigating offences associated with the importation of illicit drugs into Australia and for disrupting the international supply of illicit drugs. In this, it works in partnership with Customs and the National Crime Authority. The operation and maintenance of an overseas liaison network, which involves stationing officers in a number of foreign countries, is another important part of the AFP's work. Customs also has a number of overseas posts. Much of this liaison effort goes to working with foreign law-enforcement agencies to gather information on and monitor the movement of illicit drugs destined for Australia.

The National Crime Authority works to counteract organised criminal activity and reduce the impact of such activity on the Australian community. It collects and analyses crime-related information and intelligence and investigates criminal activities such as illicit drug dealing. Cooperative arrangements between partner law-enforcement agencies are coordinated by the Authority through national task forces.

The Australian Bureau of Criminal Intelligence provides Australasian police services with a national focus for reporting and assessing developments connected with illicit drugs on a daily and continuing basis. Each year it publishes a national assessment of the illicit drug situation from a law-enforcement perspective.

# Abbreviations

ABS	Australian Bureau of Statistics
AFP	Australian Federal Police
AHMAC	Australian Health Ministers Advisory Council
AHMC	Australian Health Ministers Conference
AIDS	acquired immunodeficiency syndrome
AIHW	Australian Institute of Health and Welfare
ANCARD	Australian National Council on AIDS and Related Diseases
ANCD	Australian National Council on Drugs
APMC	Australasian Police Ministers Council
AUSTRAC	Australian Transaction Reports and Analysis Centre
HIV	human immunodeficiency virus
IGCD	Intergovernmental Committee on Drugs
MCDS	Ministerial Council on Drug Strategy
NCHECR	National Centre in HIV Epidemiology and Clinical Research
NHMRC	National Health and Medical Research Council
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PHARM	Pharmaceutical Health and Rational Use of Medicines



# Glossary

## **Abstinence**

Refraining from drug use.

## **Age of initiation**

The age of first use of a drug or substance.

## **AIDS (Acquired immunodeficiency syndrome)**

A syndrome defined by the development of serious opportunistic infections, neoplasms or other life-threatening manifestations resulting from progressive HIV-induced immuno-suppression.

## **Alternative pharmacotherapies**

Substitution treatments for opioids, other than methadone-maintenance treatment. Some of these treatments are also being used for alcohol dependence.

## **Australian Drug Information Network**

One of the measures identified under the National Illicit Drug Strategy, the Australian Drug Information Network will disseminate information on drug use and drug-related harm to the general community, including parents, schools, universities, health professionals and health care facilities.

## **Australian National Council on Drugs**

One of the advisory bodies supporting the Ministerial Council on Drug Strategy, the Australian National Council on Drugs consists of people with relevant expertise from the government, non-government and community sectors. The Council ensures that the voice of non-government organisations and individuals working in the drug field reaches all levels of government and influences policy development. It has broad representation from volunteer and community organisations and law-enforcement, education, health and social welfare interests.

## **Best practice**

On the evidence available, the best intervention to produce improved outcomes for an identified issue.

## **Benzodiazepines**

One of a group of drugs used mainly as sedatives and muscle relaxants and for epilepsy.

## **Blood-borne virus**

A virus that can be transmitted from an infected person to another person by blood-to-blood contact, including through the sharing of injecting equipment.

## **Community Partnerships Initiative**

One of the measures identified under the National Illicit Drug Strategy, the Community Partnerships Initiative aims to establish a national model of best practice in community-based prevention of illicit drug use by young people.

## **Controlled substances**

Psychoactive substances and their precursors that are subject to controls on their manufacture, sale and distribution.

## **Culturally responsive strategies**

Strategies that take into account the practices and beliefs of a particular population group, so that the relevant initiatives are acceptable, accessible, persuasive and meaningful.

## **Demand-reduction strategies**

Demand-reduction strategies seek to reduce the desire for and preparedness to obtain and use drugs. These strategies are designed to prevent the uptake of harmful drug use and include abstinence-oriented strategies aimed at reducing drug use. Their purpose is to prevent harmful drug use and to prevent drug-related harm.

**Detoxification**

The means by which a drug-dependent person may withdraw from the drug's effects.

**Drug**

A substance that produces a psychoactive effect. Within the context of the National Drug Strategic Framework, 'drug' is used generically to include tobacco, alcohol, pharmaceutical drugs and illicit drugs. The Framework also takes account of performance- and image-enhancing drugs and substances such as inhalants and kava.

**Drug dependence**

Drug dependence is characterised by a strong desire to take a drug. Among the indicators of dependence are impaired control over drug use, a higher priority given to drug use than to other activities and obligations, increased tolerance, physical withdrawal symptoms, and repeated drug use to suppress withdrawal.

**Drug-related harm**

Any adverse social, physical, psychological, legal or other consequence of drug use that is experienced by a person using drugs or by people living with or otherwise affected by the actions of a person using drugs.

**Drug-substitution treatment**

Treatment involving the prescription of an alternative drug that is safer than a person's drug of choice. Methadone, as a substitute for heroin, is currently the most widely used drug substitute in Australia.

**Environmental tobacco smoke**

A combination of exhaled mainstream tobacco smoke and sidestream smoke from the burning tip of a cigarette.

**Evidence-based practice**

Evidence-based practice involves integrating the best available evidence with professional expertise to make decisions.

**Harm-reduction strategies**

Harm-reduction strategies are designed to reduce the impacts of drug-related harm on individuals and communities. Governments do not condone illegal risk behaviours such as injecting drug use: they acknowledge that these behaviours occur and that they have a responsibility to develop and implement public health and law-enforcement measures designed to reduce the harm that such behaviours can cause.

**Harm minimisation**

Harm minimisation is the primary principle underpinning the National Drug Strategy and refers to policies and programs aimed at reducing drug-related harm. It aims to improve health, social and economic outcomes for both the community and the individual and encompasses a wide range of approaches, including abstinence-oriented strategies. Both licit and illicit drugs are the focus of Australia's harm-minimisation strategy. Harm minimisation includes preventing anticipated harm and reducing actual harm. Harm minimisation is consistent with a comprehensive approach to drug-related harm, involving a balance between demand reduction, supply reduction and harm reduction.

**Harmful drug use**

A pattern of drug use that has adverse social, physical, psychological, legal or other consequences for a person using drugs or people living with or otherwise affected by the actions of a person using drugs. Hazardous drug use is any drug use that puts the person using drugs, or those living with or otherwise affected by the actions of a person using drugs, at risk of these harmful consequences. Hazardous drug use includes any use of illicit drugs.

**HIV**

A human retrovirus that leads to AIDS.

**Illicit drug**

A drug whose production, sale or possession is prohibited. ‘Illegal drug’ is an alternative term.

**Inhalants**

Substances inhaled for psychoactive effects—for example, glues, aerosol sprays, paints, industrial solvents, thinners, petrol and cleaning fluids.

**Intergovernmental Committee on Drugs**

One of the advisory bodies supporting the Ministerial Council on Drug Strategy, the Intergovernmental Committee on Drugs is a Commonwealth–State–Territory government forum. It consists of senior officers representing health and law-enforcement agencies in each Australian jurisdiction (appointed by their respective health and law-enforcement Ministers) and other people with expertise in identified priority areas (for example, representatives of the Australian Customs Service and the Department of Education, Training and Youth Affairs).

**Kava**

A drink or preparation obtained from the kava plant, *Piper methysticum*.

**Licit drug**

A drug whose production, sale or possession is not prohibited. ‘Legal drug’ is an alternative term.

**Methadone-maintenance treatment**

Methadone is a synthetic opioid. Methadone-maintenance treatment is the most widely used drug-substitution treatment for opioid dependence in Australia.

**Ministerial Council on Drug Strategy**

The peak policy- and decision-making body in relation to licit and illicit drugs in Australia, the Ministerial Council on Drug Strategy brings together Commonwealth, State and Territory Ministers responsible for health and law enforcement to collectively determine national policies and programs to reduce drug-related harm. The Ministerial Council ensures that the Australian approach to harmful drug use is nationally coordinated and integrated. Its collaborative approach is designed to achieve national consistency in policy principles, program development and service delivery.

**Narcotic drug**

‘Narcotic drug’ is usually used to refer to opioids. It is also a preferred term in United Nations conventions, where it may be used to refer more widely to other drugs.

**National Drug Action Plans**

The National Drug Strategic Framework will be accompanied by a series of National Drug Action Plans, which will identify priorities for redressing the harm arising from the use of licit and illicit drugs and other substances, strategies for taking action on these priorities, and performance indicators.

**National Drug Monitoring and Evaluation Strategy**

A comprehensive National Drug Monitoring and Evaluation Strategy will be developed to determine whether the objectives of the National Drug Strategic Framework have been met and priority areas acted upon and whether specific strategies identified in National Drug Action Plans have been effective. An annual monitoring report will be forwarded to the Ministerial Council on Drug Strategy.

**National Drug Research Strategy**

A mechanism for coordinating research priorities to ensure that the policy principles underlying the National Drug Strategy are based on the best available evidence and information. The National Drug Research Strategy, with the same status as the National Drug Action Plans, will be developed during 1998–99.

**National Drug Strategy**

The National Drug Strategy, formerly the National Campaign against Drug Abuse, was initiated in 1985, following a Special Premiers Conference. The Strategy provides a comprehensive, integrated approach to the harmful use of licit and illicit drugs and other substances. The aim is to achieve a balance between harm-reduction, demand-reduction and supply-reduction measures to reduce the harmful effects of drugs in Australian society. The Strategy promotes partnerships between health, law-enforcement and education agencies, drug users, people affected by drug-related harm, community-based organisations and industry, to reduce drug-related harm in Australia.

**National Drug Strategy Household Survey**

The National Drug Strategy Household Survey series has been the principal data-collection vehicle used to monitor trends and evaluate progress under the National Drug Strategy. The Surveys have been conducted nationally in 1985, 1988, 1991, 1993, 1995 and 1998 and provide data on behaviour, knowledge and attitudes relating to drug use among people aged 14 years and over.

**National Illicit Drug Strategy**

The National Illicit Drug Strategy, a Commonwealth government initiative, commenced implementation in 1998; it is a major component of the next phase of the National Drug Strategy. Funding for the National Illicit Drug Strategy is split between demand-reduction strategies, which are being implemented by the Department of Health and Aged Care and the Department of Education, Training and Youth Affairs, and supply-reduction strategies, which are being implemented by the Attorney-General's Department, the Australian Federal Police and the Australian Customs Service.

**National Drug Strategy Unit**

The National Drug Strategy Unit, within the Department of Health and Aged Care's Population Health Division, has primary carriage at the Commonwealth level of activities connected with the National Drug Strategic Framework. The Unit's activities and priorities are determined by the Ministerial Council on Drug Strategy and its advisory structures.

**National expert advisory committees**

The national expert advisory committees provide a range of advice to the Ministerial Council on Drug Strategy. Committee members are selected on the basis of their expertise in the areas of health, law enforcement, community-based organisations, education, research, government and industry. Committees are established for tobacco, alcohol, illicit drugs and school-based drug education. Additional committees may be established as other priorities are identified. The committees have tasks clearly defined in the National Drug Action Plans.

**Needle and syringe exchange programs**

Authorised programs for distributing, disposing of or selling needles and syringes.

**Non-medical use of drugs**

The use of pharmaceutical drugs either alone or with other drugs in order to induce or enhance a drug experience.

**Opioid**

The generic term applied to alkaloids and their derivatives obtained from the opium poppy (*Papaver somniferum*), including methadone, morphine, heroin and codeine.

**Overdose**

The use of a drug in an amount that causes acute adverse physical or mental effects. Overdose may produce transient or lasting effects and can sometimes be fatal.

**Partnership approach**

In the context of national public policy, a partnership approach for the National Drug Strategy is defined as a close working relationship between the Commonwealth, State and Territory, and local governments, affected communities (including drug users and those affected by drug-related harm), business and industry, community-based organisations, professional workers and research institutions.

**Performance- and image-enhancing drugs**

A range of drugs used to improve physical or mental capacity or to influence body shape.

**Pharmaceutical drugs**

Drugs available through a pharmacy: over-the-counter and prescription medicines.

**Polydrug use**

The use of more than one psychoactive drug, simultaneously or at different times. The term ‘polydrug user’ is often used to distinguish a person with a varied pattern of drug use from someone who uses one kind of drug exclusively.

**Population group**

‘Population group’ can refer to an entire population group, as defined by geographical location, or to sub-groups defined by geographical location, age, risk factor, or possession of a common condition or disease.

**Prevention**

Within the context of the National Drug Strategic Framework, prevention refers to preventing harmful drug use and preventing drug-related harm. Prevention includes preventing the uptake of illicit drugs.

**Psychoactive effects**

Effects that alter mental processes—mood, cognition, thinking or behaviour.

**Psychostimulant**

A drug that activates, enhances or increases neural activity. Caffeine, nicotine, amphetamines, cocaine and MDMA (ecstasy) are the psychostimulants most commonly used in Australia.

**Psychotropic substances**

In the context of international drug policy, ‘psychotropic substances’ refers to substances controlled by the *Convention on Psychotropic Substances 1971*.

**Relapse**

A return to drug use after a period of deliberate abstinence or controlled use.

**Safe sex; safe sexual practice**

Sexual activity that involves no exchange of body fluids such as semen, vaginal fluids or blood.

**Steroids**

A group of naturally occurring or synthetic hormones that may affect chemical processes in the body, rate of growth, and other physiological functions.

**Supply-reduction strategies**

Supply-reduction strategies are designed to disrupt the production and supply of illicit drugs. They may also be used to impose limits on access to and the availability of licit drugs—an example is legislation regulating the sale of alcohol and tobacco to people under the age of 18 years.

**Therapeutic community**

A structured residential environment in which people live while undergoing drug treatment.

**Tolerance**

Reduced effects following repeated drug use. Tolerance develops more quickly if use is frequent and heavy.

**Uptake**

The commencement of drug use.

**User groups**

Community-based organisations representing the interests of drug users.

**Withdrawal symptoms**

Symptoms that can occur when a person using a drug over a prolonged period reduces or ceases use.



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