



National Action Plan on Illicit Drugs

2001 to 2002-03



endorsed by the

Ministerial Council on Drug Strategy

July 2001

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Companion documents:

**Background Paper
Summary Fold-out**

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National Action Plan on Illicit Drugs

Purpose

This National Action Plan on Illicit Drugs, agreed by all jurisdictions through the Ministerial Council on Drug Strategy (MCDS), provides nationally agreed direction for addressing illicit drug issues until the year 2002-03. It is one of four action plans developed under the National Drug Strategic Framework 1998-99 to 2002-03. The other plans deal with tobacco, alcohol and school-based drug education. The action plans are to be reviewed and reported on annually. The plans limit themselves to actions that are within the sphere of the MCDS influence and Commonwealth, State and Territory policy.

Companion documents to the National Action Plan on Illicit Drugs are the detailed background paper that sets out relevant epidemiology and other supportive material, and a summary fold-out.

This Plan recognises that illicit drug use is a complex issue—there are no simple solutions. It acknowledges the need for a multifaceted, multilayered approach that calls on the resources of a range of players in all three levels of government, the non-government and community sectors, and illicit drug users, their families and friends. The Plan acknowledges the key role that can be played by families in preventing use and harm, and supporting young people who use drugs. It also acknowledges the importance of local government, which can play a key role in implementing local, State and national programs to ensure effective implementation relevant to local needs. Local governments are also uniquely placed to influence the management and use of public places, and to facilitate partnerships with local communities and businesses to increase public safety and the health and well-being of drug users.

Policing and other law enforcement agencies are primarily responsible for enforcing the laws that exist within state and national legislation. However, law enforcement recognises that efforts to deal with licit and illicit drug problems can be enhanced by balancing their legislative responsibilities with a more proactive approach. Working in close partnership with health and other key stakeholders, law enforcement organisations have integrated traditional policing strategies with a problem solving approach, to more effectively address drug-related harms.

As a document that sets a national direction, this Action Plan is not intended to be prescriptive or to define detailed, specific implementation strategies or timelines. Instead, it specifies priorities for preventing the uptake of illicit drug use and reducing harm associated with use. The Plan gives examples of actions to address each of these priorities, and lists performance measures that will be used to measure outcomes over its life. Jurisdictions will report annually against the Action Plan as part of the annual report to the MCDS under the National Drug Strategic Framework.

The Plan thus provides a nationally consistent focus for determining resourcing priorities under the National Drug Strategic Framework, and the flexibility to allow all levels of government and the non-government sector to pursue strategies appropriate to their circumstances.

Key strategy areas

Seven key strategy areas have been identified for this National Action Plan on Illicit Drugs.

The first four are content areas:

1. Demand reduction: promotion of opportunities, settings and values that promote resilience and reduce the uptake and use of drugs and the risks of drug use.
2. Supply reduction: interventions to reduce availability and supply.
3. Treatment.
4. Harm reduction.

The final three are critical areas of investment to sustain the strategies throughout the life of the Plan:

5. Workforce development.
6. Research.
7. Monitoring illicit drug trends: performance measurement.

Each of areas 1–6 has a set of objectives (what is to be achieved), a set of areas for action and a set of examples of actions to address the identified objectives set out in table form. Area 7 includes a set of performance measures, including baseline data, where available, to measure trends in illicit drug use and harm over time.

Introduction

The National Drug Strategic Framework 1998-99 to 2002-03 sets out broad principles, policies and priority areas for reducing the harm caused by drugs in the Australian community.* The Strategic Framework is based on a philosophy of harm minimisation that incorporates strategies on supply reduction, demand reduction and harm reduction. It seeks 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. A key target group for intervention is young people, who are seen as especially important because of the potential for change and their relative inexperience and higher risk of harm from drug use. This National Action Plan on Illicit Drugs offers guidance in setting priorities under the Framework. It reflects agreement by the Council of Australian Governments that the National Illicit Drug Strategy, launched by the Prime Minister in 1997, will be a major part of the next phase of Australia's National Drug Strategy (NDS). It also takes into account the priorities identified in related strategies or plans, including the National School Drug Education Strategy and the National Supply Reduction Strategy for Heroin and Other Illicit Drugs (currently being reviewed as the National Supply Reduction Strategy for Illicit Drugs).

Australia's approach to illicit drugs has been acknowledged internationally and has provided leadership in the region and globally. Nevertheless, illicit drug use and related problems remain significant community concerns.

Australia has to consider strategies that may not be relevant for large, densely populated cities with deep social divisions, or for geographically more compact countries. Australia's great distances and the isolation of rural and remote communities require tailored strategies. The Plan recognises the varied demographic and socio-economic context of Australian society. In recognition of the special challenges faced by Aboriginal and Torres Strait Islander peoples, a National Drug Strategic Plan for Aboriginal and Torres Strait Islander substance misuse is to be developed to complement all other National Action Plans spanning all substances, including inhalants and kava.

This complementary strategy will:

- specify priorities for reducing harm arising from the use of licit and illicit drugs in Aboriginal and Torres Strait Islander peoples;
- develop strategies for taking action on these priorities; and
- develop measurable performance indicators which are meaningful for Aboriginal and Torres Strait Islander peoples.

*Ministerial Council on Drug Strategy. *National Drug Strategic Framework 1998-99 to 2002-03*. Prepared for the Ministerial Council by a joint steering committee of the Intergovernmental Committee on Drugs and the Australian National Council on Drugs. Canberra: Commonwealth of Australia, 1998

A key feature of Australia's drug strategy has been to bring together government agencies across traditional boundaries. New evidence requires even broader thinking and existing partnerships to be extended into alliances with local government, business, industry, the community and families, who can harness the current level of community concern into action. This Plan sets out the evidence that problems with a common set of causes require integrated and coordinated responses. It also recognises that efforts which intervene early in every child's development to promote resilience and identify risk will be needed to prevent uptake of drug use. A wide range of Commonwealth, State, local and community programs must be involved to achieve the best long-term outcomes.

Given the complexities surrounding illicit drug issues and interventions, it is not surprising that several national plans and strategies have the potential to affect illicit drug use and harm. This National Action Plan on Illicit Drugs does not seek to duplicate these existing strategies but acknowledges their existence and seeks to facilitate cooperative action across sectors and issues. For example, this Plan acknowledges that polydrug use is now the norm among illicit drug users in Australia, and it is therefore essential that action under this National Action Plan links with related strategies such as the National Alcohol Strategy and activities under the Implementation Plan for the Quality Use of Benzodiazepines.

Other related strategies include those that seek to reduce the prevalence of blood-borne viruses, such as:

- the National HIV/AIDS Strategy 1999-2000 to 2003-2004: Changes and Challenges;
- the National Hepatitis C Strategy 1999-2000 to 2003-04;
- initiatives aimed at supporting families and communities, such as the Stronger Families and Communities Strategy;
- initiatives under the National Mental Health Strategy, including the National Suicide Prevention Strategy; and
- supply reduction strategies including the National Supply Reduction Strategy for Heroin and Other Illicit Drugs (currently being reviewed as the National Supply Reduction Strategy for Illicit Drugs).

In addition, initiatives that affect employment, education and other social capacity-building policies and programs will potentially have an impact on illicit drug use and harm.

Broader activities under the National Drug Strategic Framework will also complement and enhance drug-specific activities identified in this Action Plan. For example, the Intergovernmental Committee on Drugs has agreed to support the development and implementation of a comprehensive prevention agenda to inform future policy, strategy and practice. The development of a robust drug-prevention agenda that identifies the best mix of protective factors to minimise risk from drug supply, use and harm will inform the development of effective drug prevention policy and practice, and contribute to improving and maintaining good health for all Australians.

In addition to expanding links across strategies and sectors, there is a need to strengthen links among demand and supply reduction and treatment interventions, and to ensure that they are firmly founded on and responsive to the findings of research, monitoring and evaluation. In the final analysis, what happens in streets, suburbs and regions of Australia through linking government action to informed community responses to local issues will determine whether

efforts are sustainable and effective. Recent efforts in public place management at the local government level, with their emphasis on local partnerships in managing supply, demand and supporting harm reduction and treatment, are a welcome addition to the partnerships necessary to achieve sustainable change in the level and extent of drug-related harm.

Extent and nature of illicit drug-related harm in Australia

Several important general observations can be made about the nature, level and context of illicit drug use and related harms in Australia (the evidence that informs these observations is set out in the accompanying background paper):

- Only a small minority of Australian people use illicit drugs other than cannabis. However, there are substantial burdens of harm among those who do use, including overdose-related death, involvement in crime and the transmission of HIV/AIDS, Hepatitis C virus (HCV) and other blood-borne diseases.
- Initiation to drug use appears to be occurring at a younger age.
- More females are using drugs than ever and the gender gap in incidence and prevalence of use is closing.
- There are generational differences in the types and patterns of drug use.
- There is increased availability of a range of illicit drugs, with variations across jurisdictions.
- There is an expanded base of people using illicit drugs—a wider range of illicit drugs is being introduced and used in the Australian community. This is being fuelled by global trends and the ‘globalisation’ of all forms of trade, communication and travel.
- Multiple drug use (both licit and illicit) has become an established ‘norm’ among people who use illicit drugs.
- There is evidence of increased drug-related health and social harm, globally as in Australia, particularly (but not only) among young people. The most important is heroin-related overdose deaths.
- An increasing proportion of drug-related deaths are occurring among users at a younger age.
- Many of the drug-related harms that are arising have more to do with the manner and context in which drugs are being used rather than their properties.
- Younger people have less capacity to manage the patterns and consequences of drug use in a way that can reduce their risk of serious harm.
- There is widespread community concern in Australia about heroin and its adverse effects, but the basis of drug-related harm is much more far-reaching and complex than is commonly appreciated.

Evaluation and monitoring of illicit drug trends

Any Action Plan in this field requires long-term support and a long-term commitment to funding that is informed by a comprehensive monitoring and evaluation strategy. It also requires a well supported research agenda to describe the context of drugs in Australian society, and to understand the conditions that place people at risk of drug-related harm, those that build resilience, and those

that provide protection to individuals and the community in the face of hazardous drug use. Continuous monitoring will help build on the gains made in the past and improve on them in the future.

The elements of this plan have been agreed by all jurisdictions as the broad priorities for Australia from which they will choose local priorities and implement locally relevant strategies. It is proposed that jurisdictions report annually about implementation of the National Action Plan on Illicit Drugs as part of their report to the MCDS under the National Drug Strategic Framework. This report will include a summary of strategies that have been or are being implemented to address key strategy areas. Reporting against the set of agreed performance measures will also occur where annual data is available. The performance measures listed in this Action Plan are appropriate to the general management and monitoring of the National Drug Strategic Framework 1998-99 to 2002-03, and complement that document.

1 Demand reduction

Promotion of opportunities, settings and values that promote resilience and reduce the uptake and use of drugs and the risks of drug use

Reducing the demand for illicit drugs has long been seen as a way forward in reducing drug use and drug-related harm. A self-evident way to reduce drug-related harm is to prevent use and initiation to drug use. For example, the recently developed National School Drug Education Strategy has been developed to guide resource allocation in the school setting and the actions in this Plan are to be read as complementary to those in that Strategy. In addition, this Action Plan complements work undertaken to support the development and implementation of a comprehensive prevention agenda to inform future policy, strategy and practice, including those designed to reduce initiation into drug use.

Most recent literature points to the need for comprehensive demand-reduction strategies that:

- seek to strengthen resilience among young people in or out of school by fostering positive stable relationships with family or adults, especially in the early years, enhancing their sense of belonging to family or social group or locality, and increasing their educational and training opportunities and employment prospects;
- productively influence youth culture;
- seek to increase the community's understanding of the antecedents of drug use and effective interventions to reduce harm;
- link drug-specific interventions with interventions in related areas such as youth crime prevention and mental health promotion strategies, employment and educational strategies; and
- maximise the effectiveness of school-based programs through efforts to keep young people engaged in school as long as is appropriate, and the identification and provision of support for at-risk children, management of drug-related incidents, and a broad-based quality curriculum.

There is limited evidence to support traditional school drug education on its own as a lead strategy in reducing demand for drugs. It seems unrealistic to believe it could succeed in the absence of other supportive environments. Reviews of the literature on drug education conclude that there is no evidence that information-type drug education programs (whether 'scare' or 'balanced'), can delay or reduce initial use, and information-based educational approaches could be more effective if they were part of a comprehensive strategy. Other methods of including children in partnerships for intervention and information dissemination show more promise in the licit and illicit drug area and in the area of HIV prevention—particularly peer-led strategies.

School education authorities have made considerable progress in recent times. Those involved in school drug-education programs are making strong efforts to form community partnerships in recognition that schools cannot operate effectively in isolation from the community. There is a

growing body of research on the types of programs that work best and these findings are influencing the design and implementation of drug education in schools. The funding that has become available under the Commonwealth's National School Drug Education Strategy and the Council of Australian Governments (COAG)-agreed 'Tough on Drugs in Schools' measures has made a significant contribution to promoting and enhancing good practice in school drug education.

Evaluations of early efforts in the use of mass media public education campaigns suggest that the campaigns were ineffective, and in some cases counterproductive. However, the evaluations concluded that mass media education campaigns could play an important role if specific and realistic outcomes are identified, and if they follow certain best-practice principles. In particular:

- the agenda-setting role of mass media produces its most pervasive impact;
- media can stimulate learning and generate often dramatic changes in behaviour, where a level of pre-motivation exists;
- mass media bestow 'prestige' to a message, interpersonal communication bestows 'faith'; when the two are combined, the chances of action are increased; and
- community development and interpersonal contact are important components reinforcing, and being reinforced by, rigorously developed electronic media messages and supporting printed materials.

There is a growing body of knowledge about factors that either create risk or increase protection for children's well-being. This literature says there is a need to increase social cohesion and build capacity in communities to enhance the factors that protect the general health and well-being of all citizens, and decrease risk factors.

The finding that social exclusion can be a cause and an effect of ill health is highly relevant to actions in the illicit drugs area. If people are too ill to work or participate in everyday social life, and are isolated from mainstream opportunities by illness or disability, they become socially excluded. If they are not in society's mainstream, they are more likely to damage their health by smoking, or seek comfort in illegal drug taking, and so damage their health.

There is increasing evidence of the links between low socio-economic status and low social integration on the one hand, and illicit drug use, juvenile crime, suicide and mental illness on the other. Conditions strongly related to juvenile participation in crime include poverty, poor family adjustment and crowded dwellings. By itself, child neglect explains 57 per cent of the variation in juvenile participation in crime, 58 per cent of the variation in property crime and 49 per cent of the participation in violent crime. These factors are likely to increase vulnerability to illicit drug use among children and adolescents.

Those links mean that coming to grips with poverty, poor housing, access to educational opportunities, supportive environments for early parenting, and employment prospects all have a role to play in prevention and management of drug use and drug-related harm, as well as effective drug specific prevention and treatment strategies. In particular, there is promising evidence that family-based interventions have positive impacts on preventing the uptake of drugs among young people, the course of drug problems in the young and secondary prevention effects on the children of drug users.

Policies designed to reduce the level of economic stress or attenuate its effects, and early intervention programs designed to reduce the risk of child neglect, have an important role to play

in long-term crime prevention. They may also be important in reducing vulnerability and increasing resistance to unsanctioned and hazardous use of alcohol and tobacco and illicit drug use.

A wider model of preventive intervention broadens the focus from individual children and their families to the functioning of local community institutions, and to aspects of social organisation that affect the development of children. The general aim is a supportive, friendly and inclusive environment for children, young people and families that promotes healthy, pro-social development. It is therefore a key priority to seek not only to prevent drug use but also to delay the onset of drug use for as long as possible. There is clear evidence that people who begin to use drugs earlier are most likely to go on to experience harm.

This more recent evidence is not widely known in the community. It is therefore important to develop effective mass-communication vehicles to improve the level of understanding of the determinants of drug use and drug-related harm, in order to set an evidence-based agenda and to create a climate of supportive community opinion for a broad range of initiatives to build individual and community resilience.

In summary, the determinants of illicit drug use are multiple, interactive and complex. It follows that effective policies and strategies to prevent or reduce illicit drug use and to minimise personal, social and economic harm must match this complexity. During the life of this National Action Plan on Illicit Drugs, research, policy and practice will develop a better understanding of these factors and test promising new approaches to address this complexity.

Demand reduction: promotion of opportunities, settings and values that promote resilience and reduce the uptake and use of drugs and the risks of drug use*

Objectives: what is to be achieved	Key action areas	Examples of actions
<p>Prevent and/or delay the uptake of illicit drug use.</p> <p>Increase community understanding of drug-related harm, and increase community capacity to participate in informed debate about drugs and drug policy options.</p> <p>Promote accessible positive alternatives to drug use that are acceptable, attractive and meaningful to those most at risk of drug use, and those from socially, educationally and culturally diverse backgrounds.</p> <p>Foster a community supportive of the family and positive parenting.</p> <p>Promote school and community environments safe from drug use and related harm.</p>	<p>Programs targeting youth not in schools.</p> <p>Examination of all areas of government responsibility at local, State, Territory and national levels, to identify the potential for gaining maximum leverage from all areas of investment in social capacity.</p> <p>Engaging the community in education that allows for participation in informed debate and action.</p> <p>Community capacity-building/ community development strategies.</p> <p>Primary prevention programs for the children of drug users and young people at risk.</p> <p>Development of school-based policies to ensure environments are safe from potential drug harm.</p> <p>Dissemination of evidence-based, school-based drug-education policies, programs, curriculum and resources.</p> <p>Maintaining the visible presence of police in and around places where occasional and experimental use is likely.</p>	<p>Enhance retention in the educational process and engage students who are involved with illicit and unsanctioned drugs at school, including use of alternative educational settings.</p> <p>Provision and promotion of information about successful partnership approaches to dealing with drug-related harm in local settings.</p> <p>Briefings for government, community and industry leaders about the antecedents of illicit drug use and how their sector can contribute to the reduction of harm.</p> <p>Social marketing campaigns for agenda setting and dissemination of information.</p> <p>Provision of accurate and accessible information about drug use and drug-related harm to families and communities.</p> <p>School education authorities actively supporting school communities to implement comprehensive school drug education policies through up-to-date advice on the optimal use of available resources.</p> <p>Skills training and job creation opportunities for young people.</p> <p>Cooperative consultation with the media to improve the evidence base of reporting on drug issues, incidents and policies, and development of partnerships with youth-oriented media and sports administrators to promote positive role models for youth.</p> <p>Provision of support and resources for families and parents at risk—for example, accessible childcare, parenting support, and early intervention programs.</p> <p>Provision of supported accommodation and targeted health services for homeless and at-risk young people.</p>

* *Note to the table:* The determinants of illicit drug use are multiple, interactive and complex. It follows that effective policies and strategies to prevent or reduce illicit drug use and minimise personal, social and economic harm must match this complexity. The key strategy areas are not mutually exclusive, and actions and strategies listed in one area may affect other strategies. The plan is not intended to be prescriptive, and provides only examples of strategies, allowing flexibility for sectors to respond to community needs. As integrated action is needed to address illicit drug use, implementing most actions and strategies relies on partnerships across all levels of government, the non-government sector, and communities and families. In recognition of this, actions have not been designated to particular groups or agencies.

2 Supply reduction

Interventions to reduce availability and supply

Law enforcement and interdiction form strategic planks of the drug-control effort, based on a number of premises:

- They ensure public safety.
- They reduce the physical availability of illicit drugs.
- They reduce drug use through the deterrent effect of a perceived high risk of being caught and punished.
- They stem, suppress and disrupt the flow of trafficked drugs, sending a deterrent message to drug traffickers, and disrupting drug markets.
- They reduce demand by driving up the price of drugs.
- They reflect what is acceptable as a social norm, and send a message to the community about it.
- They punish those who offend against the law.
- They reduce the influence of organised criminal groups.
- They support treatment and harm reduction strategies at the local level.

As with demand reduction and treatment strategies, traditional law enforcement and interdiction strategies have limited success on their own. Efforts to interdict illicit drug supplies at the border will continue to be important, as will activities to disrupt illegal drug production, supply and distribution networks. A principal role of the police is to dissipate the influence of criminal groups. Law enforcement plays a key role in protecting the community while minimising drug-related harm for users. These goals are inter-linked, and community policing can play a central role in finding a balance between interventions aimed at minimising harm for the individual and protecting public health and safety.

The problems to be addressed by law enforcement are not confined to the importation and trafficking of drugs. Police deal on a day to day basis with the various crimes that are committed by individuals involved in the drug area, for example, robberies, violence, assaults, house breakings and fraud. The complexities of investigating drug-related crime extend from stealing and house breaking offences committed by users to support drug habits, through to the activities of organised crime.

Building on traditional policing responses and adopting a proactive problem solving approach ensures that law enforcement plays a crucial role in minimising the harms caused to the community by illicit drugs. An example of an enhanced role for law enforcement is demonstrated by the way policing organisations have reviewed many operating procedures to minimise the harms caused through illicit drug use. These modifications include: not attending overdoses unless called; supporting needle and syringe programs; providing expert input to community drug education; and participating at a national, state and local level in joint policy making.

Legal deterrence can work if the threat of punishment is communicated effectively, if the emphasis is on risks of apprehension rather than the severity of penalties, and if formal legal sanctions reinforce informal sanctions already operating in the community. The criminal justice system contributes to a reduction in crime not only by reactive policies of detection and punishment of offenders but also by preventive policing policies in partnership with community groups and other agencies.

Research has found that heroin users seeking methadone treatment in NSW cited the price of heroin and police activity as determining factors in their decision to seek treatment. Others expressed a wish to reduce involvement in crime and avoid more trouble with police and the courts. Those who had been stopped by police, arrested or imprisoned were more likely to want to enter treatment than those who had not. The severity of a penalty is a limited deterrent if there is perceived low risk of being intercepted and convicted. This Plan supports research into the relative cost-effectiveness of different interdiction strategies.

Diversion to treatment

In June 1999, Commonwealth, State and Territory health and law enforcement Ministers agreed on a national approach to developing the drug diversion initiative previously agreed by COAG. This will facilitate implementation of an approach that will result in:

- people being given early incentives to address their drug use problem, in many cases before incurring a criminal record;
- an increase in the number of illicit drug users diverted into drug education, assessment and treatment; and
- a reduction in the number of people appearing before the courts for use or possession of small quantities of illicit drugs.

Diversion aims to prevent new offenders from entering the criminal justice system and to divert offenders with drug problems into appropriate treatment. It involves a graduated series of interventions appropriate to the seriousness of the offence and the circumstances of the offender. Diversion is not appropriate for trafficking offences. Links between the justice and treatment systems can occur at many points.

Drug-involved offenders can be cautioned on the streets and provided with treatment referral information if their offence is possession of a small quantity of drugs. They can be sent for assessment or directly to treatment rather than prison, as long as the offence is not serious and they do not pose a threat to society. Courts and correctional systems can also use commitment or referral to community-based treatment as an adjunct to probation or conditional release (parole) from prison. There is also treatment within correctional facilities and corrections-operated or funded therapeutic communities and halfway houses. In summary, diversion can occur in the following circumstances:

- pre-arrest: when an offence is first detected, before a charge is laid;
- post-arrest: when a charge is laid but before the matter is heard in court, including release on bail;
- pre-sentence: on a finding of guilt but before sentencing;

- post-sentence: as part of sentencing; and
- pre-release: before release from detention, including on parole.

A key priority for the future will be how to balance investment in diversionary treatment services and enhance voluntary treatment. There is some indication that diverting people who are not ready to attempt change to treatment may dilute the effectiveness of existing services by increasing the numbers of 'failed' treatments. Educating the community about the importance of these strategies and seeking support for law enforcement through adoption of new policing practices will be an important focus of effort. It will also be important for all stakeholders to have a realistic view of the impact of diversion strategies for severely drug-dependent people. Drug dependence is a chronic relapsing disorder and once established often requires people to cycle through treatment several times over a number of years.

More law enforcement resources will be also targeted to disrupting the activities of organised crime groups, regardless of commodity. The same organisational networks involved in drug trafficking engage in other forms of illegal activity. Interventions that lower several forms of crime are more likely to be cost-effective. In defining harm, law enforcement gives consideration to the quantity and type of substance, the criminal behaviour surrounding the drug trafficking, the impact on end users, community and judicial attitudes, and the financial impact on the community and the government.

Supply reduction: interventions to reduce availability and supply*		
Objectives: what is to be achieved	Key action areas	Examples of actions
<p>Stabilise and ultimately reduce street-level dealing in drugs.</p> <p>Effectively disrupt illicit drug production, supply and distribution networks at local, national, and international levels.</p>	<p>Effective control and reduction in the quantity of domestic drug cultivation and manufacture.</p> <p>Disruption and reduction of illicit drug movements within and across State and Territory borders.</p> <p>Interventions in source and transit countries.</p> <p>More-effective interdiction at the international border.</p> <p>Review laws with a view to enhancing the ability of police to effectively disrupt syndicates involved in the production, supply and distribution of illicit drugs at local, national and international levels.</p> <p>Recover the proceeds of criminal activity and redirect to the funding of government programs.</p> <p>Target investigation of those involved in illicit drug trafficking whose activities inflict greatest harm on the community.</p> <p>Provision of assistance to source and transit countries in supply reduction efforts, policy and program development, when requested.</p>	<p>Support for Australia's active involvement with law enforcement authorities in source and transit countries.</p> <p>If requested, assistance for source and transit countries in institutional strengthening and capacity building to address drug-related harm.</p> <p>An enhanced leadership role in international drug issues as a component of Australian foreign policy.</p> <p>A national commitment to joint operations and enhanced intelligence sharing.</p> <p>Active participation by law enforcement agencies in partnerships with the community and other sectors of government involved in harm reduction.</p> <p>Application of technology across all areas of drug law enforcement.</p> <p>Identified best-practice methodologies for use by law enforcement agency investigators.</p> <p>A national offence for transporting illicit drugs and precursor chemicals across State/Territory boundaries, with practical powers of search and seizure.</p> <p>Comprehensive confiscation-of-assets legislation.</p> <p>Trial and evaluate strategies to target organised criminal groups, regardless of commodity, for their impact on drug availability and harm.</p> <p>Concentration of law enforcement efforts on production and distribution networks.</p> <p>Disruption of the illicit drug market at all levels.</p>

** Note to the table:* The determinants of illicit drug use are multiple, interactive and complex. It follows that effective policies and strategies to prevent or reduce illicit drug use and minimise personal, social and economic harm must match this complexity. The key strategy areas are not mutually exclusive, and actions and strategies listed in one area may affect other strategies. The plan is not intended to be prescriptive, and provides only examples of strategies, allowing flexibility for sectors to respond to community needs. As integrated action is needed to address illicit drug use, implementing most actions and strategies relies on partnerships across all levels of government, the non-government sector, and communities and families. In recognition of this, actions have not been designated to particular groups or agencies.

3 Treatment

The goals and outcomes of drug treatment

Treatment is central to any policy mix of responses to drug problems. It can offer a pathway out of drug dependence, prevent, reduce or mitigate ill-health and other harms associated with use, reduce demand, and have flow-on effects on the health and well-being of users' families, others in the community with drug problems, and the next generation, through improved parenting of recovering and recovered drug dependent people. The Australian treatment system has a mix of effective and ineffective services for drug-dependent clients. There is a need to move the treatment system towards the provision of accessible, affordable, locally relevant and carefully planned options. The available evidence supports an integrated system across in- and out-patient services, with an emphasis on community-based services and continuity of care. Drug services also need to be integrated with the full range of practical support services for homeless and unemployed drug-dependent people and their children.

Drug treatment covers a variety of approaches: different populations have different drug problems, needs, preferences, social supports and capacities to respond. Response to treatment is not all or nothing—complete success or total failure—but degrees of improvement. The public often misunderstands this reality, and may think treatment has failed if it does not produce complete and permanent cessation of drug use. Perfect outcomes are not always possible or expected in mainstream health services and social interventions, and drug treatment is no different. By present estimates, only 30 per cent of all illicit opioid users are in treatment. Many more would enter treatment if it were more attractive and accessible. Managed drug withdrawal, residential and opioid substitution programs often have long waiting lists, and in many rural and regional centres there are few if any drug treatment services.

Cost-effectiveness of drug treatment

People with drug problems should be encouraged at every opportunity to enter drug treatment, given the benefits that can accrue for them as individuals and for the community. Drug treatment is cost-effective (some forms of treatment are more cost-effective than others) when evaluated by a range of criteria including outcomes in health, social well-being, economic prosperity and incidence of crime. Every effort must be made to ensure that treatment is attractive, accessible and affordable to all who can benefit from it. At present, demand for treatment is outstripping the availability and capacity of services to respond effectively and appropriately. There is therefore a need for more services for which evidence of effectiveness exists. More attention is needed to assertive follow-up of people lost to treatment, and to supporting development and operation of mutual self-aid or self-help organisations and services.

Methadone maintenance treatment receives mixed responses in the Australian community despite the substantial weight of scientific evidence for its effectiveness in reducing drug use, improving health and social adjustment, reducing drug injection and transmission of HIV/AIDS, HCV and other blood-borne diseases, reducing premature death from overdose and other causes, and

reducing crime. Improving access will require strategies to inform the community and train health care personnel.

Though there is strong evidence to support the efficacy of methadone maintenance as a treatment for opioid dependence, the range of treatment options needs to be increased. For instance, the current emphasis on trialling an expanded range of pharmacotherapies for treatment of opioid dependency shows great promise in increasing the number of people who enter and remain in treatment (retention is a key predictor of treatment outcome). Trialling of alternative pharmacotherapies such as buprenorphine, LAAM and naltrexone offers a useful model for introduction of new therapies based on evidence. All pharmacotherapies for heroin, amphetamine and other drug dependencies need to be trialled and people carefully monitored before decisions to support widespread use. Greater attention needs to be paid to developing and adopting effective treatment options for the full range of illicit drugs.

Some sub-populations are at high risk because of the settings where they use drugs, their culture or the particular drugs they use. Others experience higher rates of uptake of drug use, limited or no access to protective factors and high personal vulnerability. Examples include prisoners, young people (particularly young females), Aboriginal and Torres Strait Islander peoples, and people from linguistically and culturally diverse backgrounds.

A relatively new area of attention in treatment is on the effectiveness of programs for drug-using prisoners that help them in the transition from prison to the community and seek to prevent relapse and overdose on release. Studies from the UK demonstrate that 'transition' and post-release programs have significant impact on post-release drug use and functioning. The studies report significant decreases in post-release drug use, the amount spent on drugs, and corresponding falls in the level of offending to finance drug use. Significantly, it was noted that unless treatment was maintained in the community, offenders were likely to relapse and return to crime and prison.

Treatment strategies with prisoners will also play a key role in decreasing overdose deaths and in increasing the effectiveness of investments in HIV and hepatitis C prevention efforts in prison and with prisoners.

Coexistence of significant mental health problems with drug dependence

Mental health problems are over-represented among people with illicit drug problems. Depression is by far the most commonly and consistently reported example of elevated mental health problems among opioid users: up to half the patients in opioid replacement therapy may have suffered a major depressive episode at some time in their lives. There is a need for increased access to timely treatment for people with mental health problems and drug dependence.

Treatment*		
Objectives: what is to be achieved	Key action areas	Examples of actions
<p>Increase capacity to provide the full range of evidence-based treatment options for illicit drug users.</p> <p>Increase capacity to provide support to the families of drug users and to include them in treatment where appropriate.</p> <p>Provide an integrated treatment system able to provide continuity of care across relapse episodes, and across the criminal justice and the health sectors.</p> <p>Maintain an illicit-drug treatment system with strong links to mainstream health and welfare systems.</p> <p>Increase capacity in the treatment system to undertake systematic needs analysis, including the capacity to respond to emerging drug problems and institute new services.</p> <p>Provide a comprehensive, relevant treatment system that is culturally appropriate and integrated with other services (including mental health), and attracts and retains drug users early in the course of harmful use.</p>	<p>Access to appropriate and timely treatment for people with mental health problems and drug dependence.</p> <p>Development and trialling of effective models of services for involving and supporting families of drug users seeking or in treatment.</p> <p>Development and trialling of effective models of care for people with cannabis problems, opiate dependence, psycho-stimulant use and polydrug use problems.</p> <p>Access to culturally appropriate and acceptable services for people from culturally and linguistically diverse groups.</p> <p>Access to evidence-based diversion programs.</p> <p>Drug treatment services in the criminal and juvenile justice systems including post-release services.</p> <p>Mechanisms to increase access to treatment in rural areas and under-served groups in the community.</p> <p>Initiatives to build capacity to intervene early in illicit drug use careers and to provide comprehensive primary care to established users through mainstream health-care providers.</p> <p>Identification and implementation of appropriate responses to drug use in pregnancy.</p> <p>Access to transition and post-release programs for prisoners.</p>	<p>Maintain support for proven opioid treatments, including detoxification, inpatient, outpatient and pharmacotherapy treatment.</p> <p>Increased attractive and accessible treatment options, including appropriate after-care and relapse prevention, and the expansion of diversion programs.</p> <p>Promoting the use of diversion with the police and judiciary, and ensuring they are well briefed on the nature of drug dependence and the extent of treatment options.</p> <p>Trials of innovative methods to treat: opiate dependence, including pharmacotherapies; people with cannabis problems; people who use psycho-stimulants, including pharmacotherapies; and people with complex problems of polydrug use.</p> <p>Development of best-practice guidelines for established and emerging treatment modalities.</p> <p>Expanded treatment programs in correctional systems, including transition and post-release programs.</p> <p>Development of capacity among primary health care practitioners in high-use areas and their training and support bodies to develop and deliver effective primary care for users at all stages of their drug-using careers.</p> <p>Policies, procedures and training to build capacity in the drug treatment and mental health systems to support users with comorbid mental health and drug-use problems.</p> <p>Implementation of a treatment outcome study to assess treatment effectiveness for the range of target groups in representative locations and settings in Australia.</p> <p>Dissemination of the results of research on the efficacy of treatment to funders, purchasers, providers and clients of services.</p> <p>Education and support for the community to understand what can be expected of treatment and the range of available treatment options.</p> <p>Ensure consumer participation at policy, planning, resource allocation, implementation, quality assurance and evaluation levels.</p> <p>Implement quality assurance and accreditation mechanisms for all parts of the treatment system.</p> <p>Develop guidelines for general practitioners, midwives, obstetricians and others involved in the care of pregnant drug-dependent women.</p> <p>Development and implementation of policies and practices to build capacity in the treatment system to provide appropriate services to people from culturally and linguistically diverse backgrounds.</p> <p>Promotion of family sensitive practice by treatment providers.</p>

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4 Reducing drug-related harms

The philosophy of harm minimisation has been the cornerstone of Australia's National Drug Strategy since its inception in 1985. This philosophy includes the strategies of supply, demand and harm reduction. The mission of the NDS is to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society. Australia has received international recognition for the leading-edge policies, programs and services it has developed to prevent or minimise drug-related harm.

This policy has been especially important in the illicit drugs area, where priority has been given to pragmatic measures that can prevent or minimise transmission of HIV/AIDS and other blood-borne diseases. Because of these measures, Australia has avoided an HIV epidemic and all the public health, social and economic harms that accompany such epidemics.

Efforts to reduce the harms caused by illicit drugs include strategies promoting abstinence from drug use. However, these efforts also aim to protect individuals who continue to use drugs despite all efforts to help them stop. It also tries to protect the community in which they live. Drug use has many social, health and economic impacts. The chief areas of drug-related harm addressed by this national drug strategy are:

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

Drug-related harm may arise in a number of ways:

- direct harms (those arising in the user as a consequence of the actions of the drug on the body—drug overdose or neurotoxicity, for example);
- indirect harms (harms that occur to others as a consequence of the use of a drug—for example, loss of property through crime, or being run over by an intoxicated driver, decreased community amenity due to fear of violence);
- intrinsic harms (attributable to the toxic effects of the drug); and
- extrinsic harms (attributable to the circumstances of use of the drug but not inherent in the properties of the drug itself—for example, HIV infection from the use of contaminated injection equipment, higher property crime rates, corruption and organised crime). One of the challenges lies in predicting the full range of benefits and harms that might arise from policy options.

Australia's harm-reduction strategies address licit and illicit drugs. They include preventing expected harm as well as reducing actual harm, and seek to improve health, social and economic outcomes for the community and the individual. They encompass a wide range of approaches, including abstinence strategies, and take account of 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. A great deal of the effort invested in reducing drug use and preventing HIV, HCV, and other blood-borne diseases is aimed at the level of individual behavioural choice, and pays insufficient attention to the broader environmental or systemic determinants of behaviour.

Among the important harm-reduction strategies are all forms of treatment from abstinence-oriented treatment to opioid substitution programs such as methadone maintenance treatment, programs that provide access to sterile injection equipment and condoms, outreach and peer education programs that inform people how they may reduce health risks when using drugs, and confidential and voluntary HIV and HCV testing with high quality pre- and post-test counselling, care and support. Harm-reduction approaches have been found effective in encouraging drug users into treatment.

Improving community amenity

Community members in some areas (residents, service users, traders) are increasingly confronted with public drug use. In some locations this includes public drug dealing, use and inappropriate disposal of injecting equipment, theft, witnessing intoxication and overdose. In areas of high exposure, this contributes to increasing fear of using public spaces, and has a negative effect on property values and the economic viability of the area. Retreat of people to their homes and curtailing children's outside activities by fearful parents can lead to other undesirable health and social outcomes.

Feelings of risk and powerlessness in local communities can build a destructive cycle from one generation to the next. There is evidence that where social policies and programs support concerted efforts by residents, service providers, traders, local government and law enforcement agencies, constructive partnerships can be built to maintain community amenity while supporting drug-dependent people in risk reduction. Destructive cycles of threat, withdrawal, fear or anger can be transformed into virtuous cycles that build resilience and protective environments and decrease risk for users and the community.

Reducing drug-related overdose deaths

Reducing drug-overdose mortality is a major goal of this Action Plan. This issue is addressed in detail in the National Heroin Overdose Strategy, which has been developed under the auspices of the Ministerial Council on Drug Strategy. Important measures to prevent opioid overdose deaths include:

- increasing access to evidence-based treatment such as methadone maintenance, given that research has consistently shown that the risk of overdose death is substantially reduced among individuals enrolled in treatment;
- interventions that increase awareness among injecting drug users about the increased risk of opioid overdose when heroin is used in combination or proximity in time with other central nervous system depressant drugs, particularly benzodiazepines and alcohol;

- peer education that increases awareness of the risks of polydrug use and overdose when resuming drug use after periods of abstinence, for example, among those leaving a drug-free treatment program or among soon-to-be-released prisoners;
- discouraging injecting drug users from injecting alone, which decreases the chances of resuscitation if an overdose occurs;
- appropriate law enforcement policies on drug-overdose incidents;
- encouraging those who witness an opioid overdose to seek urgent medical assistance for the victim and improving users' knowledge and skills to assist their peers when they overdose;
- training drug users in cardio-pulmonary resuscitation; and
- designing and managing public spaces so that people are less likely to overdose in isolated places.

Community partnerships

To be far reaching and effective, the actions in this Plan need a multitude of partnerships throughout the community, including local government, the police, health professionals such as doctors and pharmacists, and a wide range of others. Local government is a key partner in successful action in light of its responsibility for the design, management and maintenance of public areas, its influence on the use of private space and design through town planning controls, and its capacity to maximise the local impact of State, Territory and national programs in drug education. Local government has a key role in reducing the inappropriate disposal of needles and syringes and managing contested public space created by the pressures of urban renewal.

In partnership with local communities, police can have a significant role in reducing specific drug-related harms such as overdose, and in increasing community amenity and perception of public safety. This Action Plan suggests steps to support police officers in closing the gaps between community expectations and policing practices to reduce drug-related harm. It supports a harmonised approach to active street-level policing in preventing drug-related harms, and information to communities about the most effective methods police and health-care workers can adopt in reducing harms such as overdose deaths.

Local pharmacists also play an increasing role in demand reduction through community education, and in harm reduction by advice to drug users and provision of needles and syringes. They have long been a key part of Australia's drug treatment system through dispensing methadone. The location of pharmacies widely throughout the community also assists public amenity, and decreases concentrations of drug users around large clinics in a few locations.

Prisons

The prison environment can contribute to drug-related overdose and spread of blood-borne diseases. In light of high identified rates of drug use and injection, lack of access to sterile injection equipment, and the rapid throughput of people in Australian prisons, there is an urgent need to build on current initiatives such as:

- the randomised controlled trial of the NSW prison methadone program;
- the South Australian prison methadone program;

- plans to introduce prison methadone maintenance programs in two other Australian States;
- the trial of a graduated penalty program for possession of illicit drugs in South Australian prisons; and
- the bleach and condom programs as evaluated in NSW prisons.

Reducing drug-related harms*		
Objectives: what is to be achieved	Key action areas	Examples of actions
<p>Reduce the harm for individuals who use drugs, their families, and the community, in particular:</p> <ul style="list-style-type: none"> – decreased drug-related overdose deaths, illnesses and injuries; – a decrease in the spread of infectious diseases through injecting drug use (IDU) and unsafe sexual practices as a result of intoxication; – decreased suicides and attempted suicides associated with illicit drug use; and – a decrease in the incidence of drug-related crime. <p>Improve community amenity in areas of high public drug use, drug-related crime and disruption.</p> <p>Give law enforcement an increased capacity to contribute to the reduction of harm caused by illicit drugs.</p>	<p>Management of injecting equipment distribution and disposal.</p> <p>Education and information for users to assist them in reducing drug-related harm.</p> <p>Identification and removal of legislative barriers to effective harm-reduction strategies.</p> <p>Guidelines for police use of discretion in the interests of harm reduction.</p> <p>Consumer groups to advise on how to successfully engage drug users in interventions.</p> <p>Active engagement of consumer groups in planning for improved community amenity in locations of high drug use.</p> <p>Mechanisms to minimise the negative impact of drug use on the community.</p> <p>Support for National HIV and Hepatitis C strategies.</p> <p>Support for the National Heroin Overdose Strategy.</p> <p>Development of links and partnerships with other strategies such as the National Suicide Prevention, National Mental Health and Crime Prevention strategies.</p>	<p>Appropriately supported and adequately resourced needle and syringe programs.</p> <p>Development of methods to encourage safe disposal of used injecting equipment</p> <p>Needle and syringe clean-up services.</p> <p>Modifying the structure of existing offences of self-administration and paraphernalia offences with a view to minimising harm.</p> <p>Diversion alternatives for simple cannabis possession offences.</p> <p>Further development of alternatives to court appearances for first time and minor offenders (cautioning and diversion).</p> <p>Trials of a range of treatment methodologies that may increase attractiveness of and retention in treatment. This may include trials of pharmacotherapies.</p> <p>Accords between law enforcement, health and welfare services, and other sectors at the local level.</p> <p>Place-management strategies to improve community safety and amenity.</p> <p>Support and encourage policing strategies that focus drug law enforcement on reducing harm caused by illicit drug use, particularly at the local level, by encouraging people to enter treatment.</p> <p>Implement peer-education strategies about safer practices, and about the reduction of disruptive or illegal behaviour around treatment and needle and syringe programs (NSP) facilities for IDUs.</p> <p>Implement policies and programs that support police, ambulance, youth workers, families, users and community members in management of suspected overdose.</p> <p>Implement harm-reduction programs in prisons and post-release programs.</p> <p>An approach to drug users that facilitates diversion from the criminal justice system to treatment and rehabilitation.</p> <p>Investigation of opportunities for joint projects and initiatives between key suicide prevention programs and illicit drug prevention and treatment services and programs.</p> <p>Wide dissemination of information to opioid users and their family and friends on the signs and symptoms of overdose and actions to take if an overdose occurs.</p> <p>Develop, implement and evaluate intervention strategies and follow-up support programs for people who overdose.</p> <p>Encourage all stakeholders to undertake training in basic first aid that would assist in an overdose situation.</p>

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5 Workforce development

Drug problems are manifest in a variety of human-service settings, including health, law enforcement agencies, community and welfare services, corrections, local government and the education system. Strengthening existing partnerships and building new partnerships to reduce drug-related harm will require a shared understanding of drug issues and effective responses. Increasing access to a greater range of high-quality prevention and treatment services requires expanding the number of available skilled staff. Staff who can contribute to the reduction of drug-related harm are employed by all levels of government including local government, in a range of areas such as sport and recreation and occupational health and safety and are from the full range of health-related disciplines, allied health, nursing and medicine.

Staff in the various sectors need to be equipped to respond effectively to drug-related harm. Effective interventions will include strategies to prevent and respond to drug-related harm in the relevant setting and strategies to refer to drug specialist services when indicated. Facilitating responses in these domains has been demonstrated to reduce drug-related harm and increase the overall efficiency of these services (eg reducing police workload, reducing recidivism rates in corrective services and reducing hospital readmission rates).

As well as improving general human services, there is a need to enhance the capacity of the drug specialist workforce. It is important to have drug specialist staff who are able to support general health, welfare, police and education staff, develop and trial new interventions, and manage and/or share the care of complex cases.

Effective interventions in prevention and treatment require staff who have role legitimacy (the perception that responding to harm is a legitimate component of the individual's role) and the relevant skills, values, and confidence to intervene in drug-related harm. Workforce development needs to address these issues. In recent years, it has become clear that the demand for a specialised drug and alcohol workforce has outstripped supply in some places. Workforce development will be a focus of effort in strategies to recruit and retain expert workers.

Education and training can contribute to the knowledge, skills, values and confidence required for an effective workforce. To address the various needs of different target groups, and to be consistent with general workforce development, education and training will have to be delivered at several levels, including pre-service education, post-basic training, and in-service programs.

There is a need to ensure a variety of modes of delivery of education and training. For example, people who work in rural locations may require more-flexible methods of delivery. Different learning pathways may be required for different professional groups or people with different learning styles. Advances in information technology need to be incorporated into more-flexible modes of education and training delivery. A need for improved program design has also been identified, incorporating clear learning objectives, links to standards and evidence-based practice, and clear assessment protocols.

As in other areas of the strategy, it is important to address priority target groups. There is a need to enhance access to workforce development for specific target groups—for example, those responding to populations in rural and remote areas and to Aboriginal and Torres Strait Islander peoples.

To ensure the development and delivery of quality education and training, there is a need to ensure availability of professionals who can provide this service. This will include educators who can translate research into practical strategies for the broad range of professionals who respond to drug-related harms (including community staff, police, health staff and education staff). They will also need to be able to address the relevant knowledge, skills and values that can affect the quality and nature of responses to drug harms.

Role legitimacy can be enhanced through education and training, but will require organisational and structural supports. These include policies, guidelines and management support and supervision that value and legitimise a role and skills in responding to drug-related problems. Thus, workforce development includes addressing structural factors at organisational and discipline levels. Staff who work in an environment that does not legitimise or value strategies for reducing the harm caused by illicit drug use are unlikely to maintain involvement.

Education and training must be sustained through the development of tailored policies, protocols, post-training support, supervision, practice and career support (eg pathways, incentives). Management tools such as staff contracts, performance indicators and monitoring tools can facilitate the implementation of newly learned skills.

To achieve a workforce that can effectively prevent and respond to drug-related harm, a number of steps are needed, including:

- translation of research findings into practical strategies that can be implemented by the workforce;
- strategies to encourage the adoption of evidence-based practice among the workforce;
- identification, development and dissemination of standards of practice and/or competencies consistent with efforts to reduce the harm caused by illicit drug use for a range of groups including health, law enforcement, drug specialist staff, welfare and education staff;
- identification and evaluation of models of practice change that can readily be applied in workplace settings;
- development and implementation of quality education and training programs and resources (for example, through train-the-trainer approaches and consultancy support);
- identification and implementation of strategies to support staff and management in the application of strategies to reduce the harm caused by illicit drug use; and
- development of expertise to foster and disseminate models of practice change and education and training programs.

Workforce development*		
Objectives: what is to be achieved	Key action areas	Examples of actions
<p>Further develop the capacity to attract and retain an effective workforce in health, welfare, education, and law enforcement sectors:</p> <ul style="list-style-type: none"> –a generalist health and welfare workforce with increased capacity to identify drug problems and related harm and apply evidence-based interventions; –a health, education, and law enforcement workforce educated in the principles that support the reduction of harm caused by illicit drug use; –highly skilled law enforcement investigators who can be deployed flexibly; and –a skilled and supported health promotion workforce familiar with evidence-based health promotion and the antecedents of drug use. <p>Increase capacity to attract and retain a highly skilled and specialist drug and alcohol workforce in the wider health system.</p>	<p>Identify the skills, attitudes and knowledge required in various workforces (police, nursing, medicine, allied health, corrections, welfare, local government) to address drug-related harm and develop pre-service, in-service and post-service training and workforce development strategies that address these requirements.</p> <p>Develop and disseminate quality workforce development programs and resources through train-the-trainer and consultancy support methodologies.</p> <p>Develop programs to achieve an appropriate level of skilled and credible workforce developers nationally.</p> <p>Identify, trial and implement models of practice change.</p> <p>Establish and maintain a presence for drug and alcohol curricula in mainstream health, welfare, education, law enforcement and corrections workforce development programs.</p> <p>Increased capacity in all parts of the workforce to access, critically evaluate and use research findings.</p> <p>Increased organisational endorsement for health, police, education, welfare, corrections and local government workers to engage in the full range of responses to drug use.</p>	<p>Development of a national treatment workforce development strategy that: investigates agreed mechanisms for accrediting training providers; provides mutual recognition of qualifications across jurisdictions; articulates drug and alcohol courses with mainstream health and/or welfare education and training; and recommends remuneration and career path opportunities.</p> <p>Training for health, education, welfare and corrections personnel in drug law enforcement strategies and potential partnerships across sectors.</p> <p>A module on reducing the harm caused by illicit drug use for use in drug law enforcement recruitment and health and welfare curricula.</p> <p>Initiatives to enhance the supply of teachers and youth and other workers who are skilled in evidence-based health promotion and community capacity building in school and out-of-school settings.</p> <p>Encouraging establishment of PhD and other higher degree scholarship schemes to promote high-quality research and build Australia's research and evaluation workforce.</p> <p>Establishing and encouraging joint training programs for law enforcement agency investigators, and secondments between jurisdictions and agencies.</p> <p>Training for police on the nature and extent of drug treatment options and the evidence of their effectiveness.</p> <p>Research to explore the barriers and incentives to professional involvement in the treatment, prevention and minimisation of drug-related harm.</p>

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6 Research

There are concerns that Australia's expenditure on illicit-drug research is small compared with its investments in treatment, prevention and law enforcement, and disproportionately small compared with research investments in other health-related areas. However, measured by the rate of publication in the journal *Addiction*, and by involvement of Australian researchers in WHO committees on illicit drug epidemiology, treatment and policy, its output is higher than its small population and modest investment would predict. Concerns remain, however, about the level of investment in research on primary prevention.

Australian research has paid much attention to practical matters that can inform interventions to reduce drug-related harm – for example:

- the role of injecting drug use in transmission of infectious diseases;
- the epidemiology of injecting drug use, and illicit drug use more generally;
- epidemiological analyses of mortality and morbidity attributable to illicit drug use;
- evaluation of the effectiveness of different models of delivery of methadone maintenance treatment; and
- comparisons with alternative pharmacotherapies.

Australia has no agreed intersectoral research agenda in illicit drugs. There is little research that describes the place of drugs in Australian society, or helps us to understand conditions that place people at risk of harm and those that build resilience. More knowledge is needed about how best to provide health protection to individuals and the community in a range of contexts where hazardous drug use commonly occurs.

The Action Plan notes the work of the National Health and Medical Research Council on research priorities for the health sector, but recognises that Australia has not yet developed an interdisciplinary and intersectoral research agenda on illicit drug use. Research has benefits above and beyond the generation of knowledge. There are good reasons for fostering research into the political and administrative benefits of illicit drug strategies, health-sector benefits, cost reduction, quality improvement, greater equity and improved capacity of interventions to contribute to social goals of decreased crime and improved quality of life.

Most pressing are the social, cultural and geographic distinctions that can be understood only through local research. Potentially important qualitative and quantitative indicators could be collected locally and used to direct local efforts in supply reduction, demand reduction and harm minimisation. Greater attention also needs to be paid to understanding how the broader social, cultural, economic, commercial and policy environments influence individual vulnerability to illicit drug-related problems. These include criminal behaviour, illicit drug use, factors that build resilience, how to identify critical points in a person's development that may increase their vulnerability, and interventions delivered to promote more-favourable outcomes.

Research expertise in the drug and alcohol field is concentrated in too few places, geographically and institutionally. A research workforce development strategy is needed to improve training in

research methodology with special application to the drug and alcohol field, at undergraduate, postgraduate and in-service levels. It is important to strike a balance between locally identified research priorities and commissioned research founded on national priorities that fills identified research gaps.

An important challenge for researchers working in the alcohol and other drugs area is to find ways of disseminating and implementing the findings of research to all relevant personnel including policy decision-makers, planners and clinicians, and in a timely manner. This will require information systems for wide dissemination of information, and mechanisms to advise decision-makers about the findings of research and their implications for practical application.

Increasingly, governments and other funding institutions are placing importance on health services being evidence-based in style and content. Clinical services in the illicit drug area should also be expected to comply with this standard. This will require the systematic review of current research evidence and commissioning of further investigations in areas with insufficient evidence of effectiveness.

Research*		
Objectives: what is to be achieved	Key action areas	Examples of actions
<p>Increase evidence-based practice in health, education, welfare and law-enforcement.</p> <p>Increase instances of integrated and collaborative illicit drug research and development among health, law enforcement, education, welfare, corrections and juvenile justice sectors.</p> <p>Sharper focus on research priorities.</p> <p>Increase participation in international law enforcement and health research projects.</p> <p>Maintain and enhance support for policies, programs and interventions that use the best available research evidence.</p>	<p>Establish mechanisms for intersectoral development of an agreed research agenda and priorities.</p> <p>Research workforce development.</p> <p>Mechanisms for cooperative development of interdisciplinary and cross-jurisdictional research projects.</p> <p>Identification of effective methods to promote community cooperation in intelligence gathering.</p> <p>Research and development in technologies for surveillance, and analysis and signature programs.</p> <p>Improved dissemination and use of research results in the drug and alcohol profession and general community.</p> <p>Develop local data to assist with primary prevention, and reduction of supply, demand and harm.</p>	<p>Determining a systematic process for identifying illicit drug research gaps and priorities.</p> <p>Developing priorities for illicit drug research resources, including research workforce.</p> <p>Ensuring a suitable balance between commissioned and investigator-determined research.</p> <p>Establish mechanisms for cooperative development, transfer and use of research among those involved in the National Drug Strategy.</p> <p>Conduct research to better understand the demand/supply environment at local and national levels.</p> <p>Each jurisdiction to cooperate with the heroin analysis and signature program.</p> <p>Assessment of the appropriateness of the information systems used to disseminate research findings to those involved with the National Drug Strategy and the wider community, and development of ways to improve the information systems and the dissemination of findings.</p> <p>Implement and maintain local data collections that assist in developing locally responsive interventions to illicit drug use.</p> <p>Develop an illicit drugs research workforce development strategy.</p>

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7 Monitoring illicit drug trends

Performance measurement

Monitoring, evaluation and reformulation are critical to any national strategy. They allow its impacts and outcomes to be measured against predefined objectives and adjusted in accordance with the findings. Reporting on implementation of the National Action Plan on Illicit Drugs (NAPID) will be conducted at State, Territory and national levels. Reports on the progress of the national drug action plans are part of a broader monitoring and evaluation framework, implemented under the auspices of the Intergovernmental Committee on Drugs (IGCD), for the whole of the National Drug Strategic Framework. The purpose of this monitoring and evaluation strategy is to inform the IGCD and the MCDS on progress of the National Drug Strategy towards agreed national objectives, and in doing so to provide a more informed basis for policy and program development. All jurisdictions will provide the MCDS with an annual report on progress. National illicit drug trends will also be monitored.

For this purpose, a set of measures of illicit drug trends have been identified that meet the following criteria:

- They are part of an existing data collection.
- They are collected regularly and are likely to continue to be collected during the life of the National Drug Strategy (NDS).
- They are collected nationally.
- They relate to the four content areas identified as key strategy areas in the Action Plan.

There has also been an effort to choose measures that are reliable and valid, are likely to show statistically significant changes during the life of the NDS, and will provide useful information for stakeholders.

The limitations of the measures should be recognised. For example, the reliability and validity of the measures are variable. Price and purity data are particularly problematic. Moreover, changes in measures cannot be automatically attributed to the NDS or the NAPID. Trends are likely to be the result of a number of factors inside and outside Australia. In addition, jurisdictional differences will not be evident in national statistics. However, the measures provide one source of information on changes in key variables that the NDS and the NAPID aim to affect.

Other qualitative and quantitative information will be used to help interpret trends. For example, as part of the monitoring and evaluation of the NDS, an annual forum of key stakeholders will provide information relevant to the NDS as a whole, as well as to the implementation and outcomes of each drug action plan including the NAPID.

Performance measure	Data source	Frequency	Baseline	Comment
Age of first use of any illicit drug	National Drug Strategy (NDS) survey	3 years	<p><i>Cannabis</i>: mean age of first use steadily decreased from 30 years among those born 1940-44, to 14 years among those born 1980-84.</p> <p><i>Amphetamines</i>: mean age of first use steadily decreased from 23 years among those born 1950-54, to 18 years among those born 1975-79.</p> <p><i>Heroin</i>: mean age of first use steadily decreased from 33 years among those born 1945-49, to 18 years among those born 1975-79.</p>	Using data from the 1998 NDS survey, [1] NDARC researchers conducted a birth cohort analysis for a range of illicit drugs, in nine five-year cohorts among persons born between 1940 and 1984. These analyses provide a long-term view of age of initiation and identified a decrease in the age of initiation. [2, 3]
Prevalence of use of any illicit drug in the previous 12 months – in the general population – young people < 25 years	NDS survey School survey	3 years 3 years	<p>Use in last 12 months of any illicit in population aged 14 years and over: 1995: 17%; 1998: 22% [1]</p> <p>In 1996: [4] 39% of secondary students had ever used an illicit drug</p> <ul style="list-style-type: none"> – use in past month: <ul style="list-style-type: none"> • cannabis 20% • hallucinogens 4% • amphetamines 3% • heroin 1% • cocaine 1% • ecstasy 1% 	<p>Use has increased. Note: most of this increase was due to increase in cannabis use. See Table 1 below.</p> <p>Trend data not available – this was the first national school survey.</p>
Perception that it is okay to use illicit drugs regularly (at least monthly)	NDS survey	3 years	<p>Acceptability of regular (at least monthly) use of drugs by an adult among the general population aged 14 years and over in 1998: [4] [5]</p> <p>Cannabis: 26%</p> <p>Amphetamines: 3%</p> <p>Ecstasy: 3%</p> <p>Heroin at least monthly: 2%</p>	

Performance measure	Data source	Frequency	Baseline	Comment
Purity of illicit drugs	Australian Bureau of Criminal Intelligence law enforcement data	1 year	Average purity and trend across Australia 1998-99: [6] [7] amphetamines: 17% (increased) heroin 65% (increased)	
Price of illicit drugs	Illicit Drug Reporting System (IDRS) self-report survey	1 year	Average price and price range per gram in 2000 and description of 1996-2000 trend across jurisdictions: [7] Heroin \$354, \$220-\$600 (decreased) Amphetamines, \$98, \$50-\$200 (stable) Cocaine \$246, \$17-\$300 (no clear trend) Cannabis \$24, \$20-\$25 (decreased)	Prices by jurisdictions provided by IDRS. Due to substantial jurisdictional differences, national average prices were not published. These have been calculated by summing jurisdictional prices and dividing by the number of jurisdictions. Longitudinal data not available for all jurisdictions.
Number of community-based episodes of care	National Minimum data set – AOD Treatment	1 year	Data from the minimum dataset not yet available. An estimate from COTSA data: the total number in treatment for whom opiates were the principle drug problem (excluding methadone): 1990 – 1,501 [8] 1992 – 1,367 [9] 1995 – 1,241 [10]	
Number of people diverted to treatment from the police	Minimum data set—diversion	1 year	Data not yet available	
Participation in treatment by Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse (CALD) backgrounds	Minimum data set – AOD Treatment	1 year	Data not yet available From COTSA data: the total number of Aboriginal and Torres Strait Islander peoples in treatment for problems other than alcohol has doubled from 78 in 1990 to 130 in 1995. [10]	Consistent reporting on people from CALD not provided by COTSA. 'Country of birth' was changed to 'language spoken at home' at last census.

Performance measure	Data source	Frequency	Baseline	Comment
Number of people receiving methadone treatment at mid-year census	Commonwealth Department of Health and Aged Care	1 year	1997 22,239 1998 24,657 1999 27,906 2000 30,237	Unpublished data supplied by Commonwealth Department of Health and Aged Care
Number of fatal overdoses	Australian Bureau of Statistics / Coronial Data Register	1 year	958 deaths attributed to opioids in 1999 among 15-44 year olds. Rate = 112.5 per million, a 30% increase compared with 1998.	
Incidence of HIV diagnoses attributable to injecting drug use	National Centre in HIV Epidemiology and Clinical Research	1 year	Proportion of newly diagnosed HIV infections attributable to IDU (not including male homosexual plus IDU) [11] Year % of total diagnoses 1995 4.4 1996 2.8 1997 3.0 1998 3.3 1999 5.7	
Incidence of HCV diagnoses attributable to injecting drug use	National Centre in HIV Epidemiology and Clinical Research	1 year	Percent of IDUs tested for HCV antibody in NSPs who tested positive for HCV: [11] 1995 – 63% 1996 – 51% 1997 – 50% 1998 – 49% 1999 – 50%	Population prevalence of HCV, with cause of transmission, not available. Sentinel study results used.
Illicit drug use among arrestees	Drug Use Monitoring in Australia	1 year	Prevalence of arrestees testing positive in 2000 by gender: range across sites: [12] Males Females opiates 12-47% 25-68% cocaine 0-6% 0-16% amphet 8-38% 19-39% cannabis 43-65% 39-55%	Reported trends 1999–2000: Opiates and cannabis: 'relatively stable' Amphetamines: increased Cocaine: generally low Caution required with these figures. Given small number of data collection sites – value of data will be realised when trend data is available

Table 1 Summary of illicit drug use, Australia, 1991 to 1998
(n = % use in NDS Surveys)

Substance	Year:	Lifetime use				Use within past 12 months			
		1991	1993	1995	1998	1991	1993	1995	1998
Amphetamines		8	8	6	9	3	2	2	4
Barbiturates		5	4	1	2	2	—	—	—
Cocaine		3	2	3	4	1	1	1	1
Ecstasy/designer drugs		2	3	2	5	1	1	1	2
Synthetic hallucinogens/LSD		7	7	7	10	2	1	2	3
Heroin		2	2	1	2	1	—	—	1
Inhalants		3	4	2	4	1	1	—	1
Marijuana		32	34	31	39	13	13	13	18
Steroids		na	3	1	1	na	—	—	—
Injecting drugs		2	2	1	2	1	1	1	1

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