Chapter 3: Context of the National Drug Strategy

History and policy context

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

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

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

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

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

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

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

Dr Blewett’s leadership was instrumental in having the Workshop’s proposals adopted in 1985 by the Special Premiers’ Conference on Drugs, which formally established the NCADA.
The NCADA’s focus was on all drugs, and on inter-sectoral partnerships between health and law enforcement, between governments and the NGO sector, and between the Commonwealth and the States and Territories. It featured cost-shared funding of agreed-on initiatives, and endorsed the prescribing of methadone for the treatment of opioid dependence.

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

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

**Australia’s contributions to drug advice and policy**

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

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

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

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

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

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

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

- Many NDS sub-strategies were developed and published, and some of them have been through more than one phase.
- 1980s onwards: Australia pulled far above its weight in drug abuse research, particularly regarding drug abuse epidemiology and treatment, and in producing the global evidence base for tobacco control initiatives.
- In 1997 the Howard Government promulgated its ‘Tough on Drugs’ Strategy, a ‘zero tolerance’ policy that operated in parallel with the NDS with its harm minimisation underpinnings.
- Cautious acceptance of people who use illicit drugs in policy and service delivery forums.
- The 1997 High Court decision prohibiting the States and Territories from levying fees on alcohol and tobacco wholesale sales and the resulting loss of wholesale alcohol sales data and the establishment of the Alcohol Education and Rehabilitation Foundation (AERF) in 2001.
- The establishment of the Australian National Council on Drugs (ANCD) in 1998 as the Prime Minister’s advisory body on drugs.
- Development and implementation, on a state-by-state basis, of COAG’s Illicit Drug Diversion Initiative (IDDI), which was adopted in 1999.
- The rise and eventual acceptance of the Families movement, and its impacts on drugs policy and service delivery.
- The mid-to late-1990s epidemic of opioid overdose fatalities, which ended in December 2000 with the advent of the ‘heroin drought’.
- The 2003 World Health Organisation (WHO) Framework Convention on Tobacco Control: Australia played a prominent role in its development, and was an early signatory.
- A shift in the composition of the AOD workforce, from early domination by the medical and psychology professions, to the current situation where nurses and counsellors with limited training form the bulk of the workforce (with the obvious exception of medical and surgical treatment for the effects of smoking).
- A huge expansion in NGO abstinence-oriented treatment services by the Howard Government, including the direct funding of NGOs by the Commonwealth.
• An increased focus on evidence-informed patterns of drug law enforcement, in contrast to traditional patterns of policing
• Establishment of ANCD’s National Indigenous Drug and Alcohol Committee (NIDAC) in 2004
• Widespread professional, political and community acceptance of harm reduction initiatives, along with supply and demand reduction, and the recent disquiet (exacerbated by Commonwealth Parliamentary inquiries that reported in 2003 and 2007) about the terms ‘harm minimisation’ and ‘harm reduction’.
• Increasing acceptance of the importance of the social determinants of health and well-being, though very limited policy responses to it have yet been seen in the substance abuse field


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

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

Objectives

The current NDS has 12 objectives:

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

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

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

**Sub-strategies**

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

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

**Activities, programs and projects**

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

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

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

Research, data systems and evaluation

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

• National Drugs Campaign: Evaluation of Phase Two (2006)
• Evaluation of the MCDS CSFM (2005)
• Evaluation of the IDDI
  - The effectiveness of the IDDI in rural and remote Australia (2008)

Advisory structure

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

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Note: This figure illustrates the high level advisory structure, and does not include the sub-committees of the ANCD (eg NIDAC and the Asia-Pacific Drug Issues Committee).
The governance framework of the NDS consists of the Ministerial Council of Drug Strategy (MCDS), supported by an advisory structure that includes the Intergovernmental Council on Drugs (IGCD), the Australian National Council on Drugs (ANCD), the National Expert Advisory Panel (NEAP), and the National Drug Research Centres of Excellence (NDRCE). The Drug Strategy Branch of DoHA provides secretariat support to the MCDS and IGCD.

**Ministerial Council on Drug Strategy (MCDS)**

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

**Intergovernmental Committee on Drugs (IGCD)**

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

**The Australian National Council on Drugs (ANCD)**

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

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

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

**The National Expert Advisory Panel (NEAP)**

The NEAP is a multidisciplinary list of experts reporting to IGCD in the current NDS advisory structure. The NEAP identifies emerging trends in the use of alcohol and other drugs; provides expert advice on priorities and strategies for dealing with specific drug-related harm (supply...
reduction, demand reduction, and harm reduction); and provides direction and guidance to ensure that strategies targeted at specific population groups (for example, Indigenous communities).

**National Drug Research Centres of Excellence (NDRCE)**

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

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

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

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

**Evaluations of NCADA / NDS**

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

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

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

In 2003, the report of the fourth evaluation Success Works was released. The report was released on-line. It had a limited scope, and attracted little attention from the alcohol and other drug sector.
It was followed by the introduction of the *National Drug Strategy: Australia’s Integrated Framework 2004-2009*, which is the current and fifth phase of the NDS, and the focus of the current evaluation.

**Recommendations from the evaluation of the previous phase of the NDS**

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

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

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

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

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

¹⁰ See Appendix F for details