

DRUG POLICY MODELLING PROGRAM
MONOGRAPH 21

**AN ASSESSMENT OF ILLICIT DRUG POLICY IN
AUSTRALIA (1985 TO 2010): THEMES AND
TRENDS**

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March 2011



Drug Policy Modelling Program Monograph Series

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The Drug Policy Modelling Program Monograph Series is funded by Colonial Foundation Trust.

Published by National Drug and Alcohol Research Centre.

March 2011

ISBN: 978 0 7334 2991 0

The correct citation for this publication is: Ritter, A., Lancaster, K., Grech, K., & Reuter, P. (2011). Monograph No. 21: An assessment of illicit drug policy in Australia (1985-2010): Themes and trends. *DPMP Monograph Series*. Sydney: National Drug and Alcohol Research Centre.

THE DRUG MODELLING POLICY PROGRAM

This monograph forms part of the Drug Policy Modelling Program (DPMP) Monograph Series.

Drugs are a major social problem and are inextricably linked to the major socio-economic issues of our time. Our current drug policies are inadequate and governments are not getting the best returns on their investment. There are a number of reasons why: there is a lack of evidence upon which to base policies; the evidence that does exist is not necessarily analysed and used in policy decision-making; we do not have adequate approaches or models to help policy-makers make good decisions about dealing with drug problems; and drug policy is a highly complicated and politicised arena.

The aim of the Drug Policy Modelling Program (DPMP) is to create valuable new drug policy insights, ideas and interventions that will allow Australia to respond with alacrity and success to illicit drug use. DPMP addresses drug policy using a comprehensive approach that includes consideration of law enforcement, prevention, treatment and harm reduction. The dynamic interaction between policy options is an essential component in understanding best investment in drug policy.

DPMP conducts rigorous research that provides independent, balanced, non-partisan policy analysis. The areas of work include: developing the evidence-base for policy; developing, implementing and evaluating dynamic policy-relevant models of drug issues; and studying policy-making processes in Australia.

Monographs in the series are:

01. What is Australia's "drug budget"? The policy mix of illicit drug-related government spending in Australia
02. Drug policy interventions: A comprehensive list and a review of classification schemes
03. Estimating the prevalence of problematic heroin use in Melbourne
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13. Scoping the potential uses of systems thinking in developing policy on illicit drugs
14. Working estimates of the social costs per gram and per user for cannabis, cocaine, opiates and amphetamines
15. Priority areas in illicit drug policy: Perspectives of policy makers
16. A summary of diversion programs for drug and drug-related offenders in Australia
17. A review of Australian public opinion surveys on illicit drugs
18. The coordination of Australian illicit drug policy: A governance perspective
19. Media reporting on illicit drugs in Australia: Trends and impacts on youth attitudes to illicit drug use
20. Cannabis use disorder treatment and associated health care costs in New South Wales, 2007
21. An assessment of illicit drug policy in Australia (1985 to 2010): Themes and trends

DPMP strives to generate new policies, new ways of making policy and new policy activity and evaluation. Ultimately our program of work aims to generate effective new illicit drug policy in Australia. I hope this Monograph contributes to Australian drug policy and that you find it informative and useful.



Alison Ritter

Director, DPMP

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INTRODUCTION

This work aimed to provide an accessible description and assessment of drug policy in Australia from 1985 to 2010. Approaches to drug policy are constantly changing as a result of international and domestic factors, the comings and goings of governments, political imperative and the uptake of new knowledge. Consequently, this report represents the situation as it stands in Australia up to mid-2010. We take the Australian context (section 1) as our starting point, then summarise Australia's National Drug Strategies over time comparing them to those of other nations (section 2). We then provide analysis of trends and patterns of drug use and harms in Australia (section 3), government action on drugs (section 4), and finish with an analysis of the roles of some of the many actors in the Australian drug policy landscape (section 5).

We take the Australian context as our starting point because drug policy does not sit within a vacuum and is connected with broader economic, social and welfare policies. Using this as our foundation, we then focus on the development of the national drug strategies to examine the ways in which Australia's drug policy from 1985 to 2010 has been distinctly characterised by harm minimisation, partnership approaches, a balance between policy elements and a commitment to evidence-informed policy. We discuss these features by placing each in the context of the similar and contrasting approaches of the international community.

We examine trends in drug use and associated harms in Australia by analysing data from key population surveys, sentinel surveys of active drug users and data routinely collected, and consider what may account for these changing patterns. We note especially the changing rates of cannabis use in Australia and consider the impact of the notable Australian heroin drought (2000/2001). In this context we make international comparisons, and although the data are limited, we can draw some conclusions about Australia's drug use and associated harms compared to other nations and how these have changed over time.

We know that drug policy is but one of many factors affecting prevalence of drug use and harms. Due to the complexity of drug policy analysis, we seek to understand how the many competing 'voices' within the Australian drug policy landscape shape and influence the nature of drug policy in Australia. In doing so, we consider the ways that advocacy coalitions have translated their beliefs and agendas into policy impact over time, and begin to contemplate possible future impact on choice of policy solutions. We concentrate particularly on the roles played by the research community, the state, international regulatory bodies, and the 'third sector', as well as the general public more broadly.

What is perhaps striking about Australian drug policy is the degree of consistency and coherence in the overall approach since 1985 – that is almost twenty five years of a consistent approach, without deviation. But despite Australia's historical position as a champion of 'harm minimisation', it appears that Australia is now falling behind some other nations in terms of innovation and continuous development of harm minimisation strategies.

Note on coverage:

This report concerns itself with illicit drugs. Illicit drugs refer to cannabis, heroin, cocaine, amphetamines, ecstasy, hallucinogens and 'designer' drugs. Excluded from the term 'illicit drugs' are tobacco, alcohol, pharmaceuticals (e.g. benzodiazepines), performance enhancing drugs (e.g. anabolic steroids) and other common substances which may be inhaled for psychoactive effects (e.g. petrol), even when these substances are used illegally. We appreciate that this distinction is artificial and problematic for a number of reasons; for example polydrug use is the norm. However there is a concentration of harms in relation to illicit drugs, limited instruments available for control or regulation and a greater prominence of supply reduction as a mode of control lending itself to policy analysis confined to this frame.

1. THE AUSTRALIAN CONTEXT

There is now widespread acceptance that underlying social determinants of communities and individuals have an impact on health and crime. Factors such as employment status, education level, occupation, income, gender, ethnicity, religion, age and residence all contribute to the wellbeing of an individual and of communities (Commission on Social Determinants of Health, 2008; European Monitoring Centre for Drugs and Drug Addiction, 2009). More specifically, these same political, economic, cultural and social conditions contribute to the significant differences in the extent of drug use and problem drug use between countries at a population level and also within communities (Babor, et al., 2010). Drug use occurs at all levels of society, regardless of socio-economic status, but the greatest harms are experienced by marginalised members of the community who suffer multiple socio-economic difficulties (Seddon, 2006). The Australian context is therefore our starting point for a broader discussion of the Australian approach to drug policy.

Australia is a stable, multi-cultural and democratic society with a population of 21 million people (Australian Government Department of Foreign Affairs and Trade, 2010). It is one of the most economically, politically and socially stable nations in the region. Australia is a culturally diverse society with migrants from over 200 nations, as well as its indigenous Aboriginal and Torres Strait Islander people, contributing to its national identity. Most of the Australian population lives in urban areas (75%). Australia has a strong, competitive economy and is the 15th richest nation in per capita terms. It has a highly trained labour force of approximately 10 million, with almost half of this workforce having a university, trade or diploma qualification. The education system within Australia is also well developed with attendance rates among the highest in the world.

Welfare and health policies form an important backdrop to illicit drug policies. Social inclusion appears to be on the government agenda. In 2008 an Australian Social Inclusion Board was established to advise government ‘on ways to achieve better outcomes for the most disadvantaged in our community’ (reviewed in Hayes, Gray, & Edwards, 2008). This social inclusion agenda recognises the importance of allowing all Australians:

- the opportunity to secure employment;
- to access services;
- to connect with friends, family, work, personal interests and local community;
- to have the skills to deal with crises when they might arise; and
- to have their voices heard.

It is expected that this will be achieved through the use of evidence based policy in conjunction with community, business, the not-for-profit sector, academics, advisory groups and all levels of government.

The prevention of negative health outcomes (including drug use) is also high on the government agenda. A National Preventative Taskforce was established in 2008 to provide evidence-based advice to governments and health providers on preventative health programs and strategies. Its first discussion paper ‘Australia: The healthiest country by 2020’ focused on three priority areas: obesity, alcohol and tobacco. The key underlying principle was that Australia must reform its approach to the prevention of illness. The taskforce reinforced that health is ‘everybody’s business’ and identified individuals, families, communities, industries, states and the nation as all having a role to play in producing a healthy Australia by 2020. Moreover, it emphasised that behavioural change will be limited unless society as a whole provides and values healthier choices.

This demands increased attention to the roles of schools, workplaces and community leaders in changing values and providing incentives to take up healthy behaviour. Following public consultation and government review, the Taskforce released its final report in 2009 (National Preventative Health Taskforce, 2009) putting forward 136 recommendations and 35 areas for action. Many of their recommendations in relation to licit drugs are pertinent. Specific strategic directions underpinning the effective implementation of the recommendations include: shared responsibility and partnerships across government, industry and communities; engaging communities; influencing markets and developing connected and coherent policies; reducing inequity by targeting disadvantage; ‘closing the gap’ for Indigenous Australians; and refocussing primary health care towards prevention (Commonwealth of Australia, 2010).

Another relevant contextual factor for illicit drug policy in Australia is a renewed focus on innovation. ‘Venturous Australia’ is the title of the National Innovations Review report by Dr Terry Cutler (Cutler & Company Pty Ltd, 2008). This review is premised on innovation and entrepreneurship as essential for Australia to thrive. ‘Venturous Australia’ calls on government to identify and remove impediments to the conduct and uptake of innovative research through for example increasing access to and transparency of government generated information, research and content, facilitating collaboration, increasing opportunities for innovation that is bottom-up led and increasing attention to what is needed in the long term, not just short term.

The need to reform and strengthen Australia’s public administration to be responsive to the many challenges facing Australia in the 21st century is also a priority for government. A number of key challenges in the strategic environment were identified by the Advisory Group on Reform of Australian Government Administration including demographic change, technological change, globalisation and the increasing complexity of policy challenges (Advisory Group on Reform of Australian Government Administration, 2009). The latter is particularly relevant for a complex policy domain such as drug policy, which requires partnerships and coordination across multiple ministerial portfolios and agencies (e.g. health, law enforcement and social policy) as well as between Commonwealth, state and local governments. It was suggested that in light of these future challenges, the public service requires an innovative, adaptive and outward looking approach and should be better equipped to give creative and innovative policy advice to government. The blueprint for reform was released in 2010, following consultation, and proposed reform in four areas: forging stronger relationships with citizens, strengthening the capacity of the public service to provide strategic advice, investing in the capability of the public service workforce and a stronger focus on efficiency and quality (Advisory Group on Reform of Australian Government Administration, 2010).

As seen above, social inclusion, prevention of negative health outcomes, innovation and public administration reform appear to be priorities for the current Australian government. To gain a comprehensive understanding of the Australian context, we must also examine what the Australian public perceive to be the most important issues.

In a recent survey asking Australians to identify the ‘most important problem facing Australia’ (Roy Morgan Research, 2010), 29% of respondents cited economic issues, followed by the environment (25%), government issues (16%), social issues (including drug use and drug abuse) (10%) and then health (6%). These data are provided in Table 1 below. Comparing these concerns to those expressed in the same survey conducted in 2006 and 2009, what is noticeable is the fluctuating concern over economic, social and government issues. There has been drop in concern over terrorism, wars and safety while concern over environmental issues has grown. The position of drugs and drug abuse as an issue of concern remains largely unchanged over time.

Likewise in the Public Opinion Towards Governance: Results from the Inaugural ANU Poll 2008 (<http://www.anu.edu.au>), only 2% of Australians thought that illicit drugs were the most important issue facing Australia, behind the environment (19%), the economy (17%) and jobs (6%).

Table 1: Most important problems facing Australia

| Most important problem facing Australia | 2006 | 2009 | 2010 |
|--|-------------|-------------|-------------|
| Terrorism, wars, safety | 12% | 1% | 2% |
| Economic issues | 20% | 51% | 29% |
| Environmental issues | 8% | 17% | 25% |
| Health | 9% | 2% | 6% |
| (drugs and drug abuse) | 2% | 1% | 1% |
| Social issues | 11% | 6% | 10% |
| Government, human issues | 25% | 12% | 16% |

Source: Roy Morgan Research, 2010.

In addition, the extent to which regular drug use is approved of by the Australian general population is changing. As can be seen in Table 2, approval of drug use by Australians has decreased over time, with large decreases in approval of alcohol use and cannabis use. Approval of regular alcohol use has dropped from 75% in 2001 to 45% in 2007. Approval of regular cannabis has also dropped over this time (from 24% in 2001 to 7% in 2007). For the other illicit drugs, the percentage who approve in the first place is very small (less than 5% of the population) but even given these small approval figures, the rate is also dropping; for example ecstasy was approved of by 4% of the population in 2001; by 2007 this was 2% of the population.

Table 2: Approval rates for regular drug use

| | 2001 | 2004 | 2007¹ |
|-----------------|-------------|-------------|-------------------------|
| Alcohol | 74.7% | 77.0% | 45.2% |
| Cannabis | 23.8% | 23.2% | 6.6% |
| Ecstasy | 4.0% | 4.2% | 2.0% |
| Heroin | 1.1% | 0.9% | 1.0% |
| Methamphetamine | 3.2% | 3.1% | 1.4% |
| Cocaine | 2.2% | 2.0% | 1.4% |

Source: Australian Institute of Health and Welfare, 2002, 2005, 2008a.

¹ There was a wording change in the 2007 survey. In earlier surveys the choice was between 'approve' or 'disapprove'. In 2007 there were more response categories: strongly approve, approve, neither approve or disapprove, disapprove, don't know. We have combined 'strongly approve' and 'approve' for the 2007 results.

Understanding the national context is important as it affects not only the wellbeing of the community and drug use prevalence, but also choice of policy solutions. The variety of drug policy approaches across nations reflects 'differences in attitudes toward drug use itself, toward individual rights, and toward the role of government' as well as 'the nature and history of drug problems, the broader political structure of the country, and the different ways in which drugs affect a nation' (Babor, et al., 2010, p. 221). For example, Australia's unique isolation as an island continent means that interdiction and law enforcement efforts will be largely concerned with the

impact of trafficking operations on domestic drug markets. Other nations, by virtue of their geography and economic status, are situated in drug trafficking 'transit' routes and therefore require different cross-border approaches to drug law enforcement. Australia's geographical isolation and political stability has also created opportunities for a strong licit poppy industry. Tasmania is one of the world's largest producers of opium alkaloids for the pharmaceutical market (Fist, 2001). It has been argued that Tasmania's isolation makes it an ideal location for such operations as it increases security, and as such Tasmania has become the benchmark for other poppy producing nations (Fist, 2001).

Although evidence and experience can inform best practice approaches to drug policy development and review (International Drug Policy Consortium, 2010), context variation between nations means there cannot be a single 'best policy' for all nations (Babor, et al., 2010). The range of problems and responses across nations reflects the 'interplay of politics, culture and drug use' (Babor, et al., 2010, p. 233). Drug policy must therefore be thoughtfully tailored in the context of these national differences.

2. THE AUSTRALIAN APPROACH TO DRUG POLICY: NATIONAL DRUG STRATEGIES

Since 1985 Australia has had a documented strategy addressing alcohol and illicit drugs. The first of these, the National Campaign Against Drug Abuse (1985 to 1998) (NCADA) was not labelled as a strategy document per se but operated as such. This was followed by the National Drug Strategic Framework, covering the period 1998-1999 to 2002-2003. The third and current strategy document is the National Drug Strategy: Australia's integrated framework, covering the period 2004 to 2009. At the time of writing the National Drug Strategy: 2010 to 2015 was under development. Further details about the National Drug Strategies can be found in Appendix A. While these national drug strategy iterations have provided an overarching framework, they have also informed expenditure decisions.

Five basic features, as represented in these iterations of a national strategy, provide the cornerstone of the 'Australian approach': harm minimisation, a comprehensive approach, partnerships, a balanced approach and a commitment to evidence based policy. We discuss these features here placing each in the context of the similar and contrasting approaches of the international community (specifically the UK¹, USA, Canada, Sweden and Switzerland).

Harm minimisation

Harm minimisation provides the overarching framework in Australia – there are multiple ways to minimise the harms from drug use including reducing the supply of drugs, reducing the use of drugs, reducing the harmfulness of drug use and preventing the uptake of drugs. Harm minimisation is evidence-based and pragmatic (Ritter & Cameron, 2006). In Australia, harm minimisation has formed the basis of the National Drug Strategy since its inception in 1985 (Ministerial Council on Drug Strategy, 2004). In the most recent drug strategy (National Drug Strategy: Australia's Integrated Framework 2004 -2009) harm minimisation encompasses:

- supply reduction strategies to disrupt the production and supply of illicit drugs and the control and regulation of licit substances;
- demand reduction strategies to prevent the uptake of harmful drug use, including abstinence orientated strategies to reduce drug use; and
- targeted harm reduction strategies to reduce drug-related harm for individuals and communities.

The Swiss drug policy is similarly structured around the aim of reducing harms through reducing the use of drugs, reducing negative consequences for drug users and reducing negative consequences for society (Swiss Confederation, 2006). Similar language is used in the articulation of the UK's 2008 Drug Strategy which highlights the economic and social costs of drugs to society. It places policy objectives in the context of the harms caused by the supply of and demand for illicit drugs but is arranged around four slightly different strategic themes: protecting communities; preventing harm to children, young people and families; delivering new approaches to drug treatment; and public communications (HM Government, 2008). Canada's National Anti-Drug Strategy focuses less explicitly on harms and is expressed wholly within the language of prevention, treatment and enforcement with little explicit emphasis placed on harm reduction (Government of Canada, 2009).

¹ We have based our analysis on the 2008 UK drug strategy document (HM Government, 2008). At the time of publication, the UK released a new drug strategy (HM Government, 2010). The new strategy places more emphasis on 'recovery' but for the purposes of the analysis here, is generally in keeping with previous iterations.

Sweden's drug policy stands in contrast, however. The overall objective of Sweden's drug policy is 'a drug-free society' to be achieved in three ways: reduce recruitment to drug abuse; induce people with substance abuse problems to give up their abuse; and reduce the supply of drugs (Government Offices of Sweden, 2008). There is no reference to reducing the harmful consequences of drug use. This central policy objective of prevalence reduction has also historically characterised USA drug policy, with enforcement dominating both rhetoric and budget allocation (Boyum & Reuter, 2005). However, recent iterations have more heavily emphasised both prevention and harm reduction - curtailing drug use as well as aiming to improve health by reducing consequences of use, including death and morbidity (Office of National Drug Control Policy, 2010).

Harm minimisation has not been without criticism in Australia. There has been confusion over the term itself, as well as debate about the underlying principle. For example, in relation to terminology, the 1997 evaluation of NCADA noted that there was confusion over the meaning of the term 'harm minimisation' (Single & Rohl, 1997). The 2009 NDS evaluation recommended replacing the term with words that better communicate the essence of the strategy including prevention objectives (Siggins Miller, et al., 2009). Regarding the underlying principle, outside commentators (for example House of Representatives Standing Committee on Family and Community Affairs, 2007) have readily interpreted the term to focus on harms alone – and have argued against such a position. In this way the two issues (terminology and the principle's intent) are conflated. Ambiguity regarding the terminology itself has facilitated division and a lack of shared ownership of the national drug strategies. Difficulty in defining the term has left open the possibility of the perception of conflicting intent and has served to overshadow substantive debate about the goals of harm minimisation.

A comprehensive approach

Australia's comprehensive approach encompasses the harmful use of licit drugs (tobacco, alcohol and pharmaceutical drugs), as well as illicit drugs and other psychoactive substances (inhalants, kava). It is unusual to find licit and illicit drugs considered under the same strategy and with an integrated approach. For example, the UK and the USA strategies are for illicit drugs only (HM Government, 2008; Office of National Drug Control Policy, 2010). Across Europe, a minority of countries have adopted a comprehensive approach covering all drugs (e.g. France, Germany, Norway, Switzerland, Ireland, Portugal and Czech Republic) but successful implementation of such an approach has varied depending on political will and cultural values in each nation (Muscat & members of the Pompidou Group research platform, 2008). Even within countries that have not adopted an integrated approach, there is some evidence of integration in the approaches of peak bodies, such as the Swedish Council for Information on Alcohol and other Drugs (The Swedish Council for Information on Alcohol and other Drugs, 2010). An integrated strategy across all substances makes sense for example in relation to a prevention agenda, as prevention programs (at least those based on evidence) do not target any one particular drug but focus on overall emotional resilience.

The combining of alcohol, tobacco and illicit drugs into the one strategic framework accounts for some of the unique features of the alcohol and other drugs arena in Australia. For example, clinical services (with the exception of pharmacotherapy maintenance) usually provide treatment to all types of dependence rather than having a separate service system for drug users versus alcohol dependent people. Another example is in research – national research centres in Australia engage in and conduct both alcohol and drug research and there is little differentiation between them – arguably this makes for a stronger research workforce experienced at integrating or straddling the licit and illicit domains.

Partnerships

The coordination of agencies across all levels of government including health, education and law enforcement in the development and implementation of the national drug strategy is an essential element of the Australian approach. In the 2003 NDS evaluation, the evaluators recommended the inclusion of education as a full partner in the strategy (alongside health and law enforcement) (Success Works, 2003). Other essential groups that contribute to this co-ordinated approach include the community sector, industry, media, research, the local community and individuals (Ministerial Council on Drug Strategy, 2004) (governance is described in Appendix A). The cooperation between law enforcement, health and other key stakeholders has been noted as a key success factor for the NDS (Single & Rohl, 1997; Success Works, 2003). Nonetheless it is recognised that given the federal system and multiple stakeholders, the governance of Australian drug policy is a challenge (Hughes, Lodge & Ritter, 2010). The governance process has been critiqued for the lack of transparency of decision making, the inconsistent use of the evidence base and the lack of a public face for the NDS (Fitzgerald & Sowards, 2002).

The challenge to embed delivery of the National Drug Strategy within the frameworks of all partners is not unique to Australia and has also been highlighted as an issue in the UK (HM Government, 2008). Partnership approaches have been emphasised in the UK with targets specific to drug strategy allocated to various government departments including the Home Office, health and education and embedded within the performance and assessment frameworks of local governments, policing and justice (Reuter & Stevens, 2007). Sweden's drug policy similarly shares implementation responsibility across justice, finance and foreign affairs but appoints the Ministry of Health and Social Affairs as being responsible for coordination within government offices (Government Offices of Sweden, 2008). The Swiss drugs policy (Swiss Confederation, 2006) also emphasises the need for the activities of all policy players to be coordinated in order to effectively address the complexity of drug issues. The different levels of government play complementary roles in the implementation of Swiss drugs policy and voluntary coordination is overseen by a range of bodies whose aim it is to build consensus, with the federal government playing a key moderating role. Australia's National Drug Strategy also makes mention of international partnerships and co-operation, but this point is more greatly emphasised in the strategies of Sweden and the USA (Government Offices of Sweden, 2008; Office of National Drug Control Policy, 2010).

A balanced approach

One of the aims of the National Drug Strategy is 'to achieve a balance between harm-reduction, demand-reduction and supply-reduction measures to reduce the harmful effects of drugs in Australia'. This approach has been echoed recently in the USA with the Obama administration's 2010 National Drug Control Strategy emphasising a balanced policy of prevention, treatment, law enforcement and international cooperation (Office of National Drug Control Policy, 2010). Switzerland's National Drugs Policy similarly emphasises 'the four pillar model as a pragmatic middle way', and aims to increase the interchange between prevention, treatment, harm reduction and law enforcement (Swiss Confederation, 2006). However, the goal of 'balance' is not necessarily reflected in the allocation of spending and resources – an issue which has been questioned in nations such as the UK, USA and Australia alike.

There is no benchmark for what the ideal spending mix should be across the policy areas. In terms of the amount spent by governments on direct drug policy interventions, in Australia the majority is destined for law enforcement (55%), followed by prevention (23%), treatment (17%), harm reduction (3%) and other (1%) (Moore, 2008). We can compare Australia to other countries: estimates of the Netherlands spending indicate approximately 2% on prevention, 13%

on treatment, 9% on harm reduction and 76% on law enforcement (Rigter, 2006). Estimates for Sweden indicate a similar weight towards law enforcement (76%), almost none on harm reduction (0.1%) and 19% and 1% respectively on treatment and prevention (Ramstedt, 2006). USA figures are not as readily comparable, however approximately 70% of the US federal government drug spending is spent on law enforcement and the remainder (30%) on treatment and prevention (see <http://www.csdp.org/research/ondcpenron.pdf>). There are substantial difficulties in making comparisons among these figures given the differences in methodologies (see Reuter, 2006 for discussion). Nonetheless, it is reasonable to conclude that Australian spending, when viewed in light of these other country estimates, appears to be less weighted towards law enforcement.

However balance is not necessarily measured by spending. Indeed, one of the reasons the law enforcement spending is large is because the interventions and programs are expensive, especially relative to harm reduction programs like needle syringe programs. A better assessment of the balance may be in terms of services, activities or even outputs. Although Australia and other nations aspire to 'balanced' drug policy, the notion is fraught and currently exists more as rhetoric than as a systematic, evidence informed approach (Ritter, 2010). We discuss the issue of balance in more detail later.

Evidence based policy and commitment to evaluation

The Australian approach is 'evidence informed practice', with research and evaluation being a high priority in the National Drug Strategy. The government's commitment to this is evident through its continuous evaluation of the National Drug Strategies² as well as support of three dedicated National Research Centres. However, the most recent evaluation (Siggins Miller, et al., 2009) noted that the National Drug Strategy still does not have an integrated national drug research strategy and that the evidence base is lacking regarding drug law enforcement in particular. The value of integrating research into strategy documents is being recognised internationally. The need to enhance data systems to inform policy and ensure rigorous evaluation is noted as a priority in the USA's new National Drug Control Strategy (Office of National Drug Control Policy, 2010). The UK is also seeking to develop a strategic research program to develop the evidence base and support delivery of their National Drug Strategy (HM Government, 2008).

In addition to these five central features, researchers have documented some other important facets of the Australian approach to illicit drugs (Fitzgerald and Sowards, 2002). In particular a tolerance for a diversity of voices was noted – Australia's approach has been characterised by the capacity to tolerate, and in many cases encourage, multiple stakeholders around the policy table. These authors also note that the NDS had allowed the capacity for 'frank and fearless' advice and debate on contemporary drug issues. A study of the coordination of drug policy in Australia found that stakeholders viewed accountability and participation as the most important principles of good governance, and documentary analysis showed continual advancements in knowledge of coordination processes within the NDS (Hughes, Lodge & Ritter, 2010). There has been a central role for a committed bureaucracy that has maintained the system underpinning policy formulation processes. Australia's drug policy framework has achieved a balance between the needs of State and Territory governments for independence with the need for a national,

² The first evaluation of NCADA was conducted in 1988 three years after the commencement of the Strategy (Ministerial Council on Drug Strategy, 1988); the next evaluation was entitled 'No Quick Fix: An evaluation of NCADA 1992' (Ministerial Council on Drug Strategy, 1992); the NDS 1993-1997 evaluation was reported in 'Mapping the future' (Single & Rohl, 1997); followed by the evaluation of the NDS 1998-99 to 2003-2004 (Success Works, 2003). The evaluation of the latest NDS (2004-2009) was released in April 2009 (Siggins Miller, et al., 2009).

integrated and coordinated approach. The Australian approach has checks and balances – for example the capacity for service providers to input to the policy process. Fitzgerald and Swards noted that drug policy has often been ahead of public opinion and suggested that the average Australian's belief in 'giving someone a fair-go' and commitment to supporting the most vulnerable in the community, are critical ethics that have contributed to societal acceptance of Australia's drug policy (Fitzgerald & Swards, 2002).

What is perhaps striking about Australian drug policy is the degree of consistency and coherence in the overall approach since 1985 – that is almost twenty five years of a consistent approach, without deviation. This is in line with notions of policy development as small incremental shifts (Lindblom, 1959, 1979), rather than sudden changes of direction.

3. ANALYSIS OF TRENDS IN DRUG USE AND HARMS

The rate of Australian drug use is predominantly measured through general population surveys. Appendix B provides a detailed description of the types of data available, their respective sources and details of the sampling methods, sample sizes and areas covered. Further information on these and other data sources can be found in Degenhardt & Dietze, 2005; Trewin, 2001. Rates of use are distinguished from the harms associated with drug use. Here, rates of use are described first, followed by harms.

3.1 Australian trends in drug use

The table below (Table 3) summarises the key trends in drug use in Australia from the 1990's to the present time (2% up or down is regarded as an increase or decrease). Both general population surveys (National Drug Strategy Household Survey and Australian Secondary School Students Alcohol and Drug Survey) are included along with sentinel samples of active drug users (Illicit Drug Reporting System and Ecstasy and related Drug Reporting System).

As can be seen in Table 3, cannabis use has declined from the mid-1990's to the present in the general population. Cannabis use has also declined amongst a sentinel sample of injecting drug users (IDRS) and arrestees (Drug Use Monitoring in Australia) (although there appears to be an increase in cannabis use amongst regular ecstasy users). In relation to amphetamine-type stimulants (including methamphetamine and amphetamine in the crystal, powder and base forms), use across the Australian population appears stable between the mid-1990's and now. Two samples revealed declining use in amphetamine type stimulants: regular ecstasy users (EDRS) and arrestees (DUMA).

The general population household survey and secondary school students' surveys reveal low and stable prevalence of heroin use. This is not surprising as neither of these surveys sample heroin users specifically. Given the small relevant sample, these surveys are not useful for trends analysis. The sentinel samples, however, are more pertinent to understanding trends in heroin use, and show a consistent decline (IDRS, EDRS and DUMA). Similarly, the household survey and secondary school students' survey also show low and stable prevalence of cocaine use. Again, it is the sentinel samples which are more relevant and show a fluctuating trend in cocaine use amongst injecting drug users and an increase in use amongst regular ecstasy users. Finally, ecstasy use in the general population may be increasing (1.2% in 1993 to 3.5% in 2007), but is stable amongst secondary school students.

In summary, the changing nature of Australia's drug use can be characterised by:

- declining rates of cannabis use;
- stable (or declining) rates of amphetamine use;
- declining rates of heroin use;
- stable or fluctuating pattern for cocaine use; and
- an unstable pattern for ecstasy use.

What may account for these patterns of changing drug use? Epidemic cycles are important in appreciating that drug use is a fluctuating phenomenon in and of itself (see for example Behrens, Caulkins, Tragler, & Feichtinger, 2002; Frisher, 2006). In addition, there is unlikely to be one single factor that drives changing prevalence. The possible explanations are likely to differ by drug type. Research conducted in relation to changes in heroin use in Australia (Degenhardt &

Day, 2004, 2006; Rouen, et al., 2001; Weatherburn, Jones, Freeman, & Makkai, 2003) has demonstrated that there was a sudden and dramatic reduction in heroin supply across Australia in late 2000/early 2001. This accounts for the declining trend of heroin use.

In relation to cannabis, there are a number of possibilities to account for the reduction in cannabis use. Prior to considering these, we point out that while cannabis use has declined, the harms associated with cannabis use have not. Cannabis related hospitalisations have increased as has the rate of drug-induced psychosis (Degenhardt, Roxburgh, & et al., 2007; Roxburgh & Degenhardt, 2008), as will be discussed in the next section.

It is possible that the decline in cannabis use rates is due to the impact of government intervention. For example, wide spread campaigns about the association between mental health symptoms and cannabis may have been effective in creating a negative reputation for the drug and hence reduced initiation. It is possible that the previous federal government's 'Tough on Drugs' messages were effective deterrents. The probability of arrest for cannabis use, conditional on being a user, has risen substantially. There have also been advances in effectiveness and availability of cannabis treatment (as demonstrated in the increasing numbers seeking treatment). However, the decrease in cannabis use is in initiation to cannabis, so this is not a plausible explanation.

Independent of government action, the decline might be due to epidemic cycles. The Musto Effect describes the 'reputation' that a drug develops. A negative reputation leads to decreases in drug use; a positive reputation to increases in drug use. When cannabis use was increasing, the likelihood that any one person would directly experience the negative effects of cannabis (either him/herself or in a friend) was greater - more people became exposed to someone who experienced mental health problems and as word spread, use declined. There have been reductions in cannabis use in many developed countries simultaneous with Australia - the global village spreads fashionable and unfashionable drug messages, and cannabis now appears unfashionable.

The decline in cannabis use may also relate to drug properties themselves. For example, cannabis is perceived by the public as now being more potent. It may therefore be less appealing as higher THC levels may increase the likelihood of adverse psychological effects (discouraging first time users and increasing risk of dependence). It is unclear if there has also been a decline in the percentage of cannabidiol (CBD), and the ratio of THC to CBD may be the most important determinant of the effects of the drug. Preferences for other drugs may also have contributed to the decline. Alcohol use, notably the pattern of age of drinking, has increased among young people. Ecstasy use also appears to be rising in the general population. The experience of ecstasy at any one time may reduce the attraction of cannabis. Prevalence of cigarette smoking is reducing, and cannabis is often smoked with tobacco in Australia. Declines in tobacco smoking would be consistent with declines in cannabis use - inhaling smoke may be now seen as not 'cool', and the method of ingestion no longer palatable.

There may be some other factors in operation not yet identified. It is unlikely that one single factor accounts for the decline in cannabis use. What is striking is that there has been minimal research interest in explaining the falling cannabis use rates.

As this discussion of heroin and cannabis has shown, there may be many relevant factors that drive demand and influence patterns of use and harms. Factors may be as broad as activities of the state (including existing services/interventions plus law changes, new programs, and 'external'

political events) or the influence of key actors and policy structures (at state, national and international levels). The socioeconomic climate (including employment, wealth and development status) and the social policy context (and how that may influence welfare policy) also have broad relevance. Attitudes and opinions of the general public may also have an impact, as will ‘fashion’ trends and attitudes towards particular drug types. Drug market operations affect price, quality and supply of drugs which may influence patterns of use and harms.

Table 3: Summary of key trends in drug use

| USE | NDSHS 1993-2007 14+ Survey ¹ | ASSADS 1996-2005 School students survey ² 12-17 | IDRS 2000-2007 16+ Survey ³ of IDU | EDRS 2003-2007 16+ Survey ³ of REU | DUMA 2002-2005 ⁴ Adults 18+ ⁵ Urine testing + Survey |
|------------------------------------|---|--|--|--|---|
| Cannabis | Decline in recent use ⁶ 1993-2007 (12.7% to 9.1%) | Decline in recent use ⁶ 1996-2005 (32.4% to 14.2%) | Decline in recent use ⁸ 2000-2007 (84% to 81%) | Increase in recent use ⁸ 2003-2007 (85% to 87%) | Decline in cannabis positive urine samples ⁹ 2002-2005 (58% to 49%) |
| Amphetamine type stimulants | Stable in recent use ⁶ 1993-2007 (2% to 2.3%) Range: 2%-3.7% Peaking in 1998 | Stable in recent use ⁶ 1996-2005 (4.8% to 4.2%) | Stable in recent use ⁸ 2001-2005 (75% to 74%) ICE: Fluctuating Range (35% to 57%) BASE: Decline (40%-32%) SPEED: Decline (62%-55%) | Decline in recent use ⁸ 2003-2007 (84% to 71%) | Decline in positive urine samples ¹⁰ 2003-2005 (31% to 27%) |
| Heroin | Stable in recent use ⁶ 1993-2007 (0.2% to 0.2%) | Stable in recent use ^{6,7} 1996-2005 (2.5% to 1.7%) | Decline in recent use ⁸ 2000-2007 (79% to 59%) | Decline in recent use ⁸ 2003-2007 (9% to 4%) | Decline in positive urine samples ¹¹ 2002-2005 (15% to 13%) |
| Ecstasy | Increase in recent use ⁶ 1993-2007 (1.2% to 3.5%) | Stable in recent use ⁶ 1996-2005 (2.8% to 3.2%) | Decline in recent use ⁸ 2002-2007 (29% to 23%) | All participants had recent use. | Increase in positive urine samples 2002-2005 (1% to 3%) |
| Cocaine | Stable in recent use ⁶ 1993-2007 (0.5% to 1.6%) | Stable in recent use ⁶ 1996-2005 (2.2% to 2.6%) | Fluctuating in recent use ⁸ 2000-2007 Range: 16% to 35% | Increase in recent use ⁸ 2003-2007 (24% to 40%) | Due to extremely low numbers testing positive no trend can be observed. 2003-1% 2005-1% |

NOTES

¹ Multi stage, stratified area random sample design.

² Stratified two-stage probability survey design.

³ Convenience sample.

⁴ Only data between 2002-2005 is reported from the DUMA survey as prior and post to these dates the watch houses included in the sample varied. The samples between 2002-2005 includes Adelaide, Bankstown, Brisbane, East Perth, Elizabeth, Parramatta and Southport.

⁵ Data on juvenile detainees is collected but not reported here due to low numbers.

⁶ Recent use is last 12 months.

⁷ Students were asked about Heroin and Other Opiates in the same question.

⁸ Recent use is last 6 months.

⁹ A positive urinalysis result indicates use up to 30 days prior to test. The average detection time is up to 30 days for heavy users and 2-10 days for casual use.

¹⁰ Urinalysis test was for methylamphetamine as it is possible for some amphetamine use to be prescription use. Urinalysis cannot distinguish between legal and illegal use however the detection of methylamphetamine is confirmation of illegal use.

¹¹ Average detection time of opiates is 2-3 days. Heroin rapidly breaks down into its metabolites. The confirmatory test allows for the positive identification of these constituent parts. Heroin use is indicated with MAM (monoacetylmorphine) and morphine alone or where the morphine concentration is greater than or equal to the codeine concentration.

NDSHS National Drug Strategy Household Survey

ASSADS Australian Secondary School Students Alcohol and Drug Survey

IDRS Illicit Drug Reporting System

EDRS Ecstasy and related Drug Reporting System

DUMA Drug Use Monitoring in Australia

IDU Injecting Drug User

REU Regular Ecstasy User

3.2 Australian trends in drug harms

Importantly, an analysis of prevalence of use needs to be complemented with an analysis of the harmful consequences of drug use. This is because it is the harmful consequences that produce suffering and societal concern as well as convey the extent of the economic burden of drug use in society.

Table 4 below provides summary data about trends in harmful consequences of drug use over time. There has been a changing pattern of harms across time in Australia. Both cannabis and methamphetamine harms appear to be increasing amongst those who continue to use cannabis and methamphetamine (indicated by increased treatment seeking and hospital stays). In contrast, heroin harms have decreased in terms of hospital stays but also notably in terms of overdose. There is insufficient data on ecstasy and cocaine.

In relation to blood borne viruses, which are a notable harm from injecting drug use, there has been an increase in new HIV diagnosis per 100,000 persons between 2000 and 2007, from 3.4 per 100,000 to 4.9 per 100,000 persons. Of these, injecting drug use was the exposure category for 5.2% in 1999, decreasing to 4% in 2007 (excluding males who also reported a history of homosexual contact). There has been a decrease in Hepatitis C infection per 100,000 persons between 2003 and 2007 (70.7/100,000; 58.8/100,000). In 2003, injecting drug use contributed 66% of 'newly acquired' Hepatitis C, while in 2007 it increased to 78% (National Centre in HIV Epidemiology and Clinical Research, 2008).

Table 4: Summary of key trends in drug harms

| | Mortality | Hospital stays (various research reports used to source trends) | Self-reported overdose (IDRS) | Self-reported overdose (EDRS) |
|------------------------------------|--|---|---|--|
| Cannabis | No reported cannabis-related mortality. | Increasing rate of separations between 2001/02 and 2004/05 (1,798 per million to 2,243 per million) (Roxburgh & Degenhardt, 2008) Increasing % of drug induced psychotic separations related to cannabis between 1999 and 2004 (39% to 45%) (Degenhardt, et al., 2007) | No reported cannabis related overdose. | No reported cannabis related overdose. |
| Amphetamine type stimulants | Decrease in number between 2004 and 2005 (75 to 68) (Degenhardt, et al., 2007) | Increase between 1993 and 2004 in number of principle amphetamine separations (652 to 2,066) Increase between 1993 and 2004 in amphetamines mentions separations (2,530 to 10,304) Total number of bed days for amphetamine induced psychosis increased from 5,679 (1999) to 8,068 (2004) representing a 42% increase (Degenhardt, et al., 2007) | Data on stimulant overdose only included in 2007. 6% of national sample believed that they had OD on amphetamines at some stage during their lifetime 4% speed 2% ice <1% base | Data on stimulant overdose only included in 2007. 39% believed that they had OD on a 'stimulant' the last 6 months 8% speed 22% ice 2% base 56% ecstasy 8% cocaine |
| Heroin and other IDU | Decrease in number between 1999 and 2005 (1,116 to 374)(Degenhardt & Roxburgh, 2007b) | Decline in principle opioid separations in hospitals between 1999 and 2003/4 (9,262 to 5,015) (Roxburgh, Burns, & Degenhardt, 2008; Roxburgh & Degenhardt, 2006) | Decline in overdose between 2000 and 2006 (31% to 17%) (2007 not included due to change in question) Decline in 'borrowing' of injecting equipment between 2000 and 2007 (16% to 10%) | Data on 'depressant' overdose only included in 2007 43% had overdosed in the last 6 months on a depressant drug 5% of these were attributed to heroin |

IDRS Illicit Drug Reporting System
EDRS Ecstasy and related Drug Reporting System
IDU Injecting Drug User
OD Overdose

3.3 Comparisons across and between drugs

A significant limitation of much epidemiological research and policy analysis has been the focus on single and serial drug use as opposed to concurrent drug use (polydrug use). This is despite the knowledge that polydrug use is the norm (people use multiple substances simultaneously); that the markets for drugs overlap considerably (those that sell methamphetamine are also likely to sell other substances, including heroin and ecstasy); and that patterns of harmful drug use are influenced by and dependent upon co-consumption (for example heroin with alcohol or benzodiazepines). Polydrug use may refer to using multiple drugs at the same time, or using multiple drugs over the course of time but not necessarily simultaneously. This section briefly explores some of these features, and concludes with some comparisons between drugs. Our analysis is limited by the nature of data collection regarding polydrug use across different surveys.

Polydrug use

People use multiple drugs simultaneously for a number of reasons:

- to enhance the effects of a drug;
- to counteract the effect of a drug;
- to provide a substitute when the preferred drug is not available; and
- to conform to social norms (Clayton, 1986).

The extent of polydrug use in Australia can be estimated from responses in the general population surveys (NDSHS; ASSADS), where respondents are asked about what other drugs they used at the same time as (i.e. concurrently with) each drug.

Eighty-seven percent of cannabis users reported consuming alcohol and cannabis at the same time, while 28% concurrently consumed ecstasy and cannabis and 23% concurrently consumed methamphetamine and cannabis (NDSHS). Among student cannabis users, 68% drank alcohol on the same occasion as they used cannabis in the past year (ASSADS).

Heroin users most commonly reported using cannabis (66%) concurrently with heroin on at least one recent occasion, and 39% had consumed alcohol concurrently (NDSHS). Of those who used methamphetamine, 80% also consumed alcohol on the same occasion, while 63% had used cannabis and 53% ecstasy (NDSHS). Among secondary school students, 61% of the students who had used amphetamines consumed alcohol at the same time (ASSADS), and 66% of the students who had used ecstasy consumed alcohol on the same occasion (ASSADS).

Turning to the targeted surveys of existing drug users, people who inject drugs (IDRS sentinel sample) reported using a minimum of three of the following drug classes in the last six months: heroin, methamphetamine, cocaine, cannabis and other opioids.

Based on these data, only a small minority of drug users use a single substance either on one occasion or over time. Trends in the use of one drug are likely to impact on use of other drugs. The most common patterns of polydrug use, from the above results appear to be:

1. Alcohol is used with most illicit drugs
2. Cannabis is used with alcohol
3. Heroin is used with cannabis
4. Methamphetamine is used with alcohol.

This means that trends in cannabis use may influence trends in alcohol use; trends in heroin use may influence cannabis use; and trends in methamphetamine use may influence alcohol use.

Whilst logically true, it does imply a rather simplistic relationship between co-consumption: in economic terms, the relationship is complementary. However, it is also possible that drugs operate as substitutes when the preferred drug is not available – this would mean that instead of an increasing trend in both substances, one increases when the other decreases.

There is a limited economic and behavioural psychology literature on how the price of drugs affects drug use and substitution³ between drug types. Most of this work is from the USA although there is new Australian research on methamphetamine price sensitivity (Chalmers, Bradford, & Jones, 2009, 2010). The existing literature suggests that:

- in Australia, the substitution of heroin with methamphetamine and pharmaceutical opioids occurs (as heroin price increases, drug users purchase less heroin and purchase more methamphetamine) (Chalmers, Bradford, et al., 2009). Cocaine users in Sydney also use heroin (cocaine is a complement for heroin: both increase together) (Chalmers, Bradford, et al., 2009). Methamphetamine users in Australia substitute methamphetamine with cocaine, heroin and pharmaceutical opioids (i.e. as methamphetamine price increases, people purchase less methamphetamine and more of these other drugs) (Chalmers, Bradford, et al., 2009);
- in the USA alcohol was a complement for illicit drugs (Pacula, 1998; Saffer & Chaloupka, 1999);
- in the USA cocaine was a complement for heroin at relatively low heroin prices but became a substitute at relatively high heroin prices (Petry & Bickel, 1998);
- in the USA cocaine, alcohol and cannabis were complements for heroin and benzodiazepines substituted for heroin (Jofre-Bonet & Petry, 2008);
- cocaine was complementary to heroin and alcohol, and substituted with cannabis and valium in USA samples (Jofre-Bonet & Petry, 2008); and
- in the UK alcohol was a substitute for methamphetamine (Sumnall, Tyler, Wagstaff, & Cole, 2004).

However, the above research does not necessarily take into account the actual size of the cross-price elasticity – that is while some drugs are listed as complements and substitutes the effects may be small. In addition the translation of research from the USA may not be fully applicable in Australia. There is also a difference between short-run and long-run elasticities. Another aspect of substitution is to what extent the quantity that is substituted is the same amount as the previous drug consumed. Finally, demographic characteristics of users are highly associated with cross-price elasticity of demand – such that the pattern for dependent users can be different from the pattern for non-dependent, recreational users. As this is an emerging area of research there remain many uncertainties.

Comparisons between drugs

There has been little comparative analysis between drugs. For example, is the probability of arrest the same across all classes of illicit drugs? Is treatment equally dispersed across all drugs? Unfortunately due to limitations with the data such analyses can only be tenuous. With great caution, we provide some comparisons in Table 5 (noting that there is insufficient data on cocaine).

³Substitutes = two drugs are used instead of each other, which means that from a policy point of view, decreases in one drug will result in increases in another.

Complements = two drugs used together/in association with each other – policy implication is that increases in one will result in increases in another.

Firstly we compare the average price per dose. Defining a ‘dose’ of an illegal substance is difficult in and of itself, without then endeavouring to compare doses between drugs (i.e. comparing a cannabis ‘cone’ with a ‘cap’ of heroin and ‘point’ of methamphetamine). We provide some preliminary estimates: for cannabis, the average price per dose is around \$10.00 to \$20.00 (per 6 cones); for heroin it is \$50.00 (per cap) almost identical to methamphetamine (at \$50.00 per ‘point’). Ecstasy is \$30.00 per pill. More research and analysis is required to take these preliminary comparisons on price per dose any further.

How does the likelihood of arrest differ between the illicit drugs? We estimated the probability of a consumer being arrested for each drug, based on the numbers of people in the National Drug Strategy Household Survey reporting last month and last year use, compared to the numbers of consumer arrests per annum (see Table 5). Using this simplistic formula, for rates of monthly users, the probability of a cannabis consumer being arrested is 1 in 19.6. This is lower than for heroin (at 1 in 14). For methamphetamine and ecstasy users, the likelihood is lowest at 1 arrest for every 34.5 users (arrest data do not distinguish between methamphetamine and ecstasy arrests). If one uses the estimates of numbers of people who used cannabis or heroin at least once in the last year (rather than used in the last month), the rate for cannabis arrest is 1 in every 34.8 users; the rate for heroin is remarkably similar at 1 arrest for every 35.6 users. Again, for methamphetamine and ecstasy users combined, the rate of arrest is much lower at 1 in every 86.4 users.

The ratio of consumer (user) to provider (seller) arrests is also of interest. For every 1 provider arrested in Australia, there are 6 cannabis users arrested; 2.4 heroin users arrested; and 2.6 methamphetamine or ecstasy users arrested. Again, we caution against drawing firm conclusions from these data. Nonetheless, it appears that cannabis users are arrested at a greater frequency than cannabis providers, relative to all other drugs.

The extent to which the population of drug users access drug treatment does vary between the drug classes. Estimating the proportion of dependent users in treatment at any one point in time reveals that heroin users are more likely to be in treatment (approximately 50% in treatment at any one point in time) compared to cannabis users (approximately 5%) and methamphetamine users (approximately 20%). This is consistent with the widespread availability of opioid pharmacotherapy maintenance programs across Australia.

Unsurprisingly, there are vast differences in the rate of mortality between drugs, with cannabis and ecstasy having no known mortality, and heroin the highest level of mortality (at 32.5 deaths per million persons). Hospital admissions also appear to vary by drug type. According to the hospital admissions data (principal diagnosis), heroin has the highest number of hospital admissions followed by methamphetamine.

Table 5: Tentative comparisons between drugs on price per dose, arrest rates, treatment rates, mortality, and hospital admissions

| | Average price per dose (Black, Dunn, et al., 2008; Black, Roxburgh, et al., 2008) | Probability of consumer arrest (Last month use in the NDSHS/# consumer arrests) (last yr use in NDSHS/# consumer arrests) (Australian Crime Commission, 2009; Australian Institute of Health and Welfare, 2008a) | Ratio of consumer to provider arrests (Australian Crime Commission, 2009) | % in treatment at any one point in time – treatment penetration (see also section 5) (Australian Institute of Health and Welfare, 2008a, 2009a) | Mortality rate (per million persons) (Degenhardt & Roxburgh, 2007a, 2007b) | Hospital admissions (no. of principal diagnosis 2003/04) (Roxburgh & Degenhardt, 2006) |
|------------------|--|---|--|--|---|---|
| Cannabis | Between \$10 and \$20 (1 gram=\$20) ¹ | Last month users: 1 in 19.6 Last year users: 1 in 34.8 | 44,860:7,460 For every 6 consumer arrests there is 1 provider arrest | 31,864 episodes, 603,700 weekly users: =5.3% | Not available | 1,254 |
| Heroin | \$50 per 'cap' | Last month users: 1 in 14 Last year users: 1 in 35.6 | 1,599:676 For every 2.4 consumer arrests there is 1 provider arrest | 50% (modelling estimate Chalmers et al 2009) | 32.5 | 5,015 |
| Meth/amph | \$50 per 'point' | Includes ecstasy Last month users: 1 in 34.5 Last year users: 1 in 86.4 | 11,608:4,399 (includes ecstasy) For every 2.6 consumer arrests there is 1 provider arrest | 16,588 episodes; 81,600 used in last week =20% | 5.9 | 2,066 |
| Ecstasy | \$30 per pill | Included in Meth/amph arrests | Included in Meth/amph arrests | zero | Not available | Not available |

Notes

¹ One standard cannabis unit has been defined as ¼ gram (NCPIC website). One cone (most commonly used form) is 1/3 of a standard cannabis unit. Given an average of 6 cones, this represents 2 standard cannabis units, which is 0.5 grams.

3.4 Comparison with global trends

Most Western nations have had illicit drug issues comparable to those of Australia in the last quarter century. For example, cannabis experimentation is almost a normative element of adolescence in Western Europe and North America, while many of the same countries have had serious epidemics of heroin use that have left small populations experiencing significant harms. These countries have also responded in ways that are broadly similar to Australia's drug policy, with many arrests for drug use and a substantial effort to provide treatment for those who are dependent.

Thus it should be possible to learn from the experiences of other countries as to how well Australia is doing in tackling its drug problems. For example, the rise in treatment seeking by cannabis users in Australia over the last decade is paralleled in many other countries over almost the same period. Thus the factors explaining the rise are unlikely to be Australia-specific.

This section of the report offers a number of key comparisons. The comparison countries were chosen on the basis of data availability, similarity to Australia and variation in drug policy. Where available, the four Anglo countries Canada, New Zealand, UK and USA are included for comparison along with Austria, Netherlands, Sweden, Switzerland, Germany and France.

The reader should be warned that cross-national comparisons, fraught in almost any field, are particularly difficult with respect to illicit drugs. For example, in estimating the percentage of the population using drugs, most Western nations rely on a population survey, such as the Australian National Drug Strategy Household Survey. However these surveys differ in the age range covered (12+ years in the United States and Australia, 15-64 years in Germany), the method of data collection (in-person interview in the United States, drop and collect and computer assisted phone interview in Australia) and the period covered by the questions. These can all lead to substantial differences in terms of the population estimates; for example, in-person interviews produce higher prevalence estimates than do phone interviews (Gfroerer & Highes, 1991). Similarly, outcome measures can be defined differently. For example, some countries measure the number of people arrested, while others measure the number of arrest events or even number of drug offences charged at all arrests.

Thus the comparisons offered here are quite rough. They are meant to be indicative rather than probative. They are nonetheless informative.

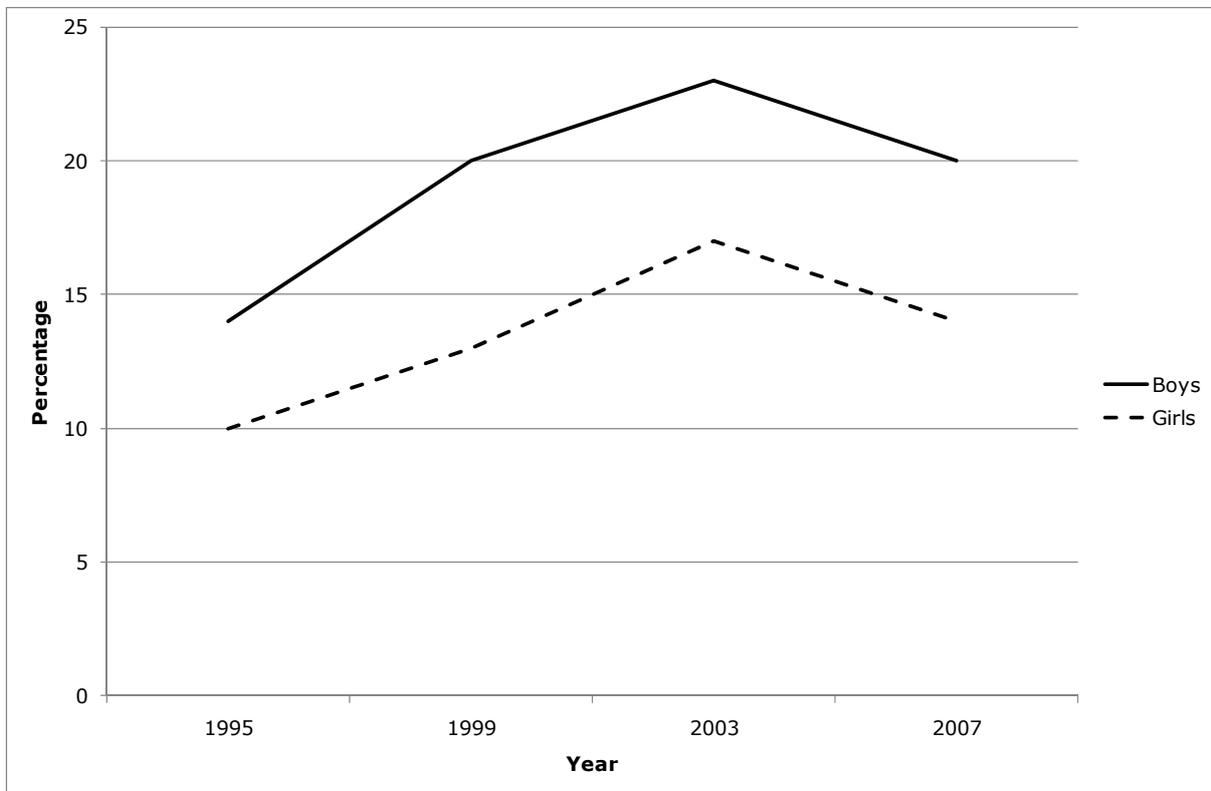
Recent use

1) Trends over time

Australia, Canada, the UK and the USA have all experienced an overall decline in cannabis use since the late 1990's (Reuter & Trautmann, 2009). Similarly the EMCDDA report that cannabis prevalence has been stabilising or even decreasing in some EU countries since the early 2000's (European Monitoring Centre for Drugs and Drug Addiction, 2008).

Most striking perhaps is that these declining trends appear to be most pronounced in younger school-age groups. As reported earlier (see Table 3), recent cannabis use among Australian school students has halved since 1996 and similarly European trends indicate stable or decreasing cannabis use among 15-year-old school students in most EU countries since the early 2000's (see Figure 1) (European Monitoring Centre for Drugs and Drug Addiction, 2008; Hibell, et al., 2009).

Figure 1: Lifetime use of cannabis by gender 1995-2007, percentage averages for 20 European countries



Source: Hibell, et al., 2009.

2) Most recent point in time

Even with stable or decreasing trends in cannabis use the prevalence of recent use remains high. Within Europe it has been estimated that on average 7% of all 15 to 64 year olds used cannabis in 2007 (European Monitoring Centre for Drugs and Drug Addiction, 2008), while (as seen in Table 6) standardized data on recent cannabis use among young people across a number of countries ranges from 4.8% in Sweden to 26.0% in Australia (Reuter & Trautmann, 2009). Notably, Australia has one of the highest rates of recent cannabis use in the world within this age group.

Table 6: Prevalence of past year and lifetime cannabis use, among younger age groups ca. 2004 from various national household surveys

| Country (age range) | Lifetime | Last Year |
|------------------------------|-----------------|------------------|
| Australia (20-29) | 54.5% | 26.0% |
| Austria (15-34) | 28.0% | 12.1% |
| Canada (25-34) | 56.8% | 18.0% |
| France (15-43) | 43.6% | 16.7% |
| Germany (18-34) ¹ | 36.1% | 14.6% |
| Netherlands (15-34) | 32.3% | 9.5% |
| New Zealand (25-34) | 62.0% | 18.0% |
| Sweden (15-34) | 19.1% | 4.8% |
| Switzerland (13-29) | 46.1% | 13.3% |
| UK (15-34) | 41.4% | 16.3% |
| USA (26-34) | 56.7% | 19.9% |

¹ 2003

Source: Australian Institute of Health and Welfare, 2005; Bundesamt für Gesundheit (BAG), 2008; European Monitoring Centre for Drugs and Drug Addiction, 2009; Reuter & Trautmann, 2009.

Fatal opioid overdose

Opioids, predominantly heroin and its metabolites are present in the majority of fatal drug overdoses reported in Australia and the EU and have risen substantially since the early 1990's (Darke, Degenhardt, & Mattick, 2007; European Monitoring Centre for Drugs and Drug Addiction, 2008). More recently however trends in fatal opioid overdoses have varied across the EU with many countries reporting declining trends while others have reported increases. For example, fatal opioid deaths peaked during the 1990's in Germany and the UK, and during the 2000's in Sweden, and are now in decline, while in the Netherlands the trend has continued to increase without an indication of a peak. In Australia, opioid related deaths have remained lower than in the late 1990's and have remained stable since 2003 (Degenhardt & Roxburgh, 2007b).

Treatment

Across the EU drug treatment services have traditionally been tailored towards opioid users with many treatment services directed toward pharmacotherapy. In some countries this has resulted in a large number of clients in pharmacotherapy maintenance, with estimates suggesting that Australia, the Netherlands and the UK have half of the opioid dependent population in opioid pharmacotherapy maintenance (Reuter & Trautmann, 2009). This however may not be the norm with estimates for Sweden and the USA suggesting less than 25% of the opioid dependent population is in opioid pharmacotherapy maintenance (Reuter & Trautmann, 2009).

Table 7: Percentage of illicit drug treatment episodes for cannabis versus opiates as primary drug of concern

| | Cannabis | Opiates |
|-------------|-----------------|------------------|
| Australia | 41% | 22% ¹ |
| Austria | 21% | 66% |
| Canada | 31% | 16% |
| France | 37% | 49% |
| Germany | 30% | 50% |
| Netherlands | 21% | 43% |
| New Zealand | 53% | 31% |
| Sweden | 20% | 28% |
| Switzerland | 14% | 44% |
| UK | 13% | 69% |
| USA | 27% | 30% |

¹ This accounts for only 36% of all opioid treatment in Australia as it does not include pharmacotherapy treatment in non-specialist primary care settings (Australian Institute of Health and Welfare, 2009b).
Source: United Nations Office on Drugs and Crime, 2009.

These data (Table 7) suggest that Australia has one of the highest cannabis treatment rates in the world. For opiates, the data are not comparable due to the absence of most pharmacotherapy maintenance treatment from the Australian drug treatment data.

The United Nations Office on Drugs and Crime (2009) provides data on the amount of drug treatment provided across countries. The results are provided in Table 8.

Table 8: Per capita treatment provided (includes cannabis, opiates, cocaine, amphetamine, ecstasy, hallucinogens, hypnotics, sedatives, inhalants)

| | # Treatment provided¹ | 2006 population² | Treatment rate per 1,000 people |
|-------------|---|------------------------------------|--|
| Australia | 78,545 | 20,600,000 | 3.8 |
| Austria | 5,603 | 8,300,000 | 0.7 |
| Canada | 66,062 | 32,600,000 | 2.0 |
| France | 79,600 | 61,200,000 | 1.3 |
| Germany | 42,638 | 82,400,000 | 0.5 |
| Netherlands | 30,766 | 16,400,000 | 1.9 |
| New Zealand | 20,000 | 4,100,000 | 4.9 |
| Sweden | 6,962 | 9,100,000 | 0.8 |
| Switzerland | 20,000 | 7,500,000 | 2.7 |
| UK | 195,464 | 60,500,000 | 3.2 |
| USA | 1,406,000 | 299,100,000 | 4.7 |

¹ May reflect number of persons treated or number of treatment episodes.

² Population Reference Bureau, 2006.

Source: United Nations Office on Drugs and Crime, 2009.

Australia appears to have a treatment rate just below that of the USA – when compared in per capita terms (above table), but the Australian figures do not include opioid pharmacotherapy maintenance provided in primary health settings.

Law enforcement (number of arrests)

1) Arrests, broken down by possession and supply

As is the case in Australia, the EMCDDA report that the number of arrests attributable to drug use and possession is higher than the number of arrests attributable to supply (dealing, trafficking production) and that both types of arrests are increasing (see Table 5 for the Australian ratio of drug use to drug supply arrests). A notable exception to this is the Netherlands where supply related arrests predominate (European Monitoring Centre for Drugs and Drug Addiction, 2008), probably reflecting the small number of cannabis possession arrests in that country.

United Nations Office on Drugs and Crime (2009) also provide an estimate of the rate of ‘drug-related crime/possession/abuse’⁴ offences per ‘drug trafficking’ offences. The lowest rate is in the Netherlands; the highest rate in Switzerland (that is the highest number of drug crime offences relative to trafficking offences). Australia sits in the middle of the range, and perhaps surprisingly it is not dissimilar to the USA.

2) Cannabis arrest rates

As noted earlier the majority of arrests for drug offences in Australia are against cannabis consumers, however this is not reflected in a high individual risk of arrest due to the large numbers of individuals consuming. Below (Table 9) are cannabis arrest rates across the EU, the USA and Australia and what is noteworthy is the relative similarity of the rates of arrests (with the exception of the Netherlands) across countries that vary in law enforcement policy.

Table 9: Cannabis arrest rates for eight nations around 2005

| | per 100,000 population | per 1,000 users¹ |
|--------------------------|-------------------------------|------------------------------------|
| Australia | 276 | 24 |
| Austria | 333 | 44 |
| France | 225 | 26 |
| Germany | 237 | 34 |
| Netherlands | 19 | 3 |
| Switzerland ² | 650 | 140 |
| UK | 206 | 20 |
| USA | 269 | 31 |

¹ Users: estimated number of past year users from most current household survey.

² Reuter (2009) notes that the estimated total cannabis user population appears to be a substantial underestimate.

Source: Room, Fischer, Hall, Lenton, & Reuter, 2010.

Injecting drug use and HIV among people who inject drugs

Estimating the prevalence of both heroin use and HIV are fraught with challenges. However, in a recent review by Mathers et al. (2008) involving a systematic evaluation of peer reviewed

⁴ The UNODC supplied definition of the data under drug-related crime/possession/abuse appears to exclude trafficking offences, but the definition is somewhat subjective, and depends on the individual country's own data systems. See World Drug Report (2009), p. 286. The intention is to separate out possession and use offences from large scale trafficking offences, with lower level supply offences more likely to be recorded in the drug crime category than in the trafficking category.

research, grey literature, data from UN agencies and key experts, light has been shed on this global health challenge (see Table 10). Key results from the Mathers review indicate that there are approximately 11 to 21 million individuals who inject drugs worldwide with a tenuous estimate that between 1 and 7 million of these are living with HIV. This population of injecting drug users with HIV are estimated to be spread across 120 countries with the areas of Asia, Eastern Europe and Latin America of particular concern.

Table 10: Prevalence of HIV among people who inject drugs (%)

| | Low | Mid | Upper | Estimate Type | Year of IDU estimate | Year of HIV estimate |
|-------------|------------|------------|--------------|----------------------|-----------------------------|-----------------------------|
| Australia | | 1.5 | | A | 2005 | 2006 |
| Austria | | 7.5 | | A | 2000 | 2006 |
| Canada | 2.9 | 13.4 | 23.8 | B/A | 2004 | 2005 |
| France | | 12.2 | | A | 1999 | 2003 |
| Germany | | 2.9 | | A | 2005 | 2006 |
| Netherlands | | 9.5 | | A/B | 2001 | 2002 |
| New Zealand | | 1.6 | | B | 2006 | 2006 |
| Sweden | | 5.4 | | A | - | 2007 |
| Switzerland | | 1.4 | | A | 1997 | 2004 |
| UK | 0.6 | 2.3 | 4.0 | A | 2005 | 2006 |
| USA | 8.7 | 15.6 | 22.4 | A | 2002 | 2003 |

A = 'indirect prevalence estimation' of injecting drug use AND 'multi site seroprevalence study with at least two sample types' for HIV prevalence.

B = 'general population survey' to determine injecting drug use AND 'seroprevalence study from single sample' for HIV prevalence.

Source: adapted from Mathers, et al., 2008.

4. GOVERNMENT ACTION ON DRUGS

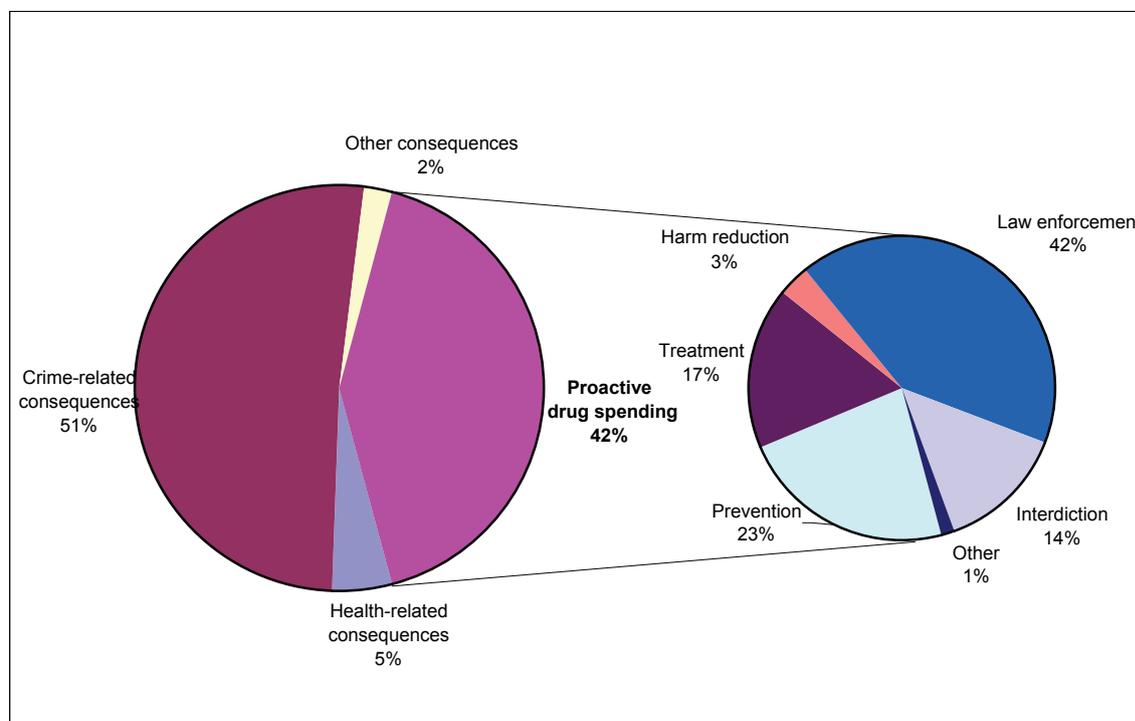
A snapshot of highlighted key events in Australian drug policy from 1985 to 2010 is given in Appendix C. It is an edited version of the Australian (illicit) drug policy timeline (Hughes, 2011) which can be found at:

<http://www.dpmp.unsw.edu.au/dpmpweb.nsf/page/Drug+Policy+Timeline>.

Following the change of government in 2007⁵, the Rudd government encouraged new thinking and planning for Australia's future across a broad range of social topics. However, there has been relatively little attention paid to illicit drug policy and little has been said that could be construed as a comprehensive policy statement on illicit drugs. In fact it seems that the Rudd and Gillard governments have adopted the 'Tough on Drugs' approach introduced under the preceding Howard government. This 'Tough on Drugs' rhetoric was in reality a pragmatic support for a harm minimisation approach, which the subsequent Rudd and Gillard governments have seemingly maintained.

That said the majority of drug-related government spending in Australia is destined for law enforcement. In estimates by Moore (2008), \$1.3 billion was spent on 'proactive' policies and \$1.9 billion spent 'reactively' (see Figure 2). Of the proactive expenditure, the largest amount is spent on law enforcement (55%), followed by prevention (23%), treatment (17%), harm reduction (3%) and other (1%). These estimates are subject to substantial uncertainty, as demonstrated in Table 11, which details the ranges from the sensitivity analyses.

Figure 2: Summary of government spending 2002/03.



Source: Moore, 2005.

⁵ The 2007 federal election was significant in Australia's recent political history. The centre-right Coalition government, led by Prime Minister John Howard, had been in government since 1996. In 2007 the Howard government was defeated by the centre-left Australian Labor Party, led by Kevin Rudd. In 2010, the then Deputy Leader Julia Gillard became Prime Minister.

Table 11: Estimates of government direct spending, sensitivity ranges

| Area | Main estimate | Sensitivity analysis |
|-----------------|----------------------|-----------------------------|
| Law enforcement | \$740.4m | \$581 to 1058m |
| Prevention | \$304.0m | \$88 to 593m |
| Treatment | \$229.2m | \$204 to 281m |
| Harm reduction | \$44.8m | \$45 to 71m |

Source: Moore, 2008.

The following section provides descriptive details of Australian drug policy as implemented through the four pillars of prevention, treatment, harm reduction and law enforcement. Current issues within each of these pillars are discussed.

Prevention

Prevention strategies in Australia are focussed on reducing initiation into drug use and impeding the development of problematic drug use⁶. Estimates on government spending by Moore et al. (2005) estimate Federal expenditure in 2002/03 to be \$303.9 million with state and territory government spending \$246.5 million of this. Most of this spending was on primary prevention strategies, with school based drug education programs receiving \$56.3 million in federal funding and \$207.09 million in state and territory funding. The remaining funds went to general drug prevention activities.

There has been a focus on prevention, as highlighted by the commissioning of a comprehensive review of prevention activities (Loxley, et al., 2004). Prevention in Australia has also focussed on strengthening communities, working with local governments to build resilient communities and research on risk and protective factors. For example, the government identified funds to spend on building stronger communities (Community Partnership Fund). Money was allocated to local community initiatives.

The role of mass media campaigns is often contentious. While the research evidence is not particularly strong (Palmgreen & Donohew, 2003), they remain a favoured policy response by governments wanting to be seen to be responsive. Issues include the extent to which mass media campaigns are built upon factual information, and do not lead to further marginalisation and stigmatisation of drug users (Drug Policy Modelling Program, 2009). Australia does not have a comprehensive National Prevention Strategy. This is surprising given the preponderance of other national strategies (see Appendix A, Box C: Overdosing on Strategic documents?).

Other current issues for prevention include the need for a clearer conceptual framework: the definition and scope of prevention requires clarification. For example, the prevention monograph noted above (Loxley, et al., 2004) took a very broad definition of prevention, and included prevention of harm thus covering harm reduction activities as well as policing activities. Such a broad definition of prevention may reduce the focus and investment in those prevention activities concerned with preventing the commencement of drug use.

Prevention also needs a stronger evidence-base, especially when compared to that which exists for drug treatment. Greater research into the efficacy, effectiveness and returns on investment (cost-benefits, cost-effectiveness) of different types of prevention programs would be laudable.

⁶ Some definitions of prevention include preventing harms in existing, dependent drug users (e.g. Loxley, et al., 2004). Here we take the more common definition of prevention as preventing use.

Finally, it would be exciting to see some new prevention interventions (Drug Policy Modelling Program, 2009; Ritter, 2007).

Treatment

Treatment services are provided by both government health services and non-government organisations. The coordination of treatment agencies across Australia is the responsibility of the Federal government as well as state and territory health authorities. In 2006-07 there were approximately 630 publically funded government and non-government agencies that provide one or more specialist alcohol and/or other drug treatment service (excluding opioid pharmacotherapy)(Australian Institute of Health and Welfare, 2008a). Government spending on treatment activities was estimated to be \$229.9 million, with the federal government spending \$65.0 million and the state and territory governments spending \$164.2 million (Moore, 2005).

In 2006/07, 633 government-funded alcohol and other drug treatment agencies from across Australia reported data to the AODTS–NMDS collection. There were 147,325 closed treatment episodes reported for that year. The types of treatment services available in Australia include withdrawal management (detoxification), counselling, rehabilitation, support and case management, information and education only and assessment only.

Table 12 provides the details of the types of treatment received for illicit drug problems.

Table 12: Types of illicit drug treatment provided in Australia (excluding opioid substitution treatment), 2006/07

| | Episodes of care | Percentage of all episodes |
|-----------------------------|-------------------------|-----------------------------------|
| Withdrawal | 24,467 | 16.6 |
| Counselling | 57,017 | 38.7 |
| Rehabilitation | 10,950 | 7.4 |
| Support and case management | 12,290 | 8.3 |
| Information/education only | 13,723 | 9.3 |
| Assessment only | 22,295 | 15.1 |
| Other | 6,583 | 4.5 |

Source: see Table A3.19 Australian Institute of Health and Welfare, 2008b, p. 83.

In terms of drug type presentations (excluding heroin treatment provided in primary care settings, which predominates), most treatment for illicit drugs is provided to people presenting with cannabis problems (39.5%), followed by methamphetamine (21%), opioids (18.4%) and then small numbers of ecstasy and cocaine (Australian Institute of Health and Welfare, 2008b).

Pharmacotherapy maintenance is a major form of treatment provided in every jurisdiction in Australia for opioid dependence. The majority of patients are prescribed methadone (72%) and the remaining buprenorphine (28%) (Australian Institute of Health and Welfare, 2008c). Pharmacotherapy maintenance treatment is largely provided in primary health care settings through GP prescribers and community pharmacies. For this reason it is not captured in the usual drug treatment data sets such as the NMDS. There were approximately 39,000 clients being treated with pharmacotherapy for their dependence on opioid drugs in 2006/07 (Australian Institute of Health and Welfare, 2008c).

One central current issue is the structures of and funding base for drug treatment services in Australia. The increase in non-government service provision, which now accounts for the bulk of services (and the NGO providers bear the risk), has given rise to concerns about quality assurance, funding formulae and benchmarks in relation to purchasing services. There is also some lack of clarity about the role of the Commonwealth vis-à-vis the states in funding services. Up until about 10 years ago, the states/territories funded drug treatment services; however under the Howard government direct federal funding became available (through competitive tendering) resulting in perceptions of less coordination and strategic service planning at the state level. The relative merits of NGO versus government sector service provision, including corporate and clinical governance, client outcomes, professional clinical qualifications and the potential downstream implications of a continued competitive tendering approach are all topics of high salience at present. Connected to these issues are questions about the respective role of a specialist versus generalist service system and the extent to which drug treatment should be embedded within usual health services as opposed to provided in specialist settings (Ritter, 2007; Ritter, et al., 2003; Spooner & Dadich, 2008).

Treatment for methamphetamine dependence is also a 'hot topic'. Despite a number of amphetamine-type stimulant initiatives by federal and state governments, we lack a range of efficacious treatment options. A pharmacotherapy option would be ideal, but aside from pharmacological research, it also requires considerable thinking about the treatment model (daily dispensing of a short-acting drug is less likely to be efficacious). At this stage, psychological therapies appear to be best (Baker & Lee, 2003; Baker, Lee, & Jenner, 2004; Grabowski, Shearer, Merrill, & Negus, 2004; Klee, Wright, Carnwaith, & Merrill, 2001; Shearer & Gowing, 2004).

Some of the other current issues regarding the provision of drug treatment in Australia include:

- the relationships between mental health services and drug treatment services;
- continuity of care;
- the need for Australian treatment research, including evaluation of treatment models in practice, and return on investment studies on usual care;
- pharmacotherapies research, especially regarding service models and patient copayments;
- treatment seeking processes, treatment access, clinical guidelines;
- patient payments for treatment; and
- the need for new treatment options for amphetamine-type stimulants, including pharmacotherapies.

(Drug Policy Modelling Program, 2009; Ritter, 2007).

Harm Reduction

Harm reduction, defined as reducing the harms associated with drug use without necessarily reducing consumption per se, has been an important part of the National Drug Strategy since 1985. The needle syringe program is the noteworthy example. Needle syringe programs (NSP) operate throughout Australia, providing clean injecting equipment as well as the opportunity for safer use interventions. Australian programs do not require 'exchange' of dirty needles to receive clean ones. Needle syringe programs come in a number of forms: those associated with drug treatment services, those in outreach settings, vending machines and the supervised injecting centre.

Other Australian harm reduction programs include:

- the medically supervised injecting centre at Kings Cross, Sydney;
- outreach and education and information services;

- brief interventions (aimed at harm reduction not use reduction); and
- overdose prevention interventions.

Despite this, the actual investment in harm reduction is very small (\$44.8 million). This is partly due to the fact that harm reduction interventions in general are inexpensive, especially when compared to treatment or law enforcement.

Australia has also had a substantial investment in ‘diversion’ – that is diverting people detected for drug use and possession offences away from the criminal justice system and into education and treatment. The Illicit Drug Diversion Initiative (Council Of Australian Governments, 1999) was an initiative of the Federal government and resulted in significant investment in diversion by the Federal government (\$110 million in stage 1 and \$215 million in stage 2) (Hughes, 2011).

To date, diversion programs have been adopted by all states and territories (3-12 programs in each) and at multiple stages of the criminal justice system (police and court). In total by late 2007, 52 diversion programs were in operation, with the majority of these being police diversion for cannabis possession (Hughes & Ritter, 2008). Other police diversion programs involve diversion for the use or possession of other illicit drugs (amphetamines, cocaine, ecstasy or heroin) and for youth offenders. Two types of court diversion predominate, the first is where minor offenders with a recognisable drug problem can be diverted to treatment in lieu of sentencing and the second where drug dependent offenders are diverted into an intensive treatments as a final opportunity to avoid imprisonment (Hughes & Ritter, 2008).

The key issues in relation to diversion in Australia concern net-widening and the silting up of drug treatment places. In relation to the former, there is a concern, demonstrated in evaluations that diversion programs can actually engage more people in the criminal justice system who would otherwise not have had contact (Roberts & Indermaur, 2006). This widening of the net of people occurs through the absence of discretion by police and/or greater police responsiveness because diversion is perceived as a good option; and because of the high likelihood that offenders will not meet their treatment conditions (i.e. breach) and then be subject to criminal justice interventions anyway. The second concern, regarding treatment places being less available for ‘voluntary’ clients, is noted to have occurred (Hughes & Ritter, 2008). However it should be pointed out that ‘voluntariness’ does not predict treatment outcome (Bull, 2003; Payne, Kwiatkowski, & Wundersitz, 2008) – that is the clients referred from the criminal justice system are likely to have the same outcomes as voluntary clients and in that sense, resources are not wasted.

Law Enforcement

Although Australia has ‘led the way’ in its harm minimisation approach, the majority of government spending is directed towards proactive law enforcement activities. Moore (2005) estimates that government spending in this area is in the region of \$740.4 million per annum.

Australia's drug law enforcement is the product of many organisations and a range of activities from general duty policing through to state and federal action. Law enforcement activities include:

- source country control (driven by the Australian Federal Police);
- interdiction (Customs Services);
- clandestine laboratory detections (primarily state police);
- disrupting distribution networks across Australia (state police);

- local policing (state police); and
- third party policing (e.g. Project STOP, partnership between police and pharmacies).

One central issue that is raised frequently regarding law enforcement is the need for more research into effectiveness, impact and unintended consequences (Drug Policy Modelling Program, 2009; Ritter, 2007). Other issues identified regarding law enforcement include:

- the need for better strategies for reducing drug-related crime;
- sustainable policing solutions that reduce displacement of the problem to other areas/locations; and
- increasing the options available to police to respond to immediate crises (including intoxicated and violent people), road safety, and public order issues (Drug Policy Modelling Program, 2009; Ritter, 2007).

5. ANALYSING THE AUSTRALIAN DRUG POLICY LANDSCAPE

We do not know what drives demand for drugs and how this varies over time. Drug policy is but one of many factors influencing drug use, which makes the task of assessing the effects of policy strategy complex (Boyum & Reuter, 2005). Furthermore, as we have demonstrated (Section 3, cannabis use), there is little research which can account for changing prevalence of drug use. In the absence of a strong research foundation, drug policy choices can continue to be driven by ‘images and beliefs’ (Boyum & Reuter, 2005). These ‘images and beliefs’ are formed and maintained through competing ‘voices’ within the drug policy landscape, which is the focus of our attention here. We focus particularly on the roles played by the research community, the state, the third sector, international regulatory bodies, as well as the general public. These five ‘voices’ form what Sabatier (1988) refers to as the policy subsystem, including public and private organisations and individuals actively concerned with drug policy issues, as well as governmental institutions.

In the following section we use this framework to raise and discuss some of the issues and challenges around drug policy in Australia. We examine to what extent the actors, stakeholders and mix of ‘voices’ in the Australian drug policy arena contribute to and affect the formation, development and implementation of effective drug policy, and assess barriers that may prevent more active participation in those processes. In doing so, we consider the ways that advocacy coalitions have translated their beliefs and agendas into policy impact over time, as well as possible future impact.

Research community – the pursuit of evidence-informed policy

As noted previously, Australia has had a long track record in providing high quality research and evaluation to inform policy. Indeed, it appears that Australia is ‘punching above its weight’ in relation to research publications (see Appendix D). The commitment by federal governments to sustained research endeavour through the three national research centres is also notable. The National Drug and Alcohol Research Centre (NDARC) based at the University of New South Wales in Sydney conducts multidisciplinary work aimed at increasing the effectiveness of Australian and international treatment and other intervention responses to alcohol and other drug-related harm. The National Drug Research Institute (NDRI) is part of Curtin University in Perth and has a particular focus on the prevention of harmful drug use. The National Centre for Education and Training on Addiction (NCETA) is located within Flinders University in Adelaide and contributes nationally to the development of a skilled, sustainable workforce and the capacity of diverse organizations to manage issues related to alcohol and other drugs.

Hall’s (2008) analysis of the contribution of research to the development of cannabis policy provides one example of how research evidence has been used in an Australian context. Hall (2008, p. 716) argues that ‘research contributes to policy debate by: clarifying factual issues where relevant; identifying options for intervention; evaluating the effects of current policies; and changing conceptual understandings of the problems that policy is designed to address.’ But, crucially, he goes on to note that ‘in policy debates the interpretation of evidence is often contested and research used selectively by different advocacy coalitions to support competing policies’. In this way, although high quality research is being produced in Australia, utilisation is limited by choice of policy options and competing agendas: the production and dissemination of research does not inevitably lead to evidence-informed policy.

The questions that arise therefore are: to what extent is research being utilised to inform drug policy in Australia; to what extent is policy strategy reflective of this evidence; and what are the barriers to research utilisation? We use these questions to explore the role the research community plays in the drug policy arena.

Firstly, we examine the extent to which the most common and well-funded Australian policy interventions are founded on research evidence. This is examined in relation to each ‘pillar’ (for a description of interventions by the four pillars, see Appendix E).

Prevention

Within the prevention pillar, Australian governments have primarily invested in school-based drug education and mass media campaigns. To a lesser extent there has been some focus on strengthening communities through encouraging resilience and protective factors. In relation to the last, while these programs have not been rolled out systematically Australia-wide, they are the ones with the highest level of positive research evidence. Research on the effectiveness of mass media campaigns demonstrates that they have very limited dissuasion powers (Palmgreen & Donohew, 2003). The evidence-base for the effectiveness of school drug education programs is variable. There is little support for the didactic, scare-based education programs, but greater support for the skills-based programs (Skager, 2007). However, we could not readily source information about the kinds of school-based drug education programs that are offered in Australia, aside from noting that ‘Life Education’, a program with limited and even negative results is still widely available (Hawthorne, Garrard, & Dunt, 1992).

Law enforcement

An analysis of the relationship between research evidence and policy choices for law enforcement is fraught – mainly because the research evidence is so limited. Mazerolle’s review of drug law enforcement (Mazerolle, Soole, & Rombouts, 2006, 2007) examined international/national interventions (such as interdiction), reactive policing (raids, crackdowns), proactive partnerships policing (including third party policing, problem-oriented policing, community policing), and individualised interventions (such as diversion). In the qualitative review (Mazerolle, et al., 2007) they were not able to directly compare all the levels of intervention, and noted the poor quality and limited nature of the existing research. In the quantitative review, which compared reactive with proactive policing they reported superior effects for the latter (Mazerolle, et al., 2006).

There is insufficient information about Australian drug law enforcement to match it against the (limited) evidence-base. It would appear that policing that is focussed on proactive strategies and in partnership with third parties is the most strongly supported by research but we do not know the extent to which Australian law enforcement agencies preferentially engage in these types of policing over others.

In conclusion it is almost impossible to assess the extent to which Australian law enforcement is evidence-based because the evidence does not exist. For treatment, which we turn to next, the reverse is the case: there is a plethora of high quality treatment research. To what extent do the Australian drug treatment programs conform to the evidence?

Treatment

There is good research evidence for the efficacy and cost-effectiveness for the main forms of drug treatment provided in Australia. For opioid dependence, the most cost-effective treatment is pharmacotherapy maintenance (Cartwright, 2000; Flynn, Kristiansen, Porto, & Hubbard, 1999; Gerstein & Harwood, 1994; Harwood, Hubbard, Collins, & Rachal, 1988; Mattick, Breen,

Kimber, Davoli, & Breen, 2003; Moore, Ritter, & Caulkins, 2007; Prendergast, 2002). This is the most common form of treatment available for opioid dependent people in Australia.

Drug withdrawal, representing 16.6% of Australian episodes of care (see Table 12) is known for its high relapse rate, especially when there is not ongoing counselling, support and relapse prevention. The goals of withdrawal are, therefore, suitably modest, and focussed on neuroadaptation reversal (rather than 'recovery'). The evidence-base for neuroadaptation reversal in relation to opioid dependence is reasonably strong, and demonstrates that medicated withdrawal is superior to unmedicated (placebo) withdrawal and that opioids are effective withdrawal agents (Gowing, Farrell, Ali, & White, 2004; Lintzeris, Bell, Bammer, Jolley, & Rushworth, 2002). In a multi-site, multi-trial comparison of heroin withdrawal options, buprenorphine-based outpatient detoxification was found to be the most cost-effective method overall, and rapid opioid detoxification under sedation was the most cost-effective inpatient method (Shanahan, et al., 2006).

How does this withdrawal/detoxification evidence-base compare to what is provided within Australia? As there is no systematic collection of types of withdrawal methods, it is difficult to draw firm conclusions. However, Australia does provide each of the methods listed above, although withdrawal with opioid agonists is not common (largely driven by the prevailing and correct view that maintenance is superior to withdrawal). In addition, rapid opioid detoxification in in-patient settings is not that common, appearing counter to the evidence cited above.

The evidence base for psychological therapies in the treatment of drug dependence is variable. For drugs such as methamphetamine and cannabis, there is evidence of effectiveness (Denis, Lavie, Fatseas, & Auriacombe, 2006; Knapp, Soares, Farrell, & Silva de Lima, 2007) notably for cognitive behavioural interventions. As noted above, for heroin dependence the preferred treatment is pharmacotherapy maintenance. Counselling services in Australia, like withdrawal services, do not document the preferred modality, but it is likely that the majority of counselling in Australia is based upon a cognitive-behavioural framework. This is consistent with the evidence-base.

Self-help programs are available in Australia but do not form the mainstay of treatment as in some countries (e.g. USA). The evidence-base is difficult to fully establish given the anonymous and confidential nature of the program. However, the existing research does support self-help and 12-step recovery programs as being effective interventions (Humphreys & Moos, 1996; Humphreys & Noke, 1997; Timko, DeBenedetti, & Billow, 2006).

This is not to say that there are some treatments which are provided in Australia that do not conform to the evidence-base. The notable example here is the provision of naltrexone implants for the treatment of opioid dependence. The trials of efficacy and safety have not been conducted, yet a small number of practitioners provide this controversial intervention (Degenhardt, Gibson, Mattick, & Hall, 2008). In addition, there may be some treatments with a strong evidence-base that have yet to become mainstream within Australia. Contingency management is a good example of this (Cameron & Ritter, 2007; Ritter & Cameron, 2007). Finally, there are some gaps in our knowledge about efficacious and cost-effective treatments, notably for methamphetamine dependence. We eagerly await new research.

Overall, the extent to which Australian treatment is largely consistent with the evidence-base for effectiveness appears high.

Harm reduction

Needle syringe programs (NSP) have a very strong evidence-base. Meta-analyses examining changes in risk behaviour have shown positive effect sizes for needle syringe programs (Ksobiech, 2003). Reductions in HIV seroconversion associated with needle syringe programs have been extensively documented (Des Jarlais, et al., 1996; MacDonald, Law, Kaldor, Hales, & Dore, 2003; Monterroso, et al., 2000; Vlahov & Junge, 1998). The cost-effectiveness of needle syringe programs has been amply demonstrated (Commonwealth Department of Health and Ageing, 2002; Holtgrave, Pinkerton, Jones, Lurie, & Vlahov, 1998; Laufer, 2001; Pollack, 2001). The provision of needle syringe programs throughout Australia is consistent with the evidence-base. However, more recent commentators have argued that Australian coverage is inadequate. A recent return on investment report recommended that government consider further expansion of needle syringe programs in all Australian jurisdictions (Wilson, 2009). Evidence suggests that although needle syringe programs have been effective in preventing HIV infection amongst injecting drug users in Australia, saturation in demand has not been met and greater coverage is required to reduce the transmission of HCV (Kwon, Iverson, Maher, Law, & Wilson, 2009). Factors currently limiting more effective coverage include limited availability of late night and weekend facilities, prohibition of peer distribution of clean injecting equipment and limits on the range of injecting equipment freely available through some services (Kwon, et al., 2009). The absence of needle syringe programs in prisons, despite compelling international evidence, has also been described as a 'glaring weak link in Australia's response to blood borne infection control' (Anex, 2010, p. 13).

There is a strong evidence base for other harm reduction strategies which have only been taken up in a limited way in Australia. That Australia has only one medically supervised injecting centre (in Kings Cross, Sydney) is one such example. Despite calls from the Australian research community for their consideration, other evidence based harm reduction measures have yet to be implemented in Australia. Political and legal barriers remain to heroin prescription trials and provision of peer-administered naloxone for example (Bammer & Douglas, 1996; Lenton, Dietze, Degenhardt, Darke, & Butler, 2009; Lenton & Hargreaves, 2000; Wodak, 1997).

Overall, aside from law enforcement, it would appear that Australia's policy interventions are largely grounded in evidence. It was difficult to identify mainstream treatment, prevention and harm reduction policy interventions occurring in Australia that do not have an evidence-base. This is encouraging.

Although individual interventions appear to adhere to the evidence base, we must ask to what extent the choice and mix of policy interventions is 'balanced' to reflect evidence generated by the research community? Although Australia has been described as having a 'balanced' approach, there is little evidence of policy processes in place that consider the issue of balance (Ritter, 2010).

In the case of drug treatment, does Australia provide sufficient drug treatment places to meet demand? The answer to that is most probably no. For example in the case of opioid pharmacotherapy maintenance a recent modelling exercise suggested that there were about as many people who had cycled out of maintenance treatment as could re-enter (Chalmers, Ritter, Heffernan, & McDonnell, 2009). This suggests that we meet about 50% of the potential demand for opioid maintenance treatment. In the case of cannabis, in 2006/2007 there were 31,980 episodes of care provided for cannabis treatment (Australian Institute of Health and Welfare, 2008b). The NDSHS figures for 2007 indicate that of all Australians who reported cannabis use in the last year (1,561,900) approximately 309,200 of those were using at least weekly indicative of

levels of usage likely to require some form of intervention at some point, especially in the context of polydrug use. While this analysis is rough and ‘episodes of care’ may count the same individual twice or three times, it still provides a notional indication of the potential unmet demand for cannabis treatment (30,000 episodes compared to 600,000 weekly users).

These figures suggest that we do not have enough treatment and that a greater investment in drug treatment would be appropriate⁷. This is further supported by the evidence on the cost-benefit of drug treatment (Cartwright, 2000; Flynn, et al., 1999; Gerstein & Harwood, 1994; Goldschmidt, 1976; Harwood, et al., 1988; Moore, et al., 2007; Prendergast, 2002). Drug treatment is a highly effective way of reducing the economic and social burden of illicit drug use – arguably more cost-effective than law enforcement (see Rydell & Everingham, 1994 for comparison of cost-effectiveness of law enforcement vs. treatment).

So the evidence suggests that we do not have enough drug treatment. Do we have enough law enforcement? How would you go about answering that question? As discussed above, the research evidence around drug law enforcement is limited. Indeed, Babor et al. (2010) conclude that the lack of evidence in this area remains a barrier to applying these policies effectively. It is difficult to ascertain whether or not investment in law enforcement is balanced according to an evidence-base in the absence of such reliable research. What the evidence does demonstrate is that, consistent with the overall Australian policy approach, law enforcement should focus its efforts on the dealers and suppliers of illicit drugs, rather than on the users of drugs – who are better managed through education and treatment systems rather than the criminal justice system. One way to assess Australia’s law enforcement efforts then, is to examine the relative balance between arrests for drug use/possess (known as consumer arrests) and arrests of suppliers of drugs (known as provider arrests). As highlighted in section 3.4, consumer arrests far outstrip provider arrests – of all arrests in 2006-07, 81% were of consumers and 19% providers, as is true in all Western countries except the Netherlands.

It is not surprising that the number of consumer arrests is higher than provider arrests given that many more people use drugs than engage in selling, manufacturing or distributing them. Therefore little can be said in itself about the relative proportions of 80:20. However, in terms of trends over time we note that consumer arrests are increasing while at the same time provider arrests have remained relatively stable (for example the Australian Crime Commission’s Illicit Drug Data Reports (2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010) reported an increase from 59,657 consumer arrests in 2002-03 to 67,920 consumer arrests in 2008-09, while provider arrests have fluctuated between 14,407 and 15,715 between 2002-09). However, some caution is required: arrests may not result in sentencing in Australia – indeed the arrestee may be diverted out of the criminal justice system (see Hughes & Ritter, 2008 for discussion). Arrest itself is inexpensive relative to prosecution and incarceration and imposes little harm on most who are arrested.

In relation to the balance of effort regarding prevention and harm reduction, it is very difficult to draw any substantive conclusions based on the evidence available. The monetary investment in harm reduction is very small, however as noted earlier, harm reduction interventions are inexpensive. But, considering the evidence above, it appears that Australia’s drug policy has a

⁷ It is important to note that this assumes that the additional treatment slots are as cost effective as the existing ones. There is no theoretical base for this. For example, the next slot may go to someone who has on average a less severe problem meaning fewer gains from treatment.

leaning towards law enforcement and an under investment in treatment, consistent with the approach of most other countries.

All the above is quite suppositional, and more research that examines the relative investment mix and balance between the drug policy domains is clearly urgently required. This is one area where the research community could certainly play a more active role, and research funding directed more strategically.

As this fraught issue of 'balance' demonstrates, although both researchers and policy makers are committed to improving the use of evidence in policy, there appear to be any number of barriers. One of the inherent barriers is that research findings, especially in the social sciences, are often equivocal, with marginal or uncertain impact. There is a large quantity of research information that is highly specific (for example relating to particular geographical communities, population groups or harms; or clinical research with highly restrictive inclusion criteria such that the more 'usual' client would not meet the intake criteria). The translation of specific hypothesis-testing research into general policy principles is a complex and highly skilled task. Rapid change within the policy environment also means that research can become less relevant than originally anticipated.

From the individual researcher's perspective, one significant barrier is the dissonance between what is rewarded within the academic community and what is valued by policy makers. There are also barriers for some researchers who see their role as knowledge-producing, rather than influencing policy. The contribution towards knowledge is separate from the processes of influencing government. Lastly, the kinds of research evidence that may be most valuable from a policy maker's perspective are not necessarily most valuable from a researcher's perspective.

Barriers are also multiple from the perspective of the policy maker. Policy makers do not necessarily have ready access to research results, in terms of where they are published, the absence of simple summaries and the lack of translation into policy-accessible language. Research does not necessarily address the most pressing questions for policy-makers. The timing of the release of research results does not often take into consideration the policy-makers decision-making cycles (e.g. budget and legislative cycles). Ritter (2009) has examined the sources of research evidence used by Australian policy makers. The positive side is that research is accessed, but disappointingly this access is not systematic and relies heavily on individual experts and 'Google'.

Finally, it is important to once again note the most recent evaluation (Siggins Miller, et al., 2009) of the National Drug Strategy made mention of the fact that Australia still does not have an integrated national drug research strategy. At the time of writing, the draft National Drug Strategy 2010-2015 includes a response to this recommendation through provision for the establishment of a National Drug Research and Data Strategy (Ministerial Council on Drug Strategy, 2010). It is possible that such an integrated approach may overcome some of the existing barriers and provide more avenues for translating evidence into policy and practice.

The State

Illicit drugs have a great symbolic significance in politics (Bertram, Blachman, Sharpe, & Andreas, 1996). However unlike in many countries where ideology and populism have often determined the views of individual elected representatives, party discipline has been a crucial factor in allowing Australia to pursue its harm minimisation approach as representatives need to be seen to publicly adhere to the party's agenda (Makkai, 2000). That said it is difficult to ascertain the

stance of current federal politicians to illicit drug issues, and therefore how this political ‘voice’ is impacting upon drug policy.

A limited number of issues can remain salient and at the forefront of the political agenda at any given time, and drugs compete with other issues for space on that agenda (Meier, 1994). At the last two federal elections (November 2007 and August 2010) illicit drugs were not a significant part of the campaigns, and since the change in government in 2007 little has been said that could be interpreted as a comprehensive policy statement. Rather, the focus has been on alcohol and tobacco, which although timely and to be encouraged, could indicate that the issue of illicit drugs has slipped off the agenda. In fact, in the absence of articulated policy statements to the contrary, between 2007 and 2010 it seems that the Rudd and Gillard governments have implicitly adopted the ‘Tough on Drugs’ approach, introduced under the Howard government in 1997.

Launched by the Howard Government and endorsed by the Council of Australian Governments (COAG), the ‘Tough on Drugs’ Strategy did not replace the existing National Drug Strategy but did signal a renewed commitment to funding initiatives that tackled both the use and harms associated with illicit drug use. The ‘Tough on Drugs’ federal strategy signalled a number of new initiatives, notably:

- Illicit Drug Diversion Initiative to divert cannabis and other drug users out of the criminal justice system and into education/treatment;
- grants program for non government treatment organisations;
- community partnerships program: an endeavour to activate local communities and build networks within communities, with a focus on intervention and prevention; and
- research into pharmacotherapies for heroin dependence (in lieu of a heroin trial which was blocked by Howard).

This strategy remained in-line with the harm minimisation philosophy of the National Drug Strategy, however it has been suggested that it also represented a conservative shift in Australian drug policy (Penington, 2010).

Harm minimisation has not been without difficulties as a unifying framework for Australia’s approach. Early evaluation noted confusion over the term (Single & Rohl, 1997) and, as mentioned previously, the 2009 NDS evaluation recommended replacing the term with words that better communicated the essence of the strategy including prevention objectives (Siggins Miller, et al., 2009). Over the years there has been much written about the scope and definition of harm minimisation and how this is distinguished from harm reduction (Erickson, 1995; Lenton & Single, 1998; Riley & O’Hare, 2000; Single, 1995). In a review of priority areas for Australia drug policy conducted in 2006 (Ritter, 2007), the continued conceptual confusion about the term ‘harm minimisation’ was noted. Another dilemma arises when trying to base policy decisions on the concept of reducing harm, when measuring drug harms is often, in practice, a difficult or impossible task (Weatherburn, 2009). Such value judgments may favour one identifiable set of harms over another.

These two factors - rhetoric of ‘Tough on Drugs’ (Howard’s campaign) and ongoing confusion about the term harm minimisation - appear to suggest that there may be subtle shifts in Australia’s drug policy framework away from harm minimisation towards a more abstentionist attitude. It has been suggested in the light of growing international support for reform agendas, that there is a need to once again mobilise both sides of federal politics to discuss the health and social consequences of drugs in the community (Penington, 2010). In recent history, this kind of discussion has not been the *modus operandi* in federal politics. Sadly, as Wodak (1997) argues, ‘in

this country illicit drug policy has become inviolable while politicians remain terrified of losing an election lest rationality be misinterpreted as 'being soft on drugs'. However, the 2010 election marked an unusual moment in Australian federal government history, with a hung parliament in the House of Representatives. Political perspectives usually marginalised by a two-party system may now be able to play a more active role in generating discussion around policy issues largely ignored by the major parties in recent election cycles. Time will tell if the Greens and Independents impact discussion of policy choices in this way, and whether Australia's drug policy becomes one such focus.

Notwithstanding the political challenges specific to drug policy, there has also been a broader shift in the nature of the role of government in today's society which in turn has affected the way the state interacts with other 'voices' in the drug policy landscape. These changing notions of governance are consistent with the rise of non-government services. The 'reinventing government' of the 1980s with a shift from public sector 'rowing' to more 'steering' (Osborne & Gaebler, 1992) has impacted on drug policy and service provision in particular. These changes in the provision of services, traditionally government-run and now privatised (including not-for-profits within this definition), are consistent with pluralised governance. Known by various terms - harnessing of non-state resources; co-production; multi-lateralisation; interagency/multi-agency partnerships; third party policing; and hybrid governance - this new mentality reflects an acknowledgement that the state has limited resources, cannot manage everything in the best way, and that non-state actors can play an effective role (Grabosky, 1997). For illicit drugs policy this includes provision of treatment, prevention, and even policing services. For example mutual aid support groups for families and friends (Baldacchino & Hussein Rassool, 2006); police working in partnership with chemists to achieve reduced harms (<http://www.projectstop.com.au/media/ProjectStopAward230607.pdf>); and the role that businesses are now playing in drug screening, monitoring and supporting employees.

With the introduction of the division of purchasers of services (government) and providers of services (NGO), there has been an increased reliance and focus on the role and function of NGOs. Placing NGOs as the primary service providers also empowers them to have a stronger voice at the policy table. It is not surprising then that the state has sought the engagement of the third sector⁸ in policy advice. In 1998 the Australian National Council on Drugs (ANCD) was launched with a mandate to 'ensur[e] the voice of the community is heard in relation to drug related policies and strategies' (www.ancd.org.au). The subsequent 1998 National Drug Strategy Framework emphasised the government's goal of 'building partnerships' and the ANCD was deemed central to these efforts (Hughes, Lodge & Ritter, 2010). Evaluations of the National Drug Strategy have identified the ANCD as having facilitated improved coordination between government and community sectors (Hughes, Lodge & Ritter, 2010; Siggins Miller, et al., 2009), playing a key role in mediating the participation of state and third sector 'voices' in Australian drug policy. This leads directly to consideration of the third sector as a crucial voice in Australian drug policy.

The third sector

The third sector by definition must have fluid boundaries to encapsulate the plethora of interested parties and individuals who contribute to policy debate around drug issues in Australia. This group loosely encompasses the 'voices' of the many NGOs, advocacy groups and family support groups who are stakeholders in the National Drug Strategy. This community is not

⁸ We use the term 'third sector' to refer to organisational forms that exist between the private, for-profit world and government entities. The term is often used to refer to non-government organisations (NGO's) specifically but here it is used more broadly to encompass community groups, ideas of volunteerism, etc.

uniform in its agendas, and may be broadly divided into two advocacy coalitions: those advocating for harm reduction or progressive approaches; and those advocating for abstentionist or conservative policies.

Many organisations continue to play an active role in advocating for harm minimisation approaches. For example, the Alcohol and Other Drugs Council of Australia (ADCA) plays an important role in representing the interests of the Australian alcohol and other drugs sector by ‘providing a national voice for people working to reduce the harm caused by alcohol and other drugs’ (www.adca.org.au) and is supported by the Commonwealth Government's Community Sector Support Scheme and the National Drug Strategy Program.

Various national and locally based organisations advocate for the interests of drug users including the Australian Injecting and Illicit Drug Users League (AIVL), Harm Reduction Victoria, Canberra Alliance for Harm Minimisation and Advocacy (CAHMA), Queensland Injectors Health Network (QUIHM), Territory's Users Forum (TUF), Users Association South Australia (UASA), Western Australian Substance Users Association (WASUA), Tasmanian Council on AIDS, Hepatitis and Related Diseases and the NSW Users & AIDS Association (NUAA). Family and Friends for Drug Law Reform (www.ffdlr.org.au) is one example of the many community and family support groups that exist within Australia. It has a progressive, law reform agenda focussed on harm reduction and treatment provision, and campaigns to raise awareness to educate and overcome stigmatisation of drug users.

At the same time, one notes the rise of conservative advocacy groups in Australia, as exemplified by the organisation entitled ‘Drug Free Australia’ (DFA). Drug Free Australia, established in 1994 has a mission to ‘To deliver a coordinated, high impact drug education and harm prevention message to key policy makers and the Australian community, with a particular focus on young people, and will complement the Federal Government's anti-drug position’ (www.drugfree.org.au). Organisational members are prolific in postings to an Australian list server (ADCA Update) disseminating information and opinion about abstinence-based programs, the importance of a ‘say no’ approach to drugs and with a keen focus on prevention. Indeed, the group use a preferred term ‘harm prevention’ instead of ‘harm minimisation’. Previously, the appointment of Major Brian Watters (1998 to 2005) as the chair of the Australian National Council on Drugs, the advisory body to the Prime Minister, was also regarded as representative of a trend towards conservative drug policy⁹. As a final example of this phenomenon of the rise of conservative, zero tolerance groups in Australia, DrugArm (established 2006) is a non-government, not-for-profit organisation which provides education, awareness, prevention and support programs based on Christian philosophies.

It is not obvious what to make of this – does it mean that Australia is gradually shifting away from its current harm minimisation approach?; is it that conservative groups have been more vocal and agenda-setting than previously but are not any more effective than they were before?; or does it merely reflect the ever-present ideological tensions in a highly emotional policy issue?

The role of non-government groups and advocacy organisations is notable, especially given the climate of engagement by government with the third sector (as discussed earlier), and the rising importance of civil society (across the globe) in social policy processes. Internationally, this has been demonstrated during the United Nations review of the 1998 UNGASS resolution on illicit

⁹ The current chair of the ANCD is Dr John Herron, a prior elected parliamentarian from the conservative side of politics, although without the obvious Salvation Army conservative bias. Since the Rudd government was appointed in Nov 2007, the ANCD membership has remained stable.

drugs. Over 2008 and 2009 many non-government groups became engaged with and contributed to the UN debate. And locally, in Australia the 2020 Summit (April 2008) firmly signalled a new focus by the government on engagement with civil society.

In conclusion, there has been a shift in key actors in Australian drug policy debate – a rise in conservative advocacy groups, coupled with the generic trend in public sector management to engage in hybrid governance. Acknowledgement of this important change in the role of government and its relation to private and not-for-profit sectors is vital to being able to be in front of the drug policy agenda.

International regulatory bodies

Many different ‘voices’ compete in the drug policy arena and international regulatory bodies play a significant role in shaping drug policy development domestically. Drug policy is a cross-border issue and for this reason an international, co-operative approach to drug control has developed between nations.

Australia is a signatory to a number of international treaty obligations in relation to illicit drugs. These include the United Nations *Single Convention on Narcotic Drugs* (which aimed to limit the possession, use, trade in, distribution, import, export, manufacture and production of drugs exclusively to medical and scientific purposes, and to combat drug trafficking through international cooperation to deter and discourage drug traffickers), the *Convention on Psychotropic Substances* (which responded to the diversification and expansion of the spectrum of drugs of abuse and introduced controls over a number of synthetic drugs), and the *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (which provided comprehensive measures against drug trafficking) (United Nations Office on Drugs and Crime, 2010). Three international bodies are responsible for the implementation of the conventions: the Commission on Narcotic Drugs (CND), the United Nations Office of Drugs and Crime (UNODC) and the International Narcotics Control Board (INCB) (Babor, et al., 2010).

In Australia, these treaty obligations are given effect in domestic law by three Commonwealth Acts, as amended: the *Narcotic Drugs Act 1967*, the *Psychotropic Substances Act 1976*, and the *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990* (Australian Institute of Criminology, 2009). Through their ratification, international obligations have a direct impact upon domestic policy choices. As a result of these obligations Australian drug policy is monitored principally by the INCB (as the independent and quasi-judicial monitoring body for the implementation of the United Nations international drug control conventions). Each year the INCB publishes a comprehensive report on estimates of annual legitimate requirements for psychotropic substances for each country as well as data on the production, manufacture, trade and consumption of these drugs worldwide. In addition they comment on the extent of the drug control situation in various parts of the world.

The ongoing role of the INCB has been strongly criticised in the drug policy community for taking a conservative stance in relation to drug policy. Indeed, it has been argued that appropriate evaluation of international drug control policy is limited by rhetoric which frames drug use as an ongoing ‘threat’, leading to ‘threat based’ rather than ‘evidence based’ policy making (Barrett, 2010). These concerns have come to a head particularly as many member nations have implemented harm reduction measures domestically. The trend towards more tolerant models of drug policy at a national level has highlighted the obstacle prohibition-based international drug control systems have placed on domestic policy reform, and the ongoing struggle to exploit any

latitude within existing international regulatory structures in the absence of regime change (Bewley-Taylor, 2003).

Even where nations are careful to work within the limits of the conventions in implementing harm reduction measures, the INCB has been known to take a narrow view and claim that the actions are contrary to the spirit of the conventions (Bewley-Taylor, 2005). This tension is demonstrated by the strong criticism Australia (along with other nations) has received in response to the implementation of some domestic harm reduction policies. For example, the INCB is well known for its historical lack of support for needle exchange programs, prescribed heroin, and to a lesser extent other substitution treatments such as methadone maintenance (Csete & Wolfe, 2007; Small & Drucker, 2007). The 2006 INCB report spoke unequivocally against Australia's supervised injecting centre, describing it along with others as 'rooms for the abuse of drugs' and declaring it to be in violation of international agreements (International Narcotics Control Board, 2006). More than this, the INCB's Secretary was quoted as saying that the INCB would restrict Australia's legal production of opiates if the supervised injecting centre was established (Babor, et al., 2010). Dialogue around decriminalisation or regulatory regimes has also been impeded by the conventions' provisions requiring criminalisation of drug use (see Chapter 13 of Babor, et al., 2010 for discussion). How much latitude exists within the conventions is a matter of ongoing rigorous discussion.

Although the INCB does not have formal powers of enforcement, the obligation of good faith remains under international law to stay true to the 'object and purpose' of the convention (Bewley-Taylor, 2003). Where the INCB lacks formal powers, other prohibition-oriented nations have taken on a persuasive 'enforcement' role in relation to the existing conventions. The central coercive role of the USA has been widely recognised, especially in opposing and criticising any nation which sought amendment to the current prohibitionist-model conventions (Bewley-Taylor, 2003). But an era of reform may be possible in light of the Obama administration's recent shift towards a more balanced approach to drug policy. The Lancet (2010) has described the plan as a 'new dawn for drug policy in the USA', and it is arguable that with this change a new role for the USA in international drug policy might be achievable. Even without this shift, there are a number of ways that progressive member nations can try to seek incremental change to the regime including coordinated responses and by reframing policy justification in the language of peace, security and human rights (Bewley-Taylor, 2005). Despite ongoing discussion of changes that would allow more flexibility for nations to pursue harm reduction and decriminalisation policies, it is deemed unlikely that significant changes will be made to the existing system of control (Babor, et al., 2010). Given the ongoing challenges posed by globalisation and transnational trafficking routes, it is likely that the role of international regulatory bodies will continue to be significant (and complex) for Australian drug policy.

The general public

The Australian public are key stakeholders in drug policy. This is because, among other reasons, large proportions of Australians are drug consumers. The 2007 NDSHS reported that of the Australian population aged 14 years or older, 89.9% had ever used alcohol, 44.6% had ever used tobacco and 38.1% had ever used an illicit drug (Australian Institute of Health and Welfare, 2008a).

Matthew-Simmons et al. (2008) in their review of public opinion in relation to illicit drugs in Australia found a generally conservative trend in attitudes towards a range of drug policy issues. But although they found that support for reforms such as cannabis legalisation had decreased along with increased support for law enforcement, they also found increased support for harm

reduction measures such as needle syringe programs and safe injecting centres. The authors concluded that this may indicate that Australians are less wedded to particular ideologies about drug issues, and more concerned with pragmatic solutions to the problem. This means that polarised political debate is unlikely to resonate with the community at large. McKnight (2005) argues that the Left-Right ideological divide is increasingly irrelevant for many issues in Australian politics, and that Australian society will increasingly prefer for policy to be judged on its own merits. The trend in public opinion in relation to drug issues would suggest that this might be the case for this policy arena, as much as any other.

The integral role of media in shaping public opinion and political debate is also significant. Media can set the agenda and define public interest, frame issues through selection and salience, indirectly shape individual and community attitudes towards risk, and feed into political debate and decision making (Lancaster, Hughes, Spicer, Matthew-Simmons, & Dillon, 2010). Crucially, media build consensus about what issues are the most important within the community (McCombs, 1997; McCombs & Shaw, 1972) and can define the nature of solutions through what they choose to present to their audiences. This has great implications for many aspects of illicit drug policy because, for many people, problems associated with injecting behaviour or drug treatment for example are ‘unobtrusive’ issues – ones which they see in the news but do not experience in everyday life (McCombs, 2004, pp. 60-62). In this way media’s social construction of drug issues can shift attitudes within the broader community. For example, Fan’s (1996) time series analysis of illicit drugs press coverage in the USA between 1985 and 1994 found that by framing drugs as a crisis, media significantly contributed to shifts in public attitudes regarding drugs as the USA’s most important problem.

Although media influence over policy rarely works in an orderly or linear way (Shaw & McCombs, 1989), there is strong evidence from the small number of studies of drugs and media in Australia that the news media is playing a crucial role in shaping not only public opinion but also policy decisions. For example, in a study of press coverage of the proposed ACT heroin trial, it was found that dominant media portrayals of heroin users as ‘deviants’ presented by opponents of the trial played a significant role in the political demise of the heroin trial proposal (Elliott & Chapman, 2000). Lawrence et al. (2000) suggested that it was the opposition coverage of *The Daily Telegraph* and 2UE talk-back radio which ultimately influenced the unprecedented intervention of the Prime Minister and Cabinet in overturning the trial (see Lancaster, et al., 2010 for discussion). Unfortunately, such negative media discourses do not reflect the rigorous policy debate surrounding illicit drugs, particularly regarding harm minimisation (Blood, Williams, & McCallum, 2003). Despite this, positive examples of the role of media in shaping public attitudes to drug issues do exist in the Australian context. For example, McArthur (1999) makes note of the shift in media coverage regarding the efficacy of methadone treatment in the 1980’s which contributed to community understanding of the value of treatment in reducing income generating crime.

But despite what we know about community attitudes to drug policy in Australia (and the role media plays in their development), the question remains: is the public playing an active role in policy processes and discussion? Is the voice of the public being heard? Despite the emphasis on ‘partnerships’, the National Drug Strategy 2004-2009 (and the 2010-2015 draft released at the time of writing) does not explicitly mention strategies by which to engage with the broader community. This absence has been noted in expert consultation submissions – particularly that there is not a sense of community ownership of the National Drug Strategy (Drug Policy Modelling Program, 2010). It was recommended that the general public be seen as an active participant in the National Drug Strategy as increased opportunities for public engagement are

likely to produce better literacy and debate around complex drug policy issues. Such engagement is also likely to reduce public stigma associated with drug use (see Australian Injecting and Illicit Drug User's League, 2010 for discussion) and provide more avenues for drug user groups (as discussed above) to communicate the viewpoint of drug users living within the community.

CONCLUSION

Australia has achieved a great deal since the adoption of the harm minimisation approach to drug policy in 1985. Overall, the prevalence of drug use within the Australian population seems to be declining, noting however that Australia still has one of the highest rates of recent cannabis use in the world. But whether or not these declines can be readily attributable to effective drug policy remains open to argument. Cultural and social circumstances, social policy such as welfare policies, macroeconomic factors, socio-economic conditions and international trends all influence patterns of use and harms. Evidence also shows that epidemic cycles are common, irrespective of government action. We contest that there are many influences on drug use, and successful government intervention is but one (albeit important).

The choice of policy interventions varies across national contexts and for that reason there cannot be a single 'best policy' (Babor, et al., 2010), although evidence can inform best practice approaches to drug policy development and review (International Drug Policy Consortium, 2010). We find evidence that Australia has done comparatively well in implementing policy which is known to be evidence based and effective. The Australian approach to drug policy still places great emphasis on law enforcement, but compared to other countries it appears that Australia has better balanced law enforcement with treatment measures. Comparing Australia's drug policy approach to global trends, we find that Australia sits alongside the Netherlands and the UK in having half of the opioid dependent population in opioid pharmacotherapy maintenance. Australia also appears to have one of the highest cannabis treatment rates in the world. In the law enforcement arena, the proportion of arrests of drug users continues to rise relative to the proportion arrested for drug dealing or trafficking. The majority of arrests for drug offences in Australia are against cannabis consumers, with relatively similar rates of arrests to other countries (with the exception of the Netherlands, where supply related arrests predominate).

After 'leading the way' for some decades as advocates for harm minimisation, it appears that Australia is now standing still on the international stage. Champions of drug policy reform are now appearing internationally and although Australian research continues to make a significant contribution to these discussions, where we were once at the forefront of policy innovation we are now falling behind (Penington, 2010). This can be seen across a number of drug policy domains including decriminalisation of drug use/possession, heroin maintenance, provision of peer-administered naloxone, supervised injecting facilities, better prison-based treatments and needle syringe program coverage.

It has been suggested that there is a need to mobilise both sides of Australian politics to recognise that realism on alcohol and other drugs is essential, and that while drug use remains 'criminalised' current policies are unlikely to be able to fully address the spectrum of drug-related harm (Penington, 2010). The challenge remains to think through models by which illicit drugs could be regulated if we step away from a zero tolerance prohibition model. Perhaps, as Boyum and Reuter (2005) suggest, the burden of proof should be also placed on those who advocate for the status quo, rather than solely upon those who advocate for reform.

The consideration of the multiple, and often competing, 'voices' in the drug policy system is important in this context. Assessment of the current success or future direction of Australian drug policy must rest upon an understanding of the dynamic interactions of the many parties involved within that policy landscape. We identify five 'voices': the research community; the state; the third sector; international regulatory bodies; and the general public. In our analysis we find

that the research community has contributed to encouraging evidence-based policy but inherent barriers remain in bridging the gap between evidence and policy. Changing notions of governance, with a shift from public sector 'rowing' to more 'steering', has impacted on drug policy and led to changes in the provision of treatment, prevention, and even policing services by non-government actors. As a result, the role of the third sector has risen in prominence in Australia as the state has shifted towards this model of pluralised governance. In association with this rise, as demonstrated through the roles of bodies such as the ANCD, ADCA and DFA, we observe the emergence of a more vocal conservative element in drug policy debate. It is unclear to what extent this signals a shift away from Australia's harm minimisation approach, or whether these 'voices' reflect ongoing ideological tensions in conceptualising optimum policy solutions for a highly complex issue. International regulatory bodies continue to be important players in influencing Australian drug policy, particularly regarding scope for developing harm reduction approaches. Finally, we argue that the Australian general public have an important stake in drug policy, but at present there are no formal mechanisms to engage with them. A critical variable in engaging the public is the role of the mass media, as evidence demonstrates that media are influential in defining the scope of policy problems and proposing solutions.

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APPENDIX A: THE NATIONAL DRUG STRATEGY

Since 1985 Australia has had a documented strategy addressing alcohol and illicit drugs. The first of these - *National Campaign Against Drug Abuse* (1985 to 1998) - was not labelled as a strategy document per se but operated as such. This was followed by the *National Drug Strategic Framework*, covering the period 1998/99 to 2002/03. The third, and current strategy document, is the *National Drug Strategy: Australia's integrated framework*, covering the period 2004 to 2009. At the time of writing, the *National Drug Strategy 2010-2015: a framework for action on alcohol, tobacco, illegal and other drugs* is currently under consultation.

Box A: Summary of the Strategies and Evaluations

| |
|--|
| 1985 to 1998 NCADA – National Campaign Against Drug Abuse Evaluations: 1988 (taskforce); 1992 ('No quick fix'); 1997 ('Mapping the future') |
| 1998 to 2003 National Drug Strategic Framework (1998/99 to 2002/03) Evaluation: 2003 (conducted by Success Works) |
| 2004 to 2009 The National Drug Strategy: Australia's integrated framework Evaluation: 2009 (Siggins Miller) |

The National Drug Strategy (NDS) and its predecessor, the National Campaign against Drug Abuse (NCADA), have been cooperative ventures between the Commonwealth and State and Territory governments and provides the framework for a coordinated and integrated approach to drug issues in Australia. The current NDS is outlined in the *National Drug Strategy: Australia's Integrated Framework 2004-2009* (Ministerial Council on Drug Strategy, 2004) and maintains the policy principles of previous strategies. Central to this is the philosophy of *harm minimisation* which has formed the basis of Australia's National Drug Strategy since 1985.

The aim of the current National Drug Strategy is 'to improve the health and socio economic outcome for Australians by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in our society'. Building upon the previous National Drug Strategy the following eight priority areas for the current strategy were identified:

- Prevention: Stopping or delaying the onset of drug use.
- Reduction of supply: Preventing and/or reducing drug availability.
- Reduction of drug use and related harms: Minimising the harmful effects of drug use on communities and individuals.
- Improved access to quality treatment: Ensuring treatment services are available for users of both licit and illicit drugs.
- Development of the workforce, organisations and systems.
- Strengthened partnerships: Developing effective working relationships between the government, industry, research and the community.
- Implementation of the National Drug Strategy Aboriginal and Torres Strait Islanders Peoples Complementary Action Plan.
- Identification and responses to emerging trends: Employing research, data and specialist advice to inform policies and programs.

It is noteworthy that this is a very comprehensive list and it is difficult to identify areas that are *not* a priority.

Australian drug policy is co-ordinated at the federal level by the Ministerial Council on Drug Strategy (MCDS) and informed by expert opinion across the community. The Ministerial Council on Drug Strategy (MCDS) is the peak policy and decision-making body in relation to licit and illicit drugs in Australia. This Council is represented by the Australian and State and Territory Ministers of Health and Law Enforcement, including the Minister responsible for Education, and has the role of determining national policies and programs intended to reduce drug-related harm within the Australian community.

Supporting the MCDS is the Intergovernmental Committee on Drugs (IGCD) which is responsible for implementing national drug policies and programs and for providing policy advice to Ministers. This Committee consists of representatives from health and law enforcement in each Australian jurisdiction as well as New Zealand, and people with expertise in identified priority areas including representatives of the Australian Customs Service, the Ministerial Council on Aboriginal and Torres Strait Islander Affairs and the Department of Education, Science and Training.

Further providing support to the MCDS is the National Expert Advisory Panel that provides expert advice on emerging trends, priorities and strategies on nationally significant matters (Ministerial Council on Drug Strategy, 2004). To assist in implementing and progressing national priorities, taskforces derived from the expert panel are also implemented on an as-needed basis.

The roles and responsibilities of each of the three levels of government in Australia's federal system are outlined in the National Drug Strategic Framework (Ministerial Council on Drug Strategy, 1998). Here it is noted that the Federal government is responsible for 'providing leadership in Australia's response to reducing drug-related harm', with The Department of Health and Ageing responsible for the National Drug Strategy. In addition, the Federal Government is responsible for national policy development, policy interventions at the national level, such as interdiction and oversight of all strategies. The State and Territory governments are responsible for 'the delivery of police, health and education services to reduce drug-related harm', as well as state-based policy development, policing and data collection and monitoring. Local governments have a role to play in working within their local communities to respond to drug-related harms. In addition, the National Drug Strategic Framework highlights the need for co-operation between all levels of government with families and communities, community-based organisation and business and industry for the effective implementation of the strategy (Box B provides more details).

Box B: Roles and responsibilities of levels of government in Australia

Federal government

- National policy development, coordination and support
- The National School Drug Education Strategy
- Monitoring adherence to international treaties
- Policy development and implementation in the areas of crime prevention, money laundering and extradition
- Border control activities
- Investigating offences associated with the importation of illicit drugs and disrupting the international supply of illicit drugs
- Counteracting organized criminal activity.

State and Territory governments

- Delivery of police, health and education services
- Drug policy development, implementation and evaluation within their jurisdiction
- Controlling the supply of illicit drugs through specialist law enforcement units and general policing
- Designing, developing and implementing public information and education prevention programs
- Providing public sector health services or funding community-based organisations to provide drug prevention and treatment programs (health departments)
- Analysing and monitoring patterns of drug use and drug-related harm.

Local governments

- Developing partnerships with local communities to respond to drug-related harms
- Being an active partner and facilitating local cooperative initiatives to reduce drug-related harm
- The development of local drug and alcohol action plans
- The support for treatment services including the operation of needle and syringe exchange programs.

Over the years in addition to the National Drug Strategy, a variety of other complimentary strategy documents have been developed (see Box C). For example, the Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009 followed from extensive consultation with Indigenous communities. This plan was developed to provide a national direction to deal with the specific alcohol, tobacco, illicit drugs and other substance issues that concern Aboriginal and Torres Strait Islander Peoples.

Box C: Overdosing on Strategic documents?

National HIV/AIDS Strategy (1989)
National Hepatitis C Action Plan (1994)
‘Tough on Drugs’ Strategy (1997)
National Heroin Supply Reduction Strategy (1998)
National Supply Reduction Strategy for Drugs Other than Heroin (1998)
National School Drug Education Strategy (1999)
National Hepatitis C Strategy 1999-2000 to 2003-2004 (2000)
National Action Plan on Illicit Drugs 2001–2002/03 (2001)
National Illicit Drug Strategy (2002)
National Strategy to Prevent the Diversion of Precursor Chemicals into Illicit Drug Manufacture (2003/04 to 2007/08) (2003)
National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2009 (2003)
National Hepatitis C Strategy 2005–2008 (2005)
National Cannabis Strategy 2006–2009 (2006)
National Amphetamine-Type Stimulants Strategy 2008–2011 (2008)

Australia is bound by the International treaties: the *1961 Single Convention on Narcotic Drugs* limits production, manufacture, import, export, distribution, trade, possession and use of narcotic drugs to medical and scientific purposes and enshrines international cooperation to deter and discourage drug traffickers; the *1971 Convention on Psychotropic Substances* specifies international control systems for psychotropic drugs, recognising the diversification and expansion of types of drugs, beyond narcotics, including synthetic drugs such as ecstasy and amphetamine-type stimulants; and the *1988 Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances* provides comprehensive measures against drug trafficking, including measures against money laundering and diversion of precursor chemicals.

APPENDIX B: DATA SOURCES

1. Population surveys

Surveys of the general population are the main methods used to measure the level and type of drug use in Australia. The most widely used surveys in Australia are the National Drug Strategy Household Survey (NDSHS) and the Australian Secondary School Alcohol and other Drugs Survey (ASSADS); both of which are semi regular surveys co-ordinated by state and federal health departments.

National Drug Strategy Household Survey (NDSHS)

Under the management of the Australian Institute of Health and Welfare (AIHW), the National Drug Strategy Household Survey is a general population survey on licit and illicit drug use in Australia. The aim of this survey is 'to gather data for the surveillance and monitoring of drug use and related issues in the general population'. To achieve these aims, participants over the ages of 12-14 (depending on the year) are asked questions on their knowledge of and attitudes towards drugs, consumption histories and related behaviours. Detailed information is gathered on the patterns of use for each particular drug, including age of first use, place of use, where the drug was obtained, prevalence of use among friends, days lost from work or education because of drug use and health problems experienced. In addition the survey asks a number of socio-demographic data questions on age, gender, marital status, ethnicity and type of employment.

Households are selected by a multistage, stratified area random sample design. In each household the participant is the person aged 12 years and over with the next birthday (a shorter questionnaire is administered to 12–13-year-olds). Since 2001 the survey has employed two collection modes: drop and collect and the computer-assisted telephone interview (CATI). The 2007 survey was the most recent survey and achieved a response rate of 49.3% (n=23,356). Previous surveys were conducted in 1985 (n=2,791), 1988 (n=2,255), 1991 (n=2,850), 1993 (n=3,500), 1995 (n=3,850), 1998 (n=10,030), 2001 (n=26,744) and 2004 (n=29,444).

Excluded from the sample are non-private dwellings and institutional settings such as hospitals, nursing homes, drug and alcohol rehabilitation centres and prisons. As illicit drug users may be marginalized and difficult to reach the estimates of illicit drug use and related behaviours are likely to be underestimates.

The findings from the survey including the questionnaire are published initially as a report of first results, followed by detailed findings. The raw data set can be accessed from the Australian Social Sciences Data Archive (ASSDA).

Australian Secondary School Alcohol and other Drugs Survey (ASSADS)

The Australian Secondary Students' Alcohol and other Drugs Survey has been collecting data on the prevalence of substance use among secondary students since 1999, with the most recent survey conducted in 2005. Coordinated between federal, state and territory health departments and state cancer councils this survey asks school students on the use and knowledge of analgesics, tranquillizers, steroids, cannabis, inhalants, amphetamines, hallucinogens, ecstasy, heroin and cocaine.

In each State and Territory, a representative sample of government, catholic and independent secondary schools are selected for surveying, with up to 80 students per school surveyed. In

2005, 21,805 students aged 12–17 years were surveyed in 376 schools. Students were asked about the number of times they had used specific drugs during the last week, during the last four weeks, in the last year and in their lifetime. Data on age, sex, level of spending money available, language spoken at home and whether they identified as an Aboriginal or Torres Strait Islander were also collected. Previous surveys were conducted in 1996 (n=29,770), 1999 (n=25,486) and 2002 (n=23,417).

Several limitations of ASSADS exist. Firstly, as only school students were used in the survey the estimates for 16 to 17-year-olds are only generalisable to the population of students rather than to all adolescents aged 16–17 years. In addition, students with good school attendance may be more likely to participate in the survey than students with poor attendance records leading to an underestimation of prevalence (if there is a correlation between attendance and drug use). Offsetting this underestimate however is the possibility that students may exaggerate their use of illicit substances, leading to slightly inflated estimates.

A report of the findings is produced by the Cancer Council Victoria and by the Australian Government Department of Health and Ageing.

2. Surveys of specific population groups

Australia has a number of surveys of specific population groups, such as active injecting drug users that can capture samples that are more likely to be excluded from general population surveys.

The Illicit Drug Reporting System (IDRS)

The IDRS is an annual survey and data analysis, funded by The Department of Health and Ageing and the National Drug Law Enforcement Research Fund, and coordinated by the National Drug and Alcohol Research Centre (NDARC). Beginning in Sydney in 1996, the IDRS has now expanded to include all capital cities in Australia.

The Illicit Drug Reporting System (IDRS) monitors the patterns of drug use in injecting drug users, with specific aims to 1) document the price, purity and availability of heroin, methamphetamine, cocaine and cannabis; 2) to document risks and harms associated with drug use; and 3) to detect emerging drug trends.

Data is collected from three sources, these being; interviews with injecting drug users, interviews with key experts and data from administrative datasets and survey results from health, law enforcement and other agencies. Surveys were conducted in 2000 (n=910), 2001 (n=951), 2002 (n=929), 2003 (n=970), 2004 (n=948), 2005 (n=943), 2006 (n=914) and 2007 (n=909 people who inject drugs)¹⁰.

As the surveys are conducted in capital cities only and using a conveniently sampled population, the results do not provide an adequate picture of Australia wide injecting drug use.

The findings from the survey include quarterly bulletins, the early release of annual survey results at a public seminar, and an annual publication for each State and Territory.

¹⁰ The IDRS and EDRS are annual surveys and have been conducted in 2008, 2009 and 2010; however for the purpose of comparison with the general population surveys, we have looked only at 2007 data.

Ecstasy and related Drugs Reporting System (EDRS)

The Ecstasy and related Drugs Reporting System monitors the price, purity availability and harms of ecstasy and other drugs such as methamphetamine, cocaine, GHB, LSD, MDA and Ketamine among regular ecstasy users. The EDRS is funded by the Australian Government Department of Health and Ageing and coordinated by the National Drug and Alcohol Research Centre (NDARC). Beginning in 2003 the survey is conducted in all Australian capital cities, utilising data from interviews with regular ecstasy users, interviews with key experts and data from administrative datasets and survey results from health, law enforcement and other agencies.

Surveys were conducted in 2003 (n=809), 2004 (n=852), 2005 (n=810), 2006 (n=752), 2007 (n=741 regular ecstasy users).

The findings from the survey are disseminated through quarterly bulletins, an annual national and jurisdictional report and through presentations at the National Drug Trends conference.

Drug Use Monitoring in Australia (DUMA)

Established in 1999, the Drug Use Monitoring in Australia (DUMA) program is a survey of police detainees across Australia. Conducted on a quarterly basis, information is collected on drug use history, drug market information, treatment history and prior contact with the criminal justice system. In addition a voluntary urine sample is obtained for drug testing.

In 2007, data collection was carried out at 10 sites: Brisbane and Southport (Queensland), Bankstown and Parramatta (New South Wales); Adelaide and Elizabeth (South Australia); East Perth (Western Australia); Footscray (Victoria); and Darwin and Alice Springs (Northern Territory). As not all sites were surveyed over all years, we present data between the years 2002–2005 from the sites; Adelaide, Bankstown, Brisbane, East Perth, Elizabeth, Parramatta, Southport.

Sample sizes in the years we present were 2002 (n=3,634), 2003 (n=3,705), 2004 (n=3,834), 2005 (n=3,786). Over all of these years the majority of the participants were male (84%) and aged between 21 and 30 years old. Of the detainees approached to participate between 2002-2005 more than 88% agreed each year.

A yearly report is produced that presents both self-report and urinalysis data from participating detainees. It includes an overview of the characteristics of the detainees at each site, including self-reported drug use, prior criminal behaviour and treatment history.

3. Routine data collections

Aside from the surveys described above, routine data collections that occur as part of ongoing monitoring and accountability measurement provide useful sources of data.

National Minimum Data Set for Alcohol and other Drug Services (NMDS-AODTS)

The NMDS-AODTS is collection of national, state and territory data from publicly funded alcohol and other drug treatment services. Implemented in 2001 to help monitor and evaluate the National Drug Strategic Framework, it contains information of clients, their drugs of concern and the type of treatment received from drug treatment services in Australia.

All publicly funded government and non-government agencies that provide one or more specialist treatment services and all clients who have completed a treatment episode at one of the

aforementioned agencies are included in the collection (excluding opioid pharmacotherapy programs).

Since 2001–02, the unit of measurement for the NMDS-AODTS has been closed (or completed) treatment episodes. A closed treatment episode refers to a period of contact between a client and a treatment agency that has a defined commencement and cessation date where the main drug of concern and the treatment type does not change. It is important to note that the number of closed treatment episodes captured in the NMDS–AODTS is not equal to the number of people receiving treatment as a client may attend a number of different agencies.

Records of mortality - Australian Bureau of Statistics (ABS)

The mortality data we present is taken from Degenhardt and Roxburgh (2007b) who accessed the information from the Australian Bureau of Statistics (ABS). Data on accidental deaths are collected from the Medical Certificates of Cause of Death and from the National Coroners Information System which the ABS then uses, collates and manages.

National HIV database and National Notifiable Diseases Surveillance System (NNDSS)

The National Notifiable Diseases Surveillance System (NNDSS) co-ordinates the surveillance of more than 50 communicable diseases or disease groups. Each state or territory health authority collects data containing a unique record reference number, state or territory identifier, disease code, date of onset, date of notification, sex, age, Indigenous status and postcode of residence.

Pharmacotherapy Client Statistics (NOPSAD)

The National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection houses information on the number of clients being treated with pharmacotherapy as well as statistics on those prescribing the medication.

The Australian Institute of Health and Welfare (AIHW) manages the NOPSAD collection, including the analysis and reporting. Data is collected using a ‘snapshot/specified’ day which varies slightly between jurisdictions. Snapshot data provides an estimate of pharmacotherapy treatment activity but does not capture the total activity throughout the year. That said, the snapshot data of NOPSAD are considered to be a good representation of the pharmacotherapy treatment in Australia.

National Hospital Morbidity Database (NHMD)

Data on the trends for cannabis, opioids, amphetamines and cocaine drug related hospital stays were obtained from Degenhardt, et al., 2007; Roxburgh, et al., 2008; Roxburgh & Degenhardt, 2006, 2008. The authors extracted and analysed the data from National Hospital Morbidity Database (NHMD), which is managed by the Australian Institute of Health and Welfare (AIHW). Hospital separations refer to the reason for a patient’s stay in hospital based on medical records after treatment, rather than the reason for admission. Ecstasy related separations were excluded from the analysis and to date no information regarding ecstasy related separations was noted.

Illicit Drug Data Report (IDDR) (Australian Illicit Drug Report (AIDR) prior to 2002)

The Illicit Drug Data report is collated by the Australian Crime Commission (ACC) using information from the state and territory police services, the Australian Federal Police (AFP), the Australian Customs Service (Customs), and drug analytical laboratories.

Data presented in the report includes consumer and provider arrests, seizures, price and purity by jurisdiction. As with many administrative databases, limitations include variation in data quality and management across the states and territories.

4. Other data sources

Further data collections exist that either require special permission to access or have been collected at only one time point. As such, these collections have not been included in this report but are listed for information:

- National Survey of Mental Health and Wellbeing (SMHWD)
- The Household Income and Labour Dynamics in Australia Survey (HILDA)
- Australian Bureau of Statistics: Drug Induced Deaths, Australia, 1991-2001
- National Hospital Morbidity Database (NHMD)
- Causes of Death (COD) Collection
- National Coroners Information System (NCIS)
- Bettering the Evaluation and Care of Health (BEACH)
- National Ambulance Non-fatal Opioid Database.

APPENDIX C: KEY EVENTS

We provide a snapshot of highlighted key events in Australian drug policy from 1985 to 2010 in Appendix C. It is an edited version of the Australian (illicit) drug policy timeline: 1985-2011 (Hughes, 2011) which can be found at:
<http://www.dpmp.unsw.edu.au/dpmpweb.nsf/page/Drug+Policy+Timeline>.

| Year | Federal |
|------|---|
| 1985 | <ul style="list-style-type: none"> • NCADA – National Campaign against Drug Abuse adopted at Special Premiers Conference. • Campaign heralded a partnerships approach to illicit and licit drugs between federal and state and territory governments with the aim of minimising harms caused by alcohol and others drugs. • National Drug Strategy Committee (NDSC) established to lead policy development in conjunction with the Ministerial Council on Drug Strategy (MCDS). • Methadone endorsed as an appropriate treatment intervention. • First national household survey on drugs conducted: ‘Social issues in Australia, 1985.’ |
| 1986 | <ul style="list-style-type: none"> • National ‘Drug Offensive’ media campaign launched. • Two research centres established: National Drug and Alcohol Research Centre in Sydney and National Drug Research Institute (then called the National Centre for Research into Prevention of Drug Abuse) in Perth. • Federal government provided funding and national recognition to newly formed Australian Federation of AIDS Organisations. • First Needle Syringe Program (NSP) opened in act of civil disobedience - Darlinghurst. |
| 1987 | <ul style="list-style-type: none"> • National Centre for HIV Epidemiology and Research began first Australian clinical trial of AZT, a promising anti-retroviral. • Commonwealth government launched a \$2.9m National AIDS Education Campaign, including the Grim Reaper television advertisement. • AZT approved as a treatment, agreement between Commonwealth and States to share costs. • ‘Treatment Works’ week established by the Alcohol and other Drug Council of Australia. |
| 1988 | <ul style="list-style-type: none"> • First evaluation of NCADA by 5 person taskforce. Report titled ‘Report of the NCADA Task Force on Evaluation (1988)’ concluded had been considerable progress – expansion of treatment services, community awareness and better monitoring and evaluation. • Australian IV League (AIVL) began as unfunded national network representing drug users and drug user organisations. • Second national household survey on drugs conducted: ‘National Campaign against Drug Abuse Social Issues Survey, 1988.’ • Australian National Council on AIDS established. |
| 1989 | <ul style="list-style-type: none"> • National HIV/AIDS Strategy launched – emphasis on prevention and harm reduction. |

AN ASSESSMENT OF ILLICIT DRUG POLICY IN AUSTRALIA (1985 TO 2010): THEMES AND TRENDS

| Year | Federal |
|------|---|
| | <ul style="list-style-type: none"> • Commonwealth Government funded first injecting drug user organisations. • First Australian Hepatitis C antibody studies initiated. Showed a high prevalence of Hepatitis C amongst injecting drug users. • Release of report of the Parliamentary Joint Committee on the National Criminal Authority: ‘Drugs, Crime and Society.’ |
| 1990 | <ul style="list-style-type: none"> • National Centre for HIV Social Research established. • Commonwealth Government ratified the United Nations Convention on Illicit Trafficking in Narcotics and Psychotropic Substances. • First national census of clients of treatment service agencies (COTSA) conducted. • National Health and Medical Research Council released first formal statement on Hepatitis C. |
| 1991 | <ul style="list-style-type: none"> • Second evaluation of NCADA: Prof Ian Webster (Chair). Report titled ‘No Quick Fix.’ • Third national household survey on drugs conducted: ‘National Campaign against Drug Abuse Social Issues Survey, 1991.’ • Commonwealth Department of Health and Ageing released a report by Collins and Lapsley, ‘Estimating the economic costs of drug abuse in Australia.’ This estimated that in 1988 drug abuse cost the Australian community more than \$14.3 billion, equivalent to 4.6% of gross domestic product for that year. Tobacco cost \$9.7 billion, alcohol cost \$3.9 billion and illicit drugs cost \$1.2 billion. |
| 1992 | <ul style="list-style-type: none"> • Manly meeting: Decision was made to assign greater role to law enforcement in administration of the National Drug Strategy. • The National Drug Strategy Committee convened a National Task Force on Cannabis to produce papers summarising the current state of knowledge about cannabis. • National Centre for Education and Training on Addiction established in Adelaide. • Launch of the Australian Parliamentary Group for Drug Law Reform. |
| 1993 | <ul style="list-style-type: none"> • Re-launch of NCADA as the National Drug Strategy (NDS). • Commonwealth funding for implementation of the NDS provided to law enforcement for the first time. • Australian Medical and Professional Society on Alcohol and Other Drugs (AMPSAD) renamed as the Australasian Professional Society on Alcohol and other Drugs (APSAD). • The Australian Parliamentary Group for Drug Law Reform launched the ‘Charter for Drug Law Reform’ which called for an end to prohibition. • Fourth national household survey on drugs conducted: ‘National Campaign against Drug Abuse Social Issues Survey, 1993.’ |
| 1994 | <ul style="list-style-type: none"> • National Cannabis Task Force recommended that possession, unsanctioned cultivation, sale and non-therapeutic use of cannabis in any quantity should remain illegal but that all Australian jurisdictions consider removing criminal penalties for personal use/possession of cannabis. • Launch of the Australian Drug Law Reform Foundation. • Launch of Drug Free Australia as unfunded national network promoting a |

AN ASSESSMENT OF ILLICIT DRUG POLICY IN AUSTRALIA (1985 TO 2010): THEMES AND TRENDS

| Year | Federal |
|------|--|
| | <p>drug free Australia.</p> <ul style="list-style-type: none"> • First National Hepatitis C Action Plan developed and endorsed by the Australian Health Ministers' Advisory Council. Strategy aimed to minimise transmission and the social and personal impact of Hepatitis C |
| 1995 | <ul style="list-style-type: none"> • Fifth national household survey on drugs conducted: 'National Drug Strategy Household Survey, 1995'. |
| 1996 | <ul style="list-style-type: none"> • Commonwealth Department of Health and Ageing released second report by Collins and Lapsley titled 'The social costs of drug abuse in Australia in 1988 and 1992.' • ADCA Diversion workshop held leading to identification of best-practice principles of diversion and called for an expansion of diversion programs in Australia. • Australian National Council on AIDS and Related Diseases (ANCARD) replaced the Australian National Council on AIDS and was established as the peak advisory body to the federal government on HIV and AIDS. |
| 1997 | <ul style="list-style-type: none"> • Family Drug Support was formed after its founder Tony Trimmingham's son died of a heroin overdose. Aimed to support families struggling with drug use issues. • Third evaluation of National Drug Strategy 'Mapping the Future' by Prof Single and Prof Rohl. Noted confusion over term harm minimisation and insufficient role of NGO sector and fragmented management. • Ministerial Council on Drug Strategy meeting held to discuss ACT heroin trial. Trial supported by Commonwealth health minister and health ministers from ACT, NSW, SA, TAS and Vic. Opposed by health ministers from NT, Qld and WA. i.e. meeting concluded 6-3 in favour of the trial. • The Australian Women's Weekly and Channel Seven's Today Tonight introduced the Australian public to naltrexone with the story subtitled 'I woke up cured of heroin.' The story told of a middle class heroin addict who was miraculously cured from addiction after the magazine had flown her for naltrexone treatment in Israel. • Prime Minister John Howard blocked ACT heroin trial. • Diversion was placed on Ministerial Council of Drug Strategy agenda. • Prime Minister's 'Tough on Drugs' strategy commenced. • Non-Government Organisation Treatment Grants Program (NGOTGP) commenced as part of the Tough on Drugs strategy. NGOTGP aimed to fund the establishment, expansion, upgrading and operation of non-government alcohol and other drug treatment services. • Community Partnerships Initiative (CPI), a community grants program commenced as part of the Tough on Drugs strategy. The CPI aimed to prevent and reduce drug-related harm through projects that promoted and supported the establishment of community driven illicit drug prevention and early intervention initiatives. |
| 1998 | <ul style="list-style-type: none"> • MCDS approved National Heroin Supply Reduction Strategy and National Supply Reduction Strategy for Drugs Other than Heroin which aimed to enhance interdiction at the international border, improve coordination, technology and best practice. |

AN ASSESSMENT OF ILLICIT DRUG POLICY IN AUSTRALIA (1985 TO 2010): THEMES AND TRENDS

| Year | Federal |
|------|--|
| | <ul style="list-style-type: none"> • Launch of Australian National Council on Drugs – Chaired by Major Brian Watters. • Australian National Council on AIDS and Related Diseases Hepatitis C Virus Projections Working Group published report: Estimates and prevalence of the Hepatitis C virus epidemic in Australia. This estimated that in 1997 there were 190,000 people infected with HCV, but prevalence was much higher (50-70%) amongst injecting drug users. • ‘Tough on Drugs’ extended. • National Drug Strategic Framework 1998-99 to 2002-03 released. • Sixth national household survey on drugs conducted: ‘National Drug Strategy Household Survey, 1998.’ |
| 1999 | <ul style="list-style-type: none"> • Naltrexone registered by the Therapeutic Goods Administration for use as part of a comprehensive treatment program for alcohol dependence. • National School Drug Education Strategy adopted. • National Drug Law Enforcement Research Fund (NDLERF) established to support evidence-based research into drug law enforcement. • Council of Australian Government-Illicit Drug Diversion Initiative (IDDI) signed off an agreement for a nationally consistent approach to the diversion of minor drug offenders to drug education and treatment. • Prime Minister John Howard allocated \$110 million to first stage of the IDDI (and \$110 million for support measures – school and community initiatives). |
| 2000 | <ul style="list-style-type: none"> • Illicit Drug Reporting System (IDRS) funded by the Commonwealth Department of Health and Ageing to enable national data collection on drug market trends and provide an early warning system on illicit drugs. This followed the success of pilots in NSW, Victoria and SA. • Launch of first Australian Hepatitis C strategy: National Hepatitis C Strategy 1999-2000 to 2003-2004. • National Minimum Data Set on Alcohol and other drugs treatment services established. • Buprenorphine (as Subutex®) was registered by the Therapeutic Goods Administration. |
| 2001 | <ul style="list-style-type: none"> • Heroin shortage reported in Sydney. Both injecting drug users and key informants noted that heroin availability had reduced, purity decreased and price increased. • National Action Plan on Illicit Drugs 2001 – 2002-03 endorsed by the MCDS. • Seventh national household survey on drugs conducted: ‘National Drug Strategy Household Survey, 2001.’ • Australia’s first Medically Supervised Injecting Centre commenced as a pilot in Kings Cross, NSW. |
| 2002 | <ul style="list-style-type: none"> • Federal Government 2002-03 Budget increased funding for National Illicit Drug Strategy through an additional \$14 million for community partnership initiatives, \$65 million for non-government organisations treatment programs and \$27.5 million to support the development of retractable needle and syringes. • Proceeds of Crime Act 2002 adopted with the aim of confiscating the |

AN ASSESSMENT OF ILLICIT DRUG POLICY IN AUSTRALIA (1985 TO 2010): THEMES AND TRENDS

| Year | Federal |
|------|---|
| | <p>proceeds of crime including current and future benefits that could be derived such as through commercial exploitation of offending.</p> <ul style="list-style-type: none"> • Report on the Return on Investment in Needle and Syringe Programs in Australia concluded that between 1991 and 2000 NSPs had cost Australia \$141 million but saved 25,000 HIV infections, 21,000 HCV infections and \$2.4 to \$7.7 billion. • Prime Minister John Howard announced that the Illicit Drug Diversion Initiative had been a success and that an additional \$215 million would be committed to fund a second stage. • A National Working Group on the Diversion of Precursor Chemicals was established to stop over-the-counter medicines being diverted into illicit drug manufacture. |
| 2003 | <ul style="list-style-type: none"> • Federal Government provided \$316 million in new funding (over four years) for the National Illicit Drug Strategy as part of the 2003-04 Budget. It included \$215 million for IDDI, and \$86 million to continue existing efforts. • \$2 million for the National Psychostimulants Initiative to identify good practice models for treatment and provide training and support for GPs and health workers. • \$4.4 million for the National Comorbidity Initiative to improve coordination and responses to individuals who had both mental health and drug use issues. • \$4 million for a National Rural and Regional Initiative to improve access to treatment for rural illicit drug users. • \$4.4 million for a National Strategy to Prevent the Diversion of Precursor Chemicals into Illicit Drug Manufacture. • National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003 – 2009 released. • Report released from the House of Representatives, Standing Committee on Family and Community Affairs, chaired by Kay Hull MP: ‘Road to recovery: Report on the inquiry into substance abuse in Australian communities.’ • Fourth evaluation of the National Drug Strategic Framework by Success Works. Report titled ‘Evaluation of the National Drug Strategic Framework 1998-99 - 2003-04.’ • Prime Minister John Howard announced funding of more than \$41.5 million to 98 organisations as part of stage 1 funding through the Non-Government Organisation Treatment Grants Program (NGOTGP). |
| 2004 | <ul style="list-style-type: none"> • Prime Minister John Howard announced funding of almost \$18 million to 63 organisations as part of stage 2 funding through the Non-Government Organisation Treatment Grants Program (NGOTGP) (funding from 2003-2006). • The National Drug Strategy: Australia's integrated framework 2004-2009 adopted. • Report on clinical trials of pharmacotherapies for opioid dependence released: ‘National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD).’ • Eighth national household survey on drugs conducted: ‘National Drug Strategy Household Survey, 2004.’ |

AN ASSESSMENT OF ILLICIT DRUG POLICY IN AUSTRALIA (1985 TO 2010): THEMES AND TRENDS

| Year | Federal |
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| | <ul style="list-style-type: none"> Abolition of the National Drug Strategy National Expert Advisory Committees. |
| 2005 | <ul style="list-style-type: none"> Trial of retractable needles and syringes cancelled after evaluation showed they could increase public health risks. Federal Government provided \$21.8 million in new funding for drug and alcohol issues as part of the 2005-2006 Budget. Included \$0.85 million for the National Illicit Drugs Campaign, \$8.0 million for Capacity Building in Indigenous Communities to address Indigenous Issues and \$12.0 million for the Non-Government Organisation Treatment Grants Program. Buprenorphine-naloxone (Suboxone®) registered by the Therapeutic Goods Administration. The first National Hepatitis C Strategy 2005-2008 was adopted. Inquiry established into the manufacture, importation and use of amphetamines and other synthetic drugs in Australia. |
| 2006 | <ul style="list-style-type: none"> Restrictions introduced on sale of medications containing pseudoephedrine requiring that all medication be sold by pharmacists and be stored away from the public. Dr John Herron appointed as Chair of the Australian National Council on Drugs (ANCD). Four Corners Report: 'The Ice Age' heralded the beginning of media attention into methamphetamine. Buprenorphine-naloxone (Suboxone®) made available on the Pharmaceutical Benefits Scheme. National Cannabis Strategy 2006-2009 endorsed. MCDS endorsed development of a National Amphetamine Type Stimulants (ATS) Strategy. Federal Government provided \$214.1 million in new funding for drug and alcohol issues as part of the 2006-2007 Budget. |
| 2007 | <ul style="list-style-type: none"> Ben Cousins, Australian Football League Brownlow medallist and former captain of the West Coast Eagles, was suspended from the club for personal reasons involving drug use. National roll out of Project STOP – tracking sales of pseudoephedrine. Federal Government committed \$150 million in new funding for drug and alcohol issues (for period 2007-08 to 2010-11) as part of the 2007-2008 budget. National Cannabis Prevention and Information Centre set up to educate and train health professionals with the aim of increasing early intervention and reducing the use of cannabis. Ninth national household survey on drugs conducted: 'National Drug Strategy Household Survey, 2007.' The House of Representatives Standing Committee on Family and Human Services chaired by the Hon Bronwyn Bishop released its report into the impact of illicit drug use on families. The report titled 'the winnable war on drugs' recommended that the Australian Government replace the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment with the ultimate aim of achieving permanent |

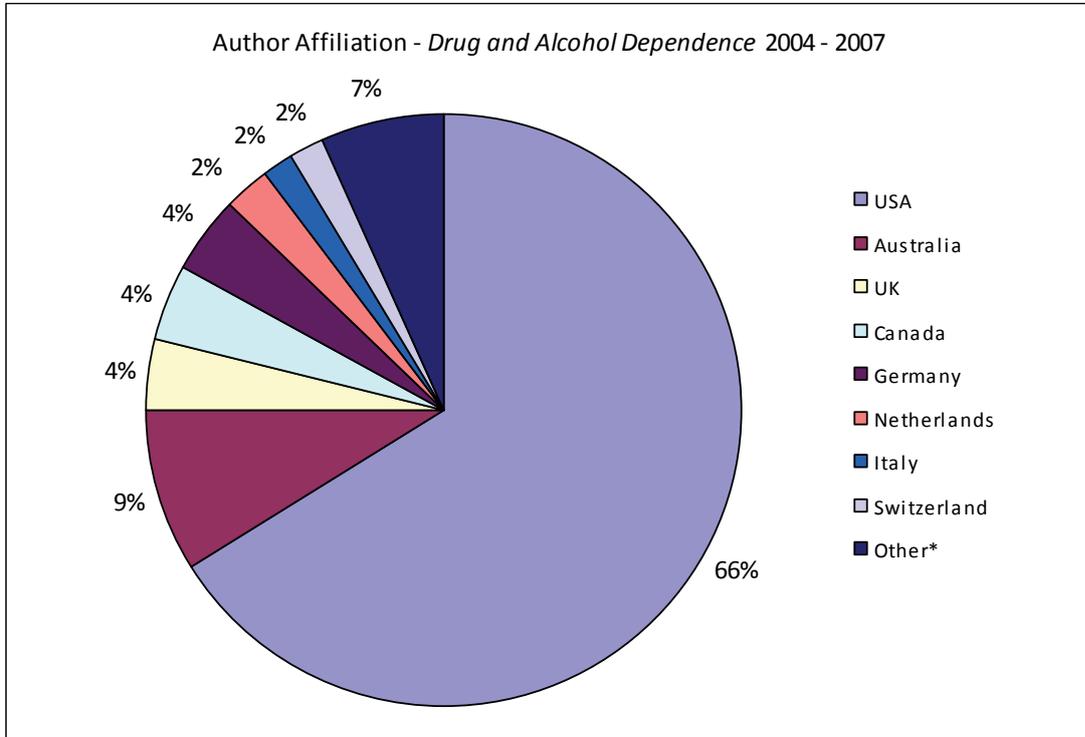
AN ASSESSMENT OF ILLICIT DRUG POLICY IN AUSTRALIA (1985 TO 2010): THEMES AND TRENDS

| Year | Federal |
|------|---|
| | <p>drug-free status.</p> <ul style="list-style-type: none"> • Labor Government elected under Prime Minister Kevin Rudd. • The Council of Australian Governments increased funding for Indigenous substance and alcohol rehabilitation and treatment services: \$100 million. |
| 2008 | <ul style="list-style-type: none"> • Report on ‘Drug Testing in Schools – evidence, impacts and alternatives’ recommended against drug testing in schools. • Media reports that heroin shortage had ended, with increased availability, increased purity and decreased price of white heroin in the Sydney area. Also evident was a rise in heroin overdoses. • Collins and Lapsley released a new report on ‘The cost of tobacco, alcohol and illicit drug abuse to Australian society in 2004-05.’ • Media attention resumed on Naltrexone implants in light of editorials and new research findings on the harms associated with their use. • Netherlands-based Synthetic Drug Unit reported that Australia had become a major destination for supplying Dutch MDMA, aided by the Italian Mafia. Led to the permanent appointment of a Dutch police officer in the Australian Federal Police. • First National Corrections Drug Strategy 2006-2009 endorsed. • MCDS endorsed the First National Amphetamine-Type Stimulants Strategy 2008-2011. • Report on ‘Police drug diversion: a study of criminal offending outcomes’ released by the Australian Institute of Criminology. The report demonstrated that that majority of offenders did not reoffend following diversion. |
| 2009 | <ul style="list-style-type: none"> • New Ministerial Advisory Committee formed on Blood Borne Viruses and Sexually Transmitted Infections. • Release of report on 2007 Australian Survey of Social Attitudes (AuSSA) on crime and justice showed 10% Australians viewed drugs as the first or second most important issue facing Australia. • Illicit Drug Data Report 2007-08 reported that trends in relation to cocaine indicated ‘a possible expansion of the domestic cocaine market.’ • Second Needle Syringe Program (NSP) return on investment study in Australia released. • 2009 Mission Australia youth survey identified that drugs were the number one issue of concern for the survey of 46,000 11-24 year olds. • Fifth evaluation of the National Drug Strategy released by Siggins Miller. • The Ministerial Council on Drug Strategy issued a request for public submissions into the next stage of the NDS: ‘Australia’s National Drug Strategy beyond 2009: Consultation,’ which 96 submissions subsequently received. • Amendments to the Customs (Prohibited Imports) Regulations 1956 were passed. This prohibited the importation of tablet presses without the permission of the Minister for Home Affairs or an authorised person. |
| 2010 | <ul style="list-style-type: none"> • Updated ‘Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings’ produced for the Commonwealth Government. • Australian Federal Police’s Australian Illicit Drug Data Centre (AIDDC) |

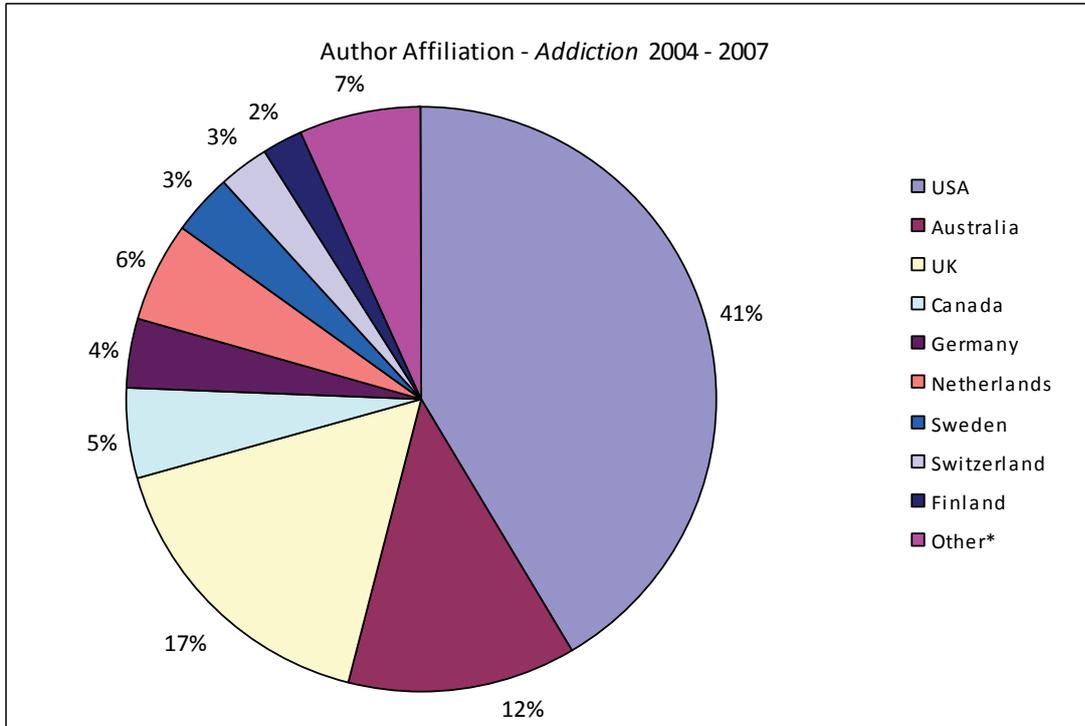
| Year | Federal |
|------|---|
| | <p>opened enabling drug profiling/chemical signature identification for off-shore and on-shore illicit drug seizures.</p> <ul style="list-style-type: none"> • 6th National HIV Strategy 2010-2013, 3rd National Hepatitis C Virus (HCV) Strategy and 3rd National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy released. All recommended that NSPs be trialled in Australian prisons. • National Drug Law Enforcement Research Fund report released: ‘An environmental scan on alcohol and other drug issues facing drug law enforcement in Australia.’ Identified synthetic drugs as the major risk. • The Australian Needle and Syringe Program Survey 2009 indicated a significant decline in the prevalence of HCV antibody: from 61-62% during the period 2005-2008, to 50% in 2009. • A Four Corners/The Age investigation – ‘Crime Incorporated’ – screened on national television with interviews from high ranking police experts including Australian Crime Commission CEO John Lawler about Australia’s fight against drug trafficking and organized crime. Show revealed Australia is making only a small dent into organised crime due to the existence of well established international drug importation syndicates. • NSW Drug Misuse and Trafficking Amendment (Medically Supervised Injecting Centre) Bill 2010 adopted, giving the Kings Cross MSIC permanent status, 9 years post establishment. • Draft National Drug Strategy 2010-2015 released for public feedback. • Bill approving an Australian National Preventive Health Agency passed. Agency will lead Australia’s fight against preventable diseases through campaigns targeting obesity, alcohol, tobacco and other substance abuse. |

APPENDIX D: RESEARCH PUBLICATIONS FROM AUSTRALIA

Figure 3: Australia as ‘punching above its weight’ in relation to research



* Others = Sweden, China, Japan, Brazil, Russia, France, Belgium, Poland, Greece, Finland, Portugal



* Others = China, Japan, Brazil, Russia, France, Italy, Belgium, Poland, Greece, Portugal

Source: Ritter, 2008.

APPENDIX E: DRUG INTERVENTIONS BY THE FOUR PILLARS

Prevention

Mass media campaigns
Targeted media campaigns to at-risk groups
Media advocacy*
Employment
Reducing poverty
Improving overall public health
School-based drug education (SBDE) programs – education and information
Affective education programs in schools
Resistance skills training programs in schools
Generic skills training/competency enhancement programs in schools
Social influence programs in schools
Community/system-wide school programs
Community-building/neighbourhood enhancement programs
Community programs for young people
Crime prevention through environmental design (CPTED)
Infancy and early childhood programs for at-risk groups
At-risk family interventions
At-risk youth programs
Post-natal support for drug dependent mothers*
Parenting skills for drug dependent women
Proactive classroom management & school policy
Mentoring and peer support programs
Renewal programs
Drug Action Teams
Screening in health settings
Drug testing in schools

Law enforcement

Drug-free zones
International treaties and conventions
Bilateral and multilateral international agreements and operations
Prohibition
Decriminalisation
Prescribed availability of drugs*
Licensed availability of drugs*
Legalisation of drugs
Crop eradication programs
Crop substitution programs
Customs and border control
Multi jurisdictions taskforces against trafficking
Crackdowns
Raids
Undercover operations
Intensive policing
Zero tolerance policing
Police management reform

Health and welfare systems management reform*
Asset forfeiture
Financial controls and monitoring re money laundering detection and prevention
Controls on precursor chemicals
Crime mapping technology
Multi agency taskforces/partnerships
Community policing
Civil remedies, third party policing, drug nuisance abatement
Police discretion
Cautioning only
Cautioning with compulsory drug education/treatment
Pre-trial court diversion
Pre-sentence court diversion
Post-sentence court diversion
Drug courts
Restorative justice programs
Detention of intoxicated drug user
Neighbourhood Watch groups
Drug driving programs
Monitoring of drug use by inmates

Treatment

Drug monitoring programs
Drug detection devices (home testing kits)
Brief interventions
Telephone information and counselling services
Withdrawal treatment: Opioid agonist medication
Withdrawal treatment: Alpha adrenergic medication
Withdrawal treatment: Opioid antagonist medication
Withdrawal treatment: Symptomatic medication
Withdrawal treatment: Other (e.g. acupuncture)
In-custody withdrawal services
Methadone maintenance
Buprenorphine maintenance
Heroin maintenance
Naltrexone maintenance
LAAM maintenance
Morphine maintenance
Therapeutic community
Supported accommodation programs
Relapse prevention programs
CBT (individual and group)
Family therapy
Psychodynamic psychotherapy
Work/industry programs
Dual diagnosis programs
Services for pregnant women - pre-natal
Narcotics Anonymous
NARAnon
Drug education in prison

Treatment programs in prison
Parole programs
Post-release programs

Harm reduction

Peer-led advocacy and support programs
Needle Syringe Programs
Outreach programs
Peer education for users
Regulations (and/or legislation) in relation to drug paraphernalia
Overdose prevention programs
Peer administered naloxone
HIV prevention and education programs
HIV/hepatitis voluntary counselling & testing programs
Supervised Injecting facilities
Tolerance zones
NIROA

*Interventions more difficult to classify.

Reproduced from:

Ritter, A., & McDonald, D. (2005). Monograph No. 02: Drug policy interventions: A comprehensive list and a review of classification schemes. *DPMP Monograph Series*. Fitzroy: Turning Point Alcohol and Drug Centre.

Ritter, A., & McDonald, D. (2008). Illicit drug policy: scoping the interventions and taxonomies. *Drugs: Education, Prevention and Policy*, 15(1), 15-35.