Response to the Draft National Drug Strategy 2016 – 2025

October 2015

1. Introduction

The format of the response primarily follows the questions in the online survey, and provides a rating scale similarly as required by the online survey. The online survey, however provides no opportunity to comment on the approach and the term of the draft Strategy. This is addressed in this introduction.

Harm minimisation and the three pillars

The Western Australian Network of Alcohol and other Drug Agencies (WANADA) welcomes the continuation of the harm minimisation approach and the continued harm reduction, demand reduction and supply reduction pillars.

There is, however some concern with the lack of maintenance of the definition of harm reduction in particular. The National Drug Strategy 2010 – 2015 states:

> *Harm reduction means strategies and actions that primarily reduce the adverse health, social and economic consequences of the use of drugs.* [1]

The draft National Drug Strategy 2016 – 2025 states:

> *Harm reduction strategies aim to reduce the negative outcomes from drug use when it is occurring by encouraging safer behaviour, creating supportive environments and reducing preventable risk factors.* [2]

While subtle, this change in definition - from reducing adverse consequences to reducing negative outcomes - is of concern in that it uses a language that adds to, rather than reduces, stigma and discrimination.

After seven iterations of a national strategy over four decades there remains lack of awareness the breadth of harm minimisation and multiple interpretations of the three pillars. Clearly, promotion of the underlying tenet of the Strategy is needed.

The ten year term of the strategy

The proposed ten year term of the National Drug Strategy is an indication of sustained commitment. However the strategies offered under each strategic principle are based on what is currently evidenced, and what is currently being provided. As such there is little scope for innovation and limited motivation by governments to support more than what is currently provided. The October 2015 Special Report by the Australian Strategic Policy Institute provides examples where drug policy success can be fleeting

There is key information under the areas of 'what we know' missing. For example under demand reduction we know from population planning processes recently undertaken (DACCP) that there are inadequate treatment and support services to meet the service needs of the community. To address inadequate services there is a need for increased resources. The service sector knows that alcohol and other drug treatment and support services work, for individuals, families and community well-being, and as a social cost saving. However there is no commitment in the strategy to support the development of outcome measures to enable a demonstration of the extent of the impact made by treatment.

The draft Strategy identifies that '*data are not always comprehensive enough to provide robust national measures of activity and progress'* and that there are no performance measures to evaluate the objectives of the Strategy. For an area that is often seen as politically sensitive and that often polarises the community this needs to be addressed. This requires national leadership, which is lacking in the draft Strategy.

Instead of presenting measurement inadequacy as a given state of affairs, enabling performance measurements needs to be a priority for a strategy that has a ten year term.

[1] National Drug Strategy 2010 – 2015: A framework for action on alcohol, tobacco and other drugs. Page 2 and page 18.
[2] Draft National Drug Strategy 2016 – 2025. Page 6.

WANADA is concerned that the draft National Drug Strategy 2015 – 2025 is lacking in leadership and courage to demonstrate a commitment to making a significant difference. The rhetoric of flexibility and proactive national coordination is not evident in the draft.

2. Purpose and Aims

WANADA **disagrees** that the purpose and aims of the draft National Drug Strategy 2016 – 2025 are clearly presented.

The primary rationale for this opinion is that there is reduced leadership in the aim and no stated purpose in the draft National Drug Strategy 2016 – 2025.

Aim

The Strategy aim has been modified from the 2010 – 2015 Strategy aim – from 'building' to 'contributing to ensuring' – safe, healthy communities. As such the draft 2016 – 2025 strategy is relinquishing a leadership role and responsibility in addressing AOD issues in the community.

It is, however, welcomed that minimising AOD related health, social and economic harms amongst individuals, families and communities remains the direction stated in the aim.

Purpose

As said, there is no stated purpose. As it stands it is difficult to identify an overriding purpose in the draft Strategy.

If there were to be a stated purpose the collective peaks would support concepts of:

- Leadership
- Integrated strategies
- Evidence informed strategies supporting a balanced resource commitment

3. Key Principles

There are four principles offered in the draft National Drug Strategy: Partnership; Coordination and collaboration; Evidence informed responses; and National direction, jurisdictional implementation.

WANADA **disagrees** that the key principles of the draft national Drug Strategy 2016 – 2025 correctly identify the factors that underpin effective responses to alcohol, tobacco and other drug use.

The rationale for this response is based on:

- the lack of depth in the descriptors of each principle;
- inadequate demonstration of the application of the principles within the strategies provided under each of the three pillars;
- lack of key principles such as consumer, family and community engagement.

Partnerships

Partnership between health and law enforcement are clearly central, however this stated partnership falls short of ensuring an integrated Strategy, as identified as needed for best effect by the Australian Strategic Policy Institute comment on the National Drug Strategy 2010 – 2015:

> *While health, education and enforcement officials continue to cooperate, current policy initiatives are at best linked to one another, as opposed to being integrated into a single strategy.* [3]

The long list of relevant partners included in the IGCD membership does not include key partners such as health (primary, tertiary or mental health). Nor does listing partners in this way instil confidence that these partnerships will be meaningfully engaged. Three half day stakeholder forums per year, as offered under the Governance of the draft Strategy, provides nothing more than token engagement of these significant partners.

Coordination and Collaboration

There is no question that coordination and collaboration at the international, national and state and territory levels is important. It is stated that the draft Strategy facilitates collaboration by describing the wide variety of responsibilities within harm minimisation. However no responsibilities have been described in the draft Strategy. The different responsibilities for local, state/territory or federal governments is not articulated. The support structure to facilitate or ensure coordination and collaboration is not evident in the draft Strategy.

Evidence informed response

It is somewhat encouraging that this is a stated principle. Evidence of the effectiveness and cost benefits of approaches under the three pillars is, however, not used as a rationale for any change in direction from the previous 2010 – 2015 Strategy.

If this draft Strategy were truly an evidence informed response there would be a considerable increase in the health focus rather than law enforcement, as reported by the Australian Strategic Policy Institute:

> *Researchers at the Australian Institute of Criminology have cast doubt on the effectiveness of Australian border enforcement agencies' use of illicit drug seizure statistics as performance measures. The research underscored the validity of Australia's 'harm minimisation through supply reduction' policies, but found that current strategies appear to be having little effect on supply… Increased seizure rates have been a consistent trend over recent years, so decreases in domestic availability should have been realised by now if the current strategy is being effective.*[4]

This same report highlights international research that demonstrates the benefit:cost ratio of rehabilitation and treatment facilities of 7 or 8:1, with benefits identified significantly through a reduction in crime and other health costs.[5]

Data, outcomes and impact need to be further developed to enable a truly informed response. This should be a priority for this Strategy to ensure ongoing community and bi-partisan support and to inform best value resource allocation to meet the Strategy aim.

National direction, jurisdiction implementation

It is encouraging to see the draft Strategy identify shared responsibilities for harm minimisation. As stated in the response under 'coordination and collaboration' the different responsibilities for local, state/territory or federal governments is not articulated, and it is therefore not evident that this draft Strategy provides the basis for coordination.

Collaboration in planning and funding to support implementation, at least in demand and harm reduction pillars, has not been consistent across jurisdictions or over time. It is not clear how this draft Strategy will address this to ensure it happens in practice.

Principles that are missing

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[3] Coyne, J., White, V. & Alvarez, C. October 2015, *Methamphetamine: focusing Australia's National Ice Strategy on the problem, not the symptoms*, Australian Strategic Policy Institute, Barton. P 12

[4] Ibid. P 24

[5] Ibid. P 21

- **Consumer, family and community engagement** is a key factor in success (whether this is prevention, treatment, harm reduction services or supply reduction initiatives).

- **Capacity building** is essential and requires resourcing. The extensive partnerships identified suggests a need for capacity building, raising the capacity and capabilities of all relevant sectors to contribute to the harm minimisation agenda.

- A barrier to cross-sector participation in a unified way to harm minimisation is **stigma and discrimination**. While there is no principle on stigma and discrimination there are also no strategies under any of the three pillars that ensure the reduction of stigma and discrimination is prioritised. Stigma and discrimination pose a barrier to the development of a shared theoretical perspective that supports an integrated approach between all stakeholder groups, including law enforcement, education and treatment.

- **Access to a diversity of services** needs to be a principle supported through the National Drug Strategy.

4. Priorities

Priorities are provided in brief within the foreword of the draft Strategy (page 3), with some expanded under a dedicated section (pages 9 – 10). The priorities include:

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

WANADA **disagrees** that the priorities of the draft National Drug Strategy 2016 – 2025 are appropriate.

The rationale for this perspective is based on:

- the mother-hood nature of some of the priority statements with inadequate description of how these priorities might be undertaken
- a failure to reference the evidence that would provide the rationale for the priorities
- priorities that only apply to specific priority drug types
- the minimisation of significant cost efficient and effective approaches
- a lack of relevance for some of the priorities in relation to how they apply across all of the three pillars of harm minimisation

Increasing processes for community to identify and respond to key alcohol, tobacco and other drug issues

There is no expansion on what this priority might look like in practice. There are also no strategies under the three pillars that talks to consumer or community engagement. Inclusion of community engagement under the governance of the draft Strategy similarly fails to identify how this might meaningfully be ensured.

WANADA is supportive of consumer, family and community engagement, however this priority is specific to identifying and responding to issues, and as such is not a comprehensive engagement initiative.

Improving national coordination

Coordination is already identified as a key principle of the draft Strategy. The direct link between key principles and the priorities is inconsistent.

The expansion of this priority is for coordination 'for identifying and addressing drug use and its harms, sharing jurisdictional information on innovative approaches, and developing effective responses'. There is considerable overlap between this and the next priority – developing and sharing data and research.

There are no strategies under the three pillars of harm minimisation for sharing jurisdictional information or approaches. It is difficult to see this effectively being a priority as such, and a priority that will not be subject to monitoring.

Developing and sharing data and research that supports evidence-informed approaches

There is no expansion on what this priority might look like in practice. It is not clear what data and research will be prioritised for developing and sharing.

Under the strategies there is only reference to data as it applies to supply reduction, and no reference to research development needs.

WANADA identifies data, outcomes and impact measures as needed. The stated data and research priority is inadequate in its scope and demonstrated commitment in the draft Strategy.

Developing innovative responses to prevent uptake, delay the first use and reduce harmful levels of alcohol, tobacco and other drug use

The expanded descriptor of this priority identifies as a sub-dot point, amongst other things, increasing access to treatment and facilitating treatment service planning and responsibility for implementation.

WANADA finds it disappointing that the population planning research undertaken, which identifies the specific need for expansion of treatment and support services, is not promoted as a guide in the draft National Strategy.

A more pertinent priority as such would be a planned approach to ensuring adequate treatment and support services. The joint responsibilities for funding this research identified service expansion is not stated. Adequate funding is justified through known benefits:cost ratios.

Restricting or regulating the availability of alcohol, tobacco and other drugs

All of the sub-dot points under this priority appear to apply only to illicit drugs or the illicit use of drugs. The title of this priority either needs to change, or more thought needs to be given to how restricting or regulating the availability of licit substances is to be prioritised. This is particularly significant given the abundance of research that identifies the harms associated with tobacco and alcohol far outweigh the harms from illicit substances.

Enhancing harm reduction approaches

Enhancing harm reduction approaches is a welcome priority, given the well-researched evidence for effectiveness and value for money. That the harm reduction pillar is specifically identified for enhancement as a priority is interesting, which is perhaps an indication of the need to raise the profile of the importance of this pillar. It does, however, demonstrate an inconsistency in the selection of the priorities.

WANADA welcomes this priority and its focus on: high risk population groups (the only priority that makes reference to priority population groups); emerging drug responses; health related responses including those that reduce blood borne viruses and overdose; diversion and pharmacotherapy.

It is encouraging to see many of these priority aspects included within the harm reduction strategies. It is hoped that the priority given to harm reduction translates to additional and adequate funding, commensurate with their demonstrated effectiveness.

5. Evidence-based strategies that can be adapted to local circumstances and issues

WANADA **disagrees** that the draft national Drug Strategy 2016 – 2025 informs evidence-based strategies that can be adapted to local circumstances and issues.

The rationale for this position is primarily based on concerns that many of the strategies are presented as headings only. It is unclear what the intention is, for example, for a strategy that reads 'Outpatient and inpatient treatment services'. While outpatient and inpatient treatment services currently exist throughout Australia there is no direction in this strategy for an expansion of these services based on evidence based planning; for increased focus on evidence based treatment; or for increased capacity to enable demonstrated efficacy.

The strategy list is based on what is currently being done, and as such does not support things being done differently, when clearly there is a need for difference. The lack of any performance indicators or targets against any of the strategies does not support continuous improvement, effectiveness, efficiency or accountability.

There are also limited links between the strategies under all three pillars and the identified priorities and key principles. In addition there are inconsistencies between the 'evidence informed approaches' within the strategy tables and the narrative on 'what the evidence shows is good practice'. This suggests the narrative is either selective, or the strategies are not all informed by evidence.

6. Appropriately identifies the priority populations and drug types

WANADA **disagrees** that the draft National Drug strategy 2016 – 2025 appropriately identifies the **priority populations**.

The rationale for this position is based on:

- the inadequate links made between the impact of AOD issues specific to the population groups. As an example, the relevance of AOD use and the over-representation of Aboriginal and Torres Strait Islander people in detention and prison receives no mention. A health and wellbeing focused harm and demand reduction would contribute to a justice reinvestment initiative, reducing this over-representation.

- a total lack of inclusion of the identified best practice approaches for each of the population groups and the strategies under each of the three pillars. That these best practice initiatives are not included in the strategy matrix devalues the intent of having priority populations identified in the first place.

- omission of significant priority population groups, including those who have experienced significant trauma, such as survivors of family and domestic violence.

WANADA **agrees** that the draft National Drug strategy 2016 – 2025 appropriately identifies the **priority drug types.**

7. What is missing?

WANADA feels that the draft National Drug Strategy 2016 – 2025 is missing:

- **Some spark, enthusiasm, challenge to the current state of play … pushing things forward, thinking outside the box, being alive and relevant and leading reform**

  It is hard to see how this draft Strategy encourages doing anything differently to what is currently in place. In the past Australia was seen as a world leader and innovator in its approach to harm minimisation, this is no longer the case. There needs to be a re-invigoration of purpose.

- **Redressing the imbalance between the three pillars**

  Funding and resourcing inequities across the three pillars exists, with a significant majority (over 64%) of the AOD budget directed to activities associated with supply reduction.[6] Some effort has to be made to balance this inequity with resourcing decisions based on value for money, impact/efficiency and effectiveness.

  There is wavering evidence supporting the effectiveness of supply reduction initiatives, as already touched on above. Despite significantly increased seizures by authorities drugs remain readily available.[7] WANADA rejects the implied assertion on page 16 of the draft Strategy that supply reduction on its own caused the heroin shortage, increasing pricing and reducing use and demand.

  In comparison to supply reduction there is a growing body of evidence supporting the cost efficiency of demand reduction initiatives such as treatment, with benefit:cost ratios reported at 7 or 8:1. [8] Similarly benefit:cost ratio of harm reduction initiatives, such as needle and syringe programs, are reported as returning a 4:1 over a ten year period through reduced health costs, with an estimated 96,667 hepatitis C and 32,050 HIV infections averted between 2000 and 2009. [9]

  The evident effectiveness in achieving financial and social returns for health and wellbeing focused harm and demand reduction initiatives highlights an opportunity for the draft Strategy to redress the imbalance in focus and support across the three pillars. Instead, what is evident is increased creep of law enforcement activity across the three pillars.

- **Measurements/monitoring**

  The measures of success included in the draft Strategy are inadequate. The measures proposed are prevalence rates that cannot be linked to any achievements that may or may not be related to the Strategy. They do not provide any indication of success/achievements or any indication of the cost benefits of any of the approaches or strategies. If such measurements are not routinely available through existing published research then this needs to change. For sustainability of a national drug strategy, for ongoing coordinated responses to drug related issues, and for public accountability there needs to be adequate justification of appropriate funding. Appropriate data and outcome measures are needed to inform policy as well as to inform improvements in practice.

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[6] Ritter, A., McLeod, R., & Shanahan, M. 2013, *Monograph No. 24: Government drug policy expenditure in Australia – 2009/10,* DPMP Monograph Series, Sydney: National Drug and Alcohol Research Centre.

[7] AIHW 2015, Trends in methylamphetamine availability, use and treatment: 2003-04 to 2013-14, Australian Institute of Health and Welfare, Drug Treatment series no. 26., Cat. no. HSE 165, Canberra.

[8] Coyne, J., White, V. & Alvarez, C. October 2015, *Methamphetamine: focusing Australia's National Ice Strategy on the problem, not the symptoms*, Australian Strategic Policy Institute, Barton.

[9] UNSW 2009, Return on investment 2: evaluating the cost-effectiveness of needle and syringe programs in Australia, Department of Health, Government of Australia: Canberra.

While there is a stated commitment in the draft Strategy for annual reporting on the progress of the IGCD 'agenda' (which is not stated in this Strategy) WANADA strongly believes there should be a concerted effort to report annually on any progress or otherwise of the application of the principles and priorities, and commitments made to each of the strategies by each state and territory.

- **Governance**

The governance structure presented in the draft National Drug Strategy 2016 – 2025 is significantly modified from previous strategy governance structures. WANADA believes:

- the disbanding of the previous Ministerial Council on Drug Strategy has diminished the collaboration and coordination of the implementation of the Strategy
- the lack of formal involvement of relevant State and Territory Health and Police Ministers in the actual implementation diminishes the commitment to this Strategy
- the loss of a direct link between the Australian National Council on Drugs and the Prime Minister similarly has resulted in diminished federal government commitment and involvement, through the redirection of direct reporting
- the lack of stated continuation of the sub-committees and time-limited working groups will result in further inaction to ensure the relevance of the Strategy over the ten year term
- the processes for engaging with stakeholders and supporting community input is underwhelming

The governance structure presented does not instil confidence that adequate oversight of the Strategy will be informed, or result in the changes needed to address alcohol, tobacco and other drug issues. The governance structure as it is presented will likely result in a 'watching what happens' strategy only rather than a leadership strategy.

During early consultations to inform this draft Strategy it is the peak bodies' understanding that there had been a commitment to more meaningful engagement with the State and Territory AOD peaks. While inclusion in the stakeholder forums is welcomed it is unlikely to result in enabling a contribution of the proven insight into the various AOD related challenges that would inform the Strategy's progress.

WANADA welcome the IGCD exploring options for expanding participation of broader government agencies. It is hoped that this is then balanced by the inclusion of community service representatives, such as the Australian Council of Social Services, as well as the relevant research centres.