VICTORIAN ALCOHOL & DRUG ASSOCIATION

Australia's National Drug Strategy: Beyond 2009

Response to the Consultation Paper

VAADA Vision

A Victorian community in which the harms associated with drug use are reduced and general health and well being is promoted.

VAADA Objectives

To provide leadership, representation, advocacy and information to the alcohol and other drug and related sectors.

February 2010

The Victorian Alcohol and Drug Association

The Victorian Alcohol and Drug Association (VAADA) is the peak body for alcohol and other drug (AOD) services in Victoria. We provide advocacy, leadership, information and representation on AOD issues both within and beyond the AOD sector.

As a state-wide peak organisation, VAADA has a broad constituency. Our membership and stakeholders include 'drug specific' organisations, consumer advocacy organisations, hospitals, community health centres, primary health organisations, disability services, religious services, general youth services, local government and others, as well as interested individuals.

VAADA's Board is elected from the membership and comprises a range of expertise in the provision and management of alcohol and other drug services and related services.

As a peak organisation, VAADA's purpose is to ensure that the issues for both people experiencing the harms associated with alcohol and other drug use, and the organisations that support them, are well represented in policy, program development, and public discussion.

VAADA's consultation process

As the peak body on alcohol and other drug issues in Victoria, VAADA has undertaken both general and targeted consultation with member services across the Victorian AOD sector to determine their views on emerging trends and issues, key directions and priorities, and workforce needs under the new National Drug Strategy 2010-2015.

Diversity is among the strengths and defining features of the Victorian, and indeed, Australian, AOD sector. This response is based on a diverse range of opinions from across our membership, and some comments may not reflect the individual views of all those who have provided input. While there was powerful consensus on many of the key issues and priorities outlined in this document, the final analysis represents the views of VAADA.

We extend our thanks to those VAADA members who have generously given of their time and professional insight to contribute to the development of this response.

Contents

Introduction

The National Drug Strategy (NDS) is unique in its potential for integrating, coordinating and facilitating a holistic response to drug use and harms that incorporates whole-of-government, non-government, and community approaches. This Consultation represents an important opportunity to review, refresh and revise the Strategy to ensure its continued relevance. We welcome the opportunity to contribute to the debate and discussion and provide input on the directions of the next phase of the Strategy.

VAADA's response to the Consultation Paper considers:

1. The need for **a better balance** in investment across the three pillars of supply, demand and harm reduction
2. Key **issues** and **priorities**
3. The need to build **workforce capacity**
4. NDS **coordination** and **governance**

As the peak body for Victorian alcohol and drug treatment providers, VAADA's response to the Consultation Paper highlights the roles, contribution and capacity of treatment services to address the harms associated with problematic use of alcohol and other drugs under the NDS. VAADA also seeks to reflect the needs and best interests of those people who access treatment services.

Alcohol and drugs policy is difficult and complex. Effectively reducing the harm associated with problematic drug use requires not only greater investment and better allocation of funding and resources, but also innovation, courage, creativity and honesty. While Australia's range of responses to licit and illicit drug use has been relatively progressive, there is a growing need to acknowledge fundamental contradictions and challenges within the conceptual frameworks on which they are based. These include the inherent tension between supply control and harm reduction measures, and the reality that the legal statuses of substances do not necessarily relate to levels of associated risk or harm. VAADA suggests that a key aim of the new NDS should be to contribute to a better informed broader community that is able to confront and debate these fundamental challenges.

Alongside changing patterns of use and harm, and new drug profiles and ways of using, our knowledge, practice and research are constantly evolving. A national drug strategy for the next five years must not merely address substances and issues that are of concern now, but must also provide the strategic policy basis for funding, infrastructure and action on a system-level beyond this period. It is crucial that the new NDS be supported by the kind of political leadership that cultivates better understanding of complex issues. Federal and State governments must also recognise that the transfer of risk, competitive tendering and time-bound funding arrangements impede effective service delivery; and must support the implementation and extension of initiatives that have a strong evidence-base.

The commitment to evidence-informed policy which has underpinned successive strategies must be applied equally to harm, demand and supply reduction strategies. More informed debate should be generated across and within communities. VAADA echoes the perennial call for better translation of research into policy and practice, and timely implementation of the substantial body of existing knowledge.

The language of 'social inclusion', and, to a lesser degree, human rights, is now firmly embedded in political discourse. These concepts provide a strong framework for addressing the structural – including economic, social and cultural – determinants of health and wellbeing, and should underwrite all public policy. Problematic and harmful drug use affects most seriously, and more frequently, groups that are already disadvantaged and/or marginalised.

VAADA believes the overall coordination and governance of the NDS could be improved by enhancing transparency and accountability within the NDS structures and by increasing broader stakeholder participation in NDS policy and decision-making processes. Good public policy is inclusive and participatory and VAADA believes stronger links should be built between the AOD NGO sector and the advisory structures of the NDS.

The evaluation and monitoring process for the NDS, and the final report and recommendations of consultants Siggins Miller, hold real value (Appendix 1) (Siggins Miller 2009). Having invested substantially in the process of monitoring and evaluation, VAADA hopes the recommendations will be considered seriously by the MCDS, alongside input from across relevant sectors and the broader community.

Summary of recommendations

A better balance

- Retain 'harm minimisation' as the principle underpinning the next phase of the NDS, with a continued commitment to the three pillars of supply, demand and harm reduction.
- Reinstate the objective of 'increasing community understanding of drug-related harm' from the 2004-09 NDS with a renewed commitment to educate and inform the community about drug issues and harm minimisation approaches and policies.
- Review the balance of expenditure across the three pillars of supply, demand and harm reduction.
- Ensure all investment decisions and policy initiatives across supply, demand and harm reduction are informed by, and equally subject to, independent evidence and critique.
- Ensure all investment decisions and policy initiatives across supply, demand and harm reduction are based on evidence of measureable outcomes and cost-effectiveness.
- Make funding allocations and information on proportional investment across the three pillars transparent and compile and publish this information annually.
- Develop indicators for the effectiveness of law enforcement, and for how law enforcement and supply reduction interventions interact with and impact on harm reduction efforts.
- Invest in the development and expansion of treatment and harm reduction services and actions.

A growing population

- Undertake forecasting and planning for short, medium and long-term AOD treatment needs based on Australia's growing population.
- Enhance links and engagement with local government and local and state planning authorities to advise on population shifts, local profiles and community needs.

An ageing population

- Support research on alcohol and other drug use and harms among older adults, including
  - risk and protective factors
  - best practice treatment options
  - interactions of prescription medications with alcohol and other drugs.
- Strengthen partnerships between AOD, mental health, aged care and primary health services and sectors.

Prescription and over-the-counter medicines

- Work with relevant bodies to incorporate AOD training components in under- to post-graduate nursing and medical curricula, vocational education and continuous professional development levels and to enhance recognition of addiction as specialist field.

- Support and extend research to build the evidence-base around prescription drugs. This could include research into: the long-term effects of various medications on cognitive functioning; long-term efficacy and therapeutic value of a range of prescription drugs and current and emerging treatment modalities for benzodiazepines and other pharmaceutical drugs.

- Increase the scope and effectiveness of national mechanisms to monitor and assess consumption and misuse of prescribed medications, including 'doctor/pharmacy shopping'.

Addressing the social and structural determinants drug use

- Invest in mechanisms to ensure cross-sectoral collaboration and linkages between AOD, mental health, Indigenous, family and community health, housing, employment and community legal services.

- Promote a definition of prevention that focuses on the social and structural determinants of drug use.

Enhancing community awareness and understanding of drug issues

- Develop a communication strategy which provides clear, consistent messages to politicians, the media and community about the work of the NDS and the AOD sector more broadly.

- Encourage and lead informed community debate about drug issues and approaches for responding to drug-related harm.

- Ensure all NDS funded health promotion and education campaigns are developed in consultation with AOD expert input (including service provider input) and provide nuanced, well-evidenced messages to address drug-related harms.

- Develop strategies to engage and encourage media providers to commit to accurate and responsible reporting of alcohol and other drug related issues.

An integrated research agenda

- Develop and resource an integrated research agenda that
    - balances quantitative and qualitative research effort and outputs
    - documents the evidence bases for the effectiveness of various treatment, harm-reduction, prevention and law enforcement activities
    - provides for the expansion of evaluative studies to determine the effectiveness of various interventions
    - addresses the knowledge gaps identified through the NDS consultation processes
    - develops mechanisms for the timely dissemination of research findings and the promotes the translation of research into practice.

Knowledge gaps

- Build the evidence bases for prevention and law enforcement initiatives and strategies.

- Build the knowledge base for addressing alcohol and drug use among refugees and newly arrived communities, including specifically *how* treatment and other services can better engage with these groups.

- Enhance the NDS focus on particular groups including: people transitioning back into the community from correctional facilities; people transitioning back into the community from residential facilities; and rural and remote communities.

- Increase the knowledge base and wider awareness of the social and structural determinants of drug use.

Improved data collection

- Regularly review the scope of the AODTS-NMDS to ensure data collected adequately captures the varied treatment types and activities and incorporates any new treatment activities.

- Identify measures to better assess outcomes and effects of treatment and other interventions. Any outcome measures must be developed in consultation with service providers and any expansion of data collection processes must be appropriately resourced.

- Improve methods for national data collection and expand the scope and capacity of national data collections systems to: produce accurate trend and outcome data and report-back to agencies on local-level trends and outcomes.

- Improve access to law enforcement data for the purposes of evaluation and review.

Funding and funding models

- Develop and implement alternative and best practice models for funding community-based AOD services.

Professionalisation, pay and conditions

- Explore the feasibility of a national minimum qualification strategy, taking account of the outcomes of the implementation of the Victorian minimum qualification strategy.

- Support the development of an industry plan for the community AOD sector that will ensure the workforce is able to continue to provide quality, effective services and sets the agenda for addressing issues of workforce pay, employment conditions and parity with related sectors.

New technologies and online services

- Undertake consultation with the AOD sector and service providers prior to the implementation of the proposed national eHealth system.

- Adequately fund and resource the AOD sector to adopt and be trained in the use of any national eHealth system.

Policy coordination

- Ensure coordination and integration of the NDS with NDS sub-strategies including the National Alcohol Strategy. Consider developing the National Alcohol Strategy concurrently with the overarching NDS.

- Identify and prioritise the national social and health policies of relevance to the AOD sector and the development of the next NDS.

- Ensure the NDS is aligned with identified social and health policies.

- Provide a rational, coordinated framework or action plan for the integration of identified policies into service practice.

- Ensure the new NDS complements and builds on, rather than replicates, alcohol-related policy directions and initiatives proposed by the National Preventative Health Taskforce.

Transparency

- Clearly articulate the various roles, responsibilities and aims of NDS bodies and make this information publicly available via the NDS website.
- Provide information on the various working groups of the IGCD and ANCD and make this publicly available via the NDS website.
- Publish documents on the governance of the NDS and its advisory bodies to enhance AOD sector and wider community understanding of how the structures supporting the NDS operate.
- Improve documentation of policy discussions, processes and decision-making by the NDS bodies.

Consumer and service provider participation

- Enhance engagement and direct dialogue with the AOD NGO sector.
- Develop formal mechanisms to gather views of service providers and incorporate these into the development and implementation of the new NDS. This could be done through state/territory and national peak bodies.
- Incorporate consumer representation and views into the NDS, potentially through national, state and territory consumer organisations.
- Incorporate consumer representation and views into the NDS, potentially through national, state and territory consumer organisations.

Performance measures and reporting

- Define responsibility for the further development and implementation of NDS performance measures, monitoring and evaluation within the NDS structures.
- Build monitoring and evaluation processes into the new NDS and sub-strategies from the outset as recommended in the Siggins Miller evaluation.

1. A better balance

Harm minimisation – time for a rethink?

Harm minimisation has been the principle underpinning successive national drug strategies. The use of the term, however, is controversial and considered in some quarters to be inappropriate and outdated. Indeed, the Siggins Miller evaluation found that a new term is needed; one that more appropriately communicates the essence of the NDS and which incorporates a greater focus on prevention (Siggins Miller 2009, p.x).

However, VAADA believes that as the conceptual basis of the national framework, 'harm minimisation' has generally served the community well. There is little, if any, value in changing, rebranding or replacing the term at the present time. This view is supported by the majority of VAADA members who provided feedback. The majority of responses to VAADA's consultation indicated broad support for continuing harm minimisation as the principle underpinning the national policy framework; and, despite awareness of inherent tensions and some internal inconsistencies between supply, demand and harm reduction strategies, there was also broad support for the three pillars.

Nonetheless, we acknowledge the continued community misunderstanding of the term. We agree 'it is not a term that has been easy to sell' (Siggins Miller 2009, p.30). We also acknowledge 'a considerable amount of ideological baggage is now associated with [the term]' (Siggins Miller 2009, p.30). However, we disagree with the perception that ''harm minimisation' addresses the consequences of harmful drug use rather than its causes, and hence does not focus adequately on the prevention of drug use' (Siggins Miller 2009, p.32).

Morever, VAADA strongly disagrees with the need to reinforce abstinence-oriented interventions. We believe the current framework embraces a balance of strategies and interventions and is inclusive of abstinence-oriented approaches as well as a range of harm reduction measures. For instance, demand-reduction efforts can and do include a range of abstinence-oriented programs and initiatives.

In the interests of enhancing and promoting a shared community understanding, we agree with the recommendation of Siggins Miller to revisit the principles of harm minimisation as set out by Single and Rohl. These principles being:

1. First, do no harm – consider the unintended harm that might result from a policy or program and ensure that benefits outweigh negative impacts

2. Focus on the harms caused by drug use rather than drug use *per se* – the primary goal of harm minimisation is reducing harm rather than the rates of drug use

3. Maximise intervention options for those in the front-line treatment, law enforcement and others dealing with drug-related problems

4. Choose appropriate outcome goals, giving priority to those that are practical and realisable – harm minimisation involves the prioritisation of goals and does not conflict with an eventual goal of abstinence and is often a first step towards reduction and even cessation of use

5. Respect the rights of persons with drug-related problems – they should be treated with dignity as normal persons [sic]

6. Harm minimisation does not imply support for drug use and should not be equated with the legalisation of drugs – rather, it implies a concern with reducing the adverse consequences of drug use (Single and Rohl 1997 cited in Siggins Miller 2009, p.30).

Both government and the AOD sector share a responsibility to provide accurate information and education to the community about the harm minimisation approach and the work we undertake within the three pillars of supply, demand and harm reduction. AOD service providers with whom VAADA consulted recognised the importance of broadening community understandings of drug issues generally and of our responses under the 'harm minimisation' approach specifically:

> The nub of the issue is if the public is going to support the NDSF then they need to understand what it's about and to some the language around harm minimisation, harm reduction, demand reduction is hard to understand. I think of lot of effort goes into this debate and I note that misconceptions abound within the AOD sector and associated stakeholders such as law enforcement... I'm not convinced that changing the term will make any difference (Service provider, VAADA consultation January 2010).

Most called for a renewed emphasis on the three pillars and a committed focus on public education to strengthen community understanding of, and support for, harm minimisation. 'The community and even mainstream health professionals are only just becoming familiar with the term and concept of harm minimisation and a change now would undermine the gains that have been made (positive branding) (Service provider, VAADA consultation January 2010).

We recommend harm minimisation be retained as the headline term for the national strategy. Furthermore, the three main strategies – demand, supply and harm reduction – should be retained as they provide a balance of approaches.

The investment mix

Achieving a balance in investment and resources across licit and illicit drugs and the three pillars of supply, demand and harm reduction to where there is evidence of the most harm has been a key principle of the NDS, yet VAADA believes the right balance has not yet been struck. This accords with the Siggins Miller evaluation which found that 'policy-setting bodies have faced challenges in finding an optimal balance of investment between licit and illicit drugs... and between supply reduction, demand reduction, and harm reduction (supply reduction continues to attract most resources) (Siggins Miller 2009, p.viii).

Clearly, a single 'balance' point is not something that can be achieved and maintained indefinitely. It requires transparency, innovation and constant review and evaluation. The general view of VAADA's members was that demand and harm reduction measures had been 'left behind' in favour of investment in supply reduction and education and early-intervention (prevention). Indeed, there has been serious historic under-investment in harm reduction and treatment services. VAADA believes this disproportionate expenditure on supply reduction strategies, namely law enforcement and interdiction, warrants immediate evaluation and review.

Further, VAADA is concerned that accurate, accessible information about government expenditure on strategies and actions across the three pillars is not available, and believes that investment decisions and funding allocations to these areas should be transparent.

Given the enormous investment in supply reduction, the evidence base supporting law enforcement as an appropriate strategy must be strengthened, with indicators developed for the effectiveness of law enforcement, as well as how such interventions impact on harm reduction efforts.

By contrast, treatment provision and harm reduction interventions draw on relatively strong and established evidence bases. These have been shown to be both effective, and to provide value for money. For example, the *Return on Investment in Needle and Syringe Programs in Australia* (2002) report demonstrated that needle and syringe programs (NSPs) are effective in reducing the incidence of injecting-related disease, and represent a good financial investment by government. The same rigour must be applied equally and consistently to

interventions across all three pillars in order to facilitate allocative efficiency, and to ensure investment in those interventions that work.

A national prevention agenda

VAADA suggests that, like harm minimisation, prevention is a complex and contested concept which represents different things to different people.

Significant work needs to be done to promote a more *accurate* and *meaningful* understanding of prevention as a continuum of responses, rather than merely preventing uptake of drug use. The prevention agenda has been largely dominated by a conservative segment of the community within an overarching prohibitionist framework. Differences of opinion exist among VAADA stakeholders as to the utility of prevention and the role of prevention in the work of the NDS. While some were in favour of expanding preventative effort (although almost always with the caveat that resourcing should not be diverted from treatment or harm reduction to support prevention efforts); others were resolute in their opposition to reframe the NDS within a prevention framework:

> The banner of 'prevention' would, in effect, perpetuate the dangerous myth that psychoactive substance use is preventable and that prevention strategies exist for reducing the uptake of drug use on a scale sufficient to meaningfully return benefits to society in the form of reduced levels of drug-related harms. This is palpably untrue and unrealistic. People have always and will always continue to make their own choices around psychoactive substances...Without any real prospect of achieving substantial net reductions in drug-related harms via 'prevention', the concept seems to involve little more than 'spin'. It might sound good...*What a prevention focus would achieve, undoubtedly, is more tough talk on law and order, greater disparity of funding between effective harm reduction and ineffective policing. In short, prevention would in effect signal the further entrenchment of supply reduction and a retreat from harm reduction* (Service provider, VAADA consultation December 2009, emphasis added).

We do recognise and accept the important role prevention can and should play in our responses to drugs. In this regard, the work of the Preventative Health Taskforce is timely and important. However, there is a need to build a stronger evidence base around prevention. There is limited evidence to suggest what works in prevention; including with which population groups and under what circumstances preventative action is effective.

To utilise prevention as the overarching banner of Australia's drug policy is not based in evidence. We advocate preventative action that embeds contemporary understandings of the structural determinants of harmful drug use. We do not believe however, that prevention can or should replace harm minimisation efforts. We therefore recommend that the next phase of the NDS commit to building the evidence base for prevention while retaining an overarching focus on harm minimisation.

Recommendations

- Retain 'harm minimisation' as the principle underpinning the next phase of the NDS, with a continued commitment to the three pillars of supply, demand and harm reduction.
- Reinstate the objective of increasing community understanding of drug-related harm from the 2004-09 NDS with a renewed commitment to educate and inform the community about harm minimisation approaches and policies.
- Review the disproportionate expenditure on supply reduction strategies, namely law enforcement and interdiction.

- ❖ Ensure all investment decisions and policy initiatives across the law enforcement, health and education sectors are informed by, and equally subject to, independent evidence and critique.
- ❖ Ensure all investment decisions and policy initiatives across the law enforcement, health and education sectors are based on evidence of cost-effectiveness and measurable outcomes.
- ❖ Make funding allocations and information on proportional investment across the three pillars transparent and compile and publish this information annually.
- ❖ Develop indicators for the effectiveness of law enforcement, and for how law enforcement and supply reduction interventions interact with and impact on harm reduction efforts.
- ❖ Invest in the development and expansion of treatment and harm reduction services and actions.
- ❖ Promote a definition of prevention that focuses on the social and structural determinants of drug use.

2. Key issues and priorities

The discussion and recommendations below respond to the series of questions posed in the Consultation Paper on where resources should be focused under the next NDS. Workforce capacity and policy coordination and governance issues are addressed in sections 3 and 4.

A growing population

Population growth demands an extension of AOD services and an expansion of capacity. VAADA believes mapping and funding services to cater to population shifts will be necessary to reduce short and long term harms to individuals and communities into the future. With Australia's population projected to reach almost 30 million over the next fifteen years (ABS 2008), the next NDS must provide a framework for addressing this sheer growth in demand for services. It must also address the changing demographics of the population as a whole, for example, the service needs of new and emerging culturally and linguistically diverse (CALD) communities and the ageing 'baby-boomer' cohort.

Engagement and partnerships across local government and state-level planning authorities will become more important as the composition and needs of particular localities grow and change. Broader stakeholder engagement in AOD-related policy processes (as recommended by Siggins Miller) should include key informants from local governments and local and state planning authorities to advise on population shifts, local profiles and concurrent needs.

Recommendations

- ❖ Undertake forecasting and planning for short, medium, and long term AOD treatment needs based on Australia's growing population.
- ❖ Enhance links and engagement with local government and local and state planning authorities to advise on population shifts, local profiles and concurrent needs.

An ageing population

Older adults are a largely hidden population of alcohol and drug users, and are the least represented of all age groups in treatment. There is also less known about the extent and type of alcohol and other drug use in this age group. However, we do know that many of the short and long term harms associated with licit and illicit

substance use are exacerbated by age, and that the treatment needs of older people are distinct and often more complex.

A complex set of factors place older people at risk of developing substance use issues including physiological changes, increased isolation, transitional periods such as retirement and experiences of 'loss'. There are also multiple barriers to the identification and therefore treatment of substance use in older adults, including lack of awareness of substance use problems by the individual, their families and health care professionals; complexity of presentation, including the ways physical and mental health disorders can mask substance use; higher use of prescription medications that may interact with alcohol and other drugs; poor social support and isolation; and limited mobility (see, for example, Crome & Crome 2005).

We know that as the baby boomer generation moves into older age there will be profound implications for our healthcare systems, including the AOD sector. VAADA believes there is already substantial capacity within the sector to provide effective and quality AOD treatment for older adults. Translating this capacity into better outcomes for older adults will entail targeted research; partnerships with mental health, aged care and medical services; funding, infrastructure and workforce development; and should draw on system strengths and the growing momentum around this issue.

Recommendations

- ❖ Support research on alcohol and other drug use and harms among older adults, including
  - risk and protective factors
  - best practice treatment options
  - the interaction of prescription medications with alcohol and other drugs.
- ❖ Strengthen partnerships between AOD, mental health, aged care and primary health services.

Prescription and over-the-counter medicines

Misuse of prescription drugs including benzodiazepines, opioids, anti-depressants and other pharmacy medicines is not new but is an area of growing concern. For example, service providers indicate that in some cases (particularly rural and regional areas) prescribed opiates are replacing use of illegal opiates, with '*...many opiate dependent people now using prescribed opiates both legally and illegally rather than chasing "street heroin"'* (Service provider, VAADA consultation 2010). Treatment providers report that misuse of over the counter and pharmacy drugs such as codeine and NurofenPlus™ are also having serious health consequences on growing numbers of individuals, and that for problematic drug users polydrug use, including licit and illicit substances, is the norm. Other issues to be addressed on this front include:

- o The need for better information, including a lack of independent, research-based evidence on the relative benefits and harms of prescribed medication, on drug interactions and iatrogenic illness
- o Limited training and knowledge within the primary and allied health workforce on addiction and misuse of prescription medicines
- o Substitution of illicit for licit substances
- o Limited availability and access to pharmacotherapy and opiate substitution therapy options
- o Chronic pain management
- o The need for better monitoring and assessment of consumption and usage of prescribed medications, including 'doctor/pharmacy shopping'

- Over-prescription of pharmaceutical drugs by GPs

Responding to the overuse and misuse of prescription medications will require ongoing, sophisticated policy interventions across multiple contexts. VAADA believes these issues require greater emphasis and attention alongside appropriate resourcing in the new NDS. One issue of particular concern for AOD treatment providers is the inappropriate prescribing practices of some medical professionals, particularly of benzodiazepines and opioid analgesics. The Victorian Parliamentary 'Inquiry into the misuse/abuse of benzodiazepines and other pharmaceutical drugs' (Drugs & Crime Prevention Committee (DCPC) 2007) similarly identified inappropriate prescribing practices as a key concern.

A growing number of treatment service providers are calling for the establishment and inclusion of AOD training components in under- to post-graduate nursing and medical curricula, vocational education and continuous professional development levels, to enhance the care provided to people using AOD at this interface. The Victorian Parliamentary Inquiry also made a series of recommendations to this end, including a specific call for training and education for Victorian general practitioners on best practice benzodiazepine and opioid analgesic prescribing and management (see recommendations 4-11 of the Inquiry (DCPC 2007)).

VAADA believes that making AOD education and training core components of medical and nursing qualifications would embed understanding of substance use and addiction in everyday primary health practices. There also needs to be ongoing and greater investment in increasing the capacity of the health workforce to identify alcohol and other drug use issues earlier, to offer brief interventions, and to make referrals to specialist AOD treatment services.

Fundamentally, misuse of prescription and pharmacy medicines highlights the somewhat arbitrary and artificial distinction between legal and illegal drugs, and signals the need to focus not only on the particular substance or individual, but also on the systemic, environmental and social influences to addiction.

Recommendations

- Work with relevant bodies to incorporate AOD training components in under- to post-graduate nursing and medical curricula, vocational education and continuous professional development levels and to enhance recognition of addiction as specialist field.
- Support and extend research to build the evidence-base around prescription drugs. This could include research into: the long-term effects of various medications on cognitive functioning; long-term efficacy and therapeutic value of a range of prescription drugs and current and emerging treatment modalities for benzodiazepines and other pharmaceutical drugs.
- Increase effectiveness of national mechanisms to monitor and assess consumption and usage of prescribed medications, including 'doctor/pharmacy shopping'.
- Increase access to and availability of pharmacotherapy and opiate substitution therapy options, including addressing the impact of dispensing fees for both clients and service providers, the need for alternative models of pharmacotherapy, and the need for greater numbers of prescribers.

Addressing the social and structural determinants of drug use

People who experience the most serious harms associated with drug use are often among the most marginalised and socially disadvantaged populations. Social cohesion, access to services, income and employment are structural and social determinants of health. These have been clearly identified by the Preventative Health Taskforce (National Preventative Health Taskforce 2008) and inform the national social inclusion agenda. Important work has been done in enhancing understanding of the multiple and causal factors that drive harmful alcohol and drug use, however VAADA believes this knowledge must be more meaningfully embedded in effective policy.

The particular needs and challenges within Aboriginal and Torres Strait Islander communities are an example of the ways substance use and harms, but also protective factors, are shaped by social and historical processes. Disparities in health and life expectancy between Aboriginal and Torres Strait Islander communities and the broader population, on which substance use is a significant influence, are a case-in-point of the critical need to integrate drug policy with broader social policy efforts. VAADA recognises that the specific and particular needs and issues within Indigenous communities require tailored policies, and supports the continuation of a separate Complementary Action Plan. However, we also contend that the broader NDS should ensure cultural relevance and validity, and believe this would be achieved through greater attention to the structural determinants of health, of which belonging to a minority group is one.

VAADA believes the next phase of the NDS should be heavily informed by an understanding of the complex interactions between social disadvantage and harm from drug use. This will require that the NDS and governance bodies better coordinate drug policy with social and welfare policies addressing disadvantage, poverty, homelessness, marginalisation and social exclusion; actively develop and direct resources to initiatives that strengthen community capacity; and ensure transparency and participation in its processes, as discussed below.

The NDS must also recognise that at practice level, addressing alcohol or drug use cannot be done effectively without also addressing financial, legal, housing and other support needs. Currently however, treatment services are obliged to deal with these issues, in addition to clients' drug use, without additional funding. As one service provider observed, 'social isolation, marginalisation, disadvantage, poverty [and] homelessness all impact negatively on individuals who are experiencing problems associated with their use of drugs' (Service provider, VAADA consultation 2009-10).

Along with greater funding to recognise work already being done, collaboration and linkages between services that span the AOD, mental health, Indigenous, family and community health, housing, employment and community legal systems are key to ensuring that individual and family needs can be addressed meaningfully. Better collaboration and service networks could be achieved, for example, through encouraging funding applications based on working partnerships and consortia, and by mandating MOUs and partnerships for cross-sector projects and programs. Investment in a connected network of quality services will result in better, more sustainable outcomes.

Further, VAADA strongly believes, as discussed above, that the next phase of the NDS should engage government, policy makers and the public in informed debate that generates better understandings of the real drivers of significant harms to drug users and the wider community. This would include acknowledgement that the criminalisation of some drugs directly contributes to negative health, social and legal consequences, and to the social exclusion of users of illicit drugs.

Recommendations

- Invest in mechanisms to ensure cross-sectoral collaboration and linkages between AOD, mental health, Indigenous, family and community health, housing, employment and community legal services.
- Develop and maintain an Aboriginal and Torres Strait Islander Complementary Action Plan.
- Ensure drug policy is coordinated with social and welfare policies addressing disadvantage, poverty, homelessness, marginalisation and social exclusion; and actively develop and direct resources to initiatives that strengthen community capacity.

Enhancing community awareness and understanding of drug issues

VAADA believes wider community understandings of drugs, drug use and effective responses are generally poor. This view was supported by feedback from several members, who observed that the population-level understanding of drugs was 'impoverished'. One service provider submitted that

there needs to be an increased understanding of the reality of drug use in our society, both licit and illicit, and that "just say no" is not based on reality (Service provider, VAADA consultation 2010).

VAADA argues there is an urgent need for nuanced, well-evidenced health promotion and education addressing drug-related harms, rather than drugs use per se. Education must be consistent, relevant and evidence-based, and should prepare the ground for informed decision and debate on drugs policy issues. Drug information and education must balance the need for nuance and sophistication with the imperative to use plain, simple language that meaningfully conveys complex issues.

Given the profound influence of the media on public perceptions and understanding of drug use, the next phase of the NDS should include a focus on engaging and encouraging media providers to commit to accurate and responsible reporting of alcohol and other drug related issues.

Better understanding and acknowledgement of why people use drugs, and of drug use and drug-related harm as strongly influenced by social and structural determinants is necessary if Australia is to develop effective policies that are embedded within broader health and social frameworks. To this end, the importance of applying a human rights framework to the NDS, as well as increasing the participation and representation of consumers, families, Indigenous people and the non-government sector in the policy process, is clear.

Recommendations

- Develop a communication strategy which provides clear, consistent messages to politicians, the media and community about the work of the NDS and the AOD sector more broadly.
- Encourage and lead informed community debate about drug issues and approaches for responding to drug-related harm.
- Ensure all NDS funded health promotion and education campaigns are developed in consultation with AOD expert input (including service provider input) and provide nuanced, well-evidenced messages to address drug-related harms.
- Develop strategies to engage and encourage media providers to commit to accurate and responsible reporting of alcohol and other drug related issues.

An integrated research agenda

> There have been major successes in the AOD field as a result of the application of evidence to policy and practice, including improvement in the quality of the techniques for drug treatment and secondary and tertiary prevention as a result of research, its effective dissemination and the development of training resources. However, still more could be done to achieve evidence-informed responses to drug trends (Siggins Miller 2009, p.56).

VAADA affirms the need to develop a strategic and integrated national research plan as part of the next NDS. Coordinating a research agenda across the NDS funded research centres could ensure that research issues are prioritised according to community need and relevance. A research agenda should also draw on the work of the broader AOD research community where possible.

An NDS research agenda should achieve a balance between quantitative and qualitative research effort. While numerical measurements of 'how much' and 'what' are absolutely critical, a recent commentary on global drug policy observed that:

> There is little or no attention paid to *why...* people are consuming drugs, what it is they achieve, obtain, and communicate about their usage, no hint of the altered states of mind that occur in drug experiences and that fascinate, captivate or compel those millions of citizens to build the consumption of drugs into

> their social identities... This lack of qualitative understanding of drug use as a cultural practice formed within a social and historical setting does little to assist with the construction of *realistic policies* dealing with such a complex and multifaceted issue (Hallam and Bewley-Taylor 2010, p.2, original emphasis).

The Rudd government's emphasis on evidence-based policy provides an opportunity to ensure drug policies are based on what works. To this end, evaluation studies will be essential to developing a stronger evidence base for responding to drug use and related harm under the next NDS. There is a need for further evaluation studies to expand the evidence-base on a range of interventions and to ensure we continue to provide high quality services to the community.

Research production needs to be supported by improved access to, and dissemination of findings. A 2003 VAADA submission noted that 'in order for research to be effective, it needs to be made accessible to organisations that can utilise it. It should not remain the sole property of research institutions or universities. When the results of research studies are not distributed to those who can best make use of them, the extent to which valuable information can be translated into policy and practice and effect a positive difference in the sector, is restricted' (VAADA 2003, p.14). The challenge of disseminating research findings in a timely manner and translating research into policy and practice should be actively tackled through the proposed research agenda.

Recommendations

- ❖ Develop and resource an integrated research agenda that
- balances quantitative and qualitative research effort and outputs
- documents the evidence bases for the effectiveness of various treatment, harm-reduction, prevention and law enforcement activities
- provides for the expansion of evaluative studies to determine the effectiveness of various interventions
- addresses the knowledge gaps identified through the NDS consultation processes
- develops mechanisms for the timely dissemination of research findings and the promotes the translation of research into practice

Knowledge gaps

VAADA members highlighted a range of knowledge gaps that could be addressed as part of a research agenda under the next NDS, some of which are discussed above while others are noted here for the first time:

Recommendations

- ❖ Build the evidence bases for prevention and law enforcement initiatives and strategies.
- ❖ Build the knowledge base for addressing alcohol and drug use among refugees and newly arrived communities, including specifically *how* treatment and other services can better engage with these groups.
- ❖ Enhance the NDS focus on particular groups including: people transitioning back into the community from correctional facilities; people transitioning back into the community from residential facilities; and rural and remote communities.
- ❖ Increase the knowledge base for and wider awareness of the social and structural determinants of drug use.

Improved data collection

In the AOD treatment sector, it has long been recognised that access to standardised, comparable national data is important for assessing the efficiency and effectiveness of our interventions and to inform policy and program planning (AIHW 2009). Yet as noted by Siggins Miller 'capacity to collect data, report on program performance, and use these results to review and improve service and system level performance has been limited' (Siggins Miller 2009, p.59). Quality of data (specifically outcome data) varies across jurisdictions, service types and program areas and the mechanisms to collect it remain limited.

The Siggins Miller evaluation report noted that although a number of national data sets exist, there remains no single aggregated national data set to produce reliable trend data on drug treatment services and treatment modalities (Siggins Miller 2009). The Alcohol and other Drug Treatment Services National Minimum Data Set (AODTS-NMDS) provides some useful information on clients accessing treatment agencies and the services received but this data is largely process and output data and is limited in its scope. For instance, work undertaken by treatment agencies with groups (eg. group counselling) and communities (eg. community education) is generally not included in the collection. Similarly, Victorian agencies are being asked to extend their practice to include families and children yet this type of work is not readily captured by many data collection systems at the present time.

Given that the number of closed treatment episodes and the number of agencies reporting to the (limited) NMDS have risen by almost a quarter and a third respectively in the past four years (Siggins Miller 2009), the production of data indicating treatment trends and effectiveness is becoming increasingly important yet is impeded by the limitations of current data collections systems and processes. VAADA members have stressed the need for 'data collection systems that are robust, consistent and that answer the questions we ask of them' (Service provider, VAADA consultation August 2009).

Limitations identified by VAADA members include:

- Timeliness (reports on trends that have often passed)
- Level of detail (global data rather than local)
- Lack of useful 'return' and feedback on input (at a service provider level, agencies report that despite contributing to data collections, they receive little or no summary data in return, which impedes local planning)
- Need for a balance in the kind of data – a better balance between statistical data; effectiveness and efficiency data and other outcomes measures
- Lack of consistency across jurisdictions
- Lack of availability of law enforcement data

Yet VAADA members were somewhat divided about how best to improve data collection processes and mechanisms and how to enhance the overall quality of data. When asked about the development of performance measures, some feedback suggested that we are not yet at a stage to develop sensible, meaningful performance measures particularly given the constraints of current data collection systems. Others suggested an increased focus on outcome measures would be a positive step forward, noting that a discussion and debate is required to elicit views on appropriate measures. VAADA believes the improving data collection, both in quality and scope, and the ways in which data is collected, should be part of the next NDS. Our data collection systems must be robust and have capacity to collect more sophisticated outcome data. Measures need to be identified that can better assess the outcomes and effects of our interventions and these measures should be developed in consultation with treatment service providers.

VAADA also notes Siggins Miller Recommendation 12 that calls for a nationally consistent monitoring system regarding the purity of illicit drugs. VAADA supports the recent launch of the Australian Illicit Drug Data Centre

as a step in this direction, with the caveat that the new Centre should not serve supply reduction and law enforcement purposes only, but be strongly aligned with and accessible to health and harm reduction services.

Recommendations

- Regularly review the scope of the AODTS-NMDS to ensure data collected adequately captures the varied treatment types and activities and incorporates any new treatment activities.
- Identify measures to better assess outcomes and effects of treatment and other interventions. Any outcome measures must be developed in consultation with service providers and any expansion of data collection processes must be appropriately resourced.
- Improve methods for national data collection and expand the scope and capacity of national data collections systems to: produce accurate trend and outcome data and report-back to agencies on local-level trends and outcomes.
- Improve access to law enforcement data for the purposes of evaluation and review.

3. Supporting the workforce

The NDS Consultation Paper affirms that 'the drug and alcohol sector's capacity to continue to deliver sustainable outcomes will be determined by the skills and energy of, and the supports available to, its workforce' (MCDS 2009, p.8). Without exception, workforce development and capacity issues were among the principal concerns of respondents to VAADA's own consultation on the Strategy.

The social and community services sector generally, and the AOD sector specifically, face serious, ongoing pressures that impact the sustainability and quality of service provision. The urgent need to strengthen and expand the capacity of our workforce is particularly salient in the context of increasing demand for treatment services - as a result of growing community awareness of alcohol and other drug issues, public health campaigns, workplace AOD testing, and more referrals from allied health and welfare services, for example. The next phase of the NDS must provide the strategic framework for the ongoing development and professionalisation of the AOD workforce. This will include addressing:

Funding and funding models

The goal of delivering quality care must be reflected in funding models that value both client outcomes and the workforce that supports these. One service provider asserted that funding models could and should be more sophisticated, and be 'based on treatment outcomes and not throughput' (VAADA consultation 2010).

Treatment agencies continue to report that the multiple treatment needs of AOD clients with complex issues – including clients with acquired brain injury, co-occurring mental health and/or medical conditions, older client groups, and clients experiencing family violence – require a level of resources and time that is not adequately reflected or captured within existing reporting and funding models. VAADA believes the 'complexity' of particular clients is, at least in part, also caused by the system itself with inflexible service delivery models, multiple reporting mechanisms and requirements, limited integration with interfacing service systems and demand for services that outstrips capacity.

In addition, quality accreditation processes, professional training and development, supervision, data collection and reporting, funding applications and administration, human resource management, and OH&S requirements all impact on time available for service delivery and remain unaccounted for in current funding models. VAADA believes one way in which we can improve responses to clients is to develop flexible funding

models that allow services to manage complexity and emerging needs and trends, and that capture the scope of work undertaken.

Agencies continue to report that their staff and services are stretched to capacity. Improved funding models would allow agencies to meet currently unmet demand and would enhance providers' capacity to retain and renumerate skilled and experienced staff, to build the evidence base and pursue innovation and best practice.

Recommendations

- ❖ Develop and implement alternative and best practice models for funding community-based AOD services

Professionalisation, pay and conditions

> AOD clinicians are now expected to be skilled in a variety of interventions and techniques, ranging from CBT (cognitive behavioural therapy) and brief interventions, to working with families, mental health, case management, CALD communities, etc. The demand on the workforce has increased substantially. This requires a better credentialed workforce that demands better remuneration (Service provider, VAADA consultation 2009-10).

The low remuneration rates across the national AOD sector generally do not reflect the skill and energy of the workforce and do not reflect the value of the services provided to the wider community. VAADA believes improved salaries and conditions would attract better quality staff, and would have an immediate impact on the poor recruitment and retention rates that currently affect service quality, individual service providers and the sector as a whole.

VAADA contends that the wider range of issues with which clients now present demand a wider range of treatment approaches drawn from a variety of disciplines. Members similarly noted the need for a greater diversity of skills and approaches together with enhancing the profile of AOD work, a requisite of which is first recognising AOD professionals with appropriate pay and conditions.

VAADA is concerned that services report 'a continued bleed' of skilled and experienced staff to better remunerated service sectors. Parity with other sectors such as mental health is increasingly important, particularly given the current emphasis on dual diagnosis capability. This applies to both pay, and to recognition of training and competencies. For example, VAADA understands that under the dual diagnosis system, addiction nurses are not recognised as having any mental health credentials and are required to undertake extensive post-graduate studies, where conversely, mental health nurses are required only to undertake one AOD TAFE subject.

VAADA proposes that a strategic means of addressing many of these issues is through the development of a national industry plan for the AOD sector. In consultation with peak bodies, an industry plan would provide a framework for ensuring the AOD workforce is able to provide quality, effective treatment and harm reduction services into the future. It could support system and organisational change, serve to set a benchmark for quality and professionalism, and contribute to enhancing the profile of AOD professionals and work. An industry plan would enable identification of workforce capacity issues of cross-jurisdictional significance, and could be supported by strategies to address the need for specialisation, for greater diversity of skilled professionals, and to increase career pathways through the sector.

In addition, VAADA believes there is value in exploring the possibility of a national minimum qualification standard. A minimum qualification strategy (MQS) is now in place in Victoria. The Victorian MQS aims to

- Ensure the development and maintenance of a consistently competent and professional AOD workforce
- Ensure consistent and high level client services

- Increase regard of AOD workers as competent and knowledgeable AOD professionals (Petroulias 2009, p.11)

While the Victorian experience could provide significant learnings and a basis for investigation, a national minimum qualification strategy would need to be highly flexible, and based on meaningful, ongoing consultation with peak bodies, NCETA, education providers and training organisations, and the AOD workforce.

Recommendations

- ❖ Explore the feasibility of a national minimum qualification strategy, taking account of the outcomes of the implementation of the Victorian Minimum Qualification Strategy.
- ❖ Support the development of an industry plan for the community AOD sector that will ensure the workforce is able to continue to provide quality, effective services and sets the agenda for addressing issues of workforce pay, employment conditions and parity with related sectors.

New technologies and online services

The Consultation Paper recognises that developments in technology and online services offer many opportunities and some challenges. For the AOD workforce, online services can and have improved access to training and professional resources, particularly for agencies operating in rural and regional areas.

However, there remain gaps in the effective integration and use of these technologies in practice. A significant obstacle is the limited resources available to agencies for implementing technology infrastructure, and for training staff in its use. The expansion of online and e-systems should have had more of an impact on data collection and improved consistency and ease of reporting.

This also extends to allied workforces where, for example, General Practice Victoria (GPV) report that the medical software currently used within Victorian general practices (eg. Medical Director) does not enable identification and recording of information about patients' AOD use (GPV 2010). This is concerning given the emphasis on early and brief intervention by GPs in primary healthcare settings.

VAADA notes the proposed roll out of a national eHealth patient information records system, and recommends the AOD workforce be consulted in its development, and adequately funded and resourced to make full use of the system.

Services must be supported to identify, develop and be trained in software that is enabling, rather than disabling; that saves time; is more accurate and reflective of client needs and issues; and contributes to better quality information and data that will allow better policy and planning for drug treatment service systems.

Recommendations

- ❖ Undertake consultation with the AOD sector and service providers prior to the implementation of the proposed national eHealth system.
- ❖ Adequately fund and resource the sector to adopt and be trained in the use of a national eHealth system.

4. Coordination and governance

This final section of our submission considers coordination and governance of the NDS, and the roles, functions and workings of the NDS advisory structures. VAADA believes the overall coordination and governance of the NDS could be improved by enhancing transparency and accountability within NDS structures and by increasing

broader stakeholder participation and representation in NDS policy and decision making processes. In particular, we believe there is a need for further engagement with AOD service providers *and* service users, and for stronger links between the AOD NGO sector and the NDS. There is also a need to build capacity to monitor outcomes of the NDS.

Policy coordination

The coordination and oversight of national drug policy is a complex task involving multiple stakeholder perspectives; jurisdictional differences in patterns of use, harm and service delivery and changing political priorities.

Coordination and integration must occur between the layers of the NDS and across NDS sub-strategies. The NDS has been criticised for limited coordination between bodies such as the IGCD and ANCD who, according to some stakeholders, have pursued individual agendas and duplicated effort. Enhancing the capacity of the various NDS bodies to work cooperatively and collaboratively in the pursuit of shared goals and objectives is necessary.

Coordination is also needed across the NDS sub-strategies. For instance, several sub-strategies have expired or are due to expire over the next 1-2 years. Updating these strategies concurrently with the development of the next NDS may avoid duplication of effort and provide greater cohesion and integration of ideas across strategies. It is timely to begin work on the development of the National Alcohol Strategy given the current focus on alcohol and the work of bodies such as the National Preventative Health Taskforce.

As we focus more intensively on cross-sectoral approaches and addressing the structural determinants of drug use, it will also be necessary to coordinate policy responses across sectors and ensure the NDS is aligned with other social policies and reforms including the Rudd Government's Social Inclusion Agenda; national homelessness strategies; taxation reform; education initiatives and health care reform. The rise of alcohol to the national health agenda points to the need for coordination across policies and responses. VAADA hopes the significant work of the National Preventative Health Taskforce and the proposed reforms will be considered within the scope of the NDS. The actions proposed by the Taskforce are broad-ranging and cover issues such as the regulation of alcohol promotions; reform of alcohol taxation; expansion of the evidence and the need to increase public awareness and reshape community attitudes to drinking and intoxication. The next NDS (and more specifically the next National Alcohol Strategy) should complement, not replicate, the work of the Taskforce.

VAADA also believes that a clear framework or action plan must be developed and distributed to service providers which details how various policy initiatives are expected to be implemented across jurisdictions.

Recommendations

- Ensure coordination and integration of the NDS with NDS sub-strategies including the National Alcohol Strategy. Consider developing the National Alcohol Strategy concurrently with the overarching NDS.
- Identify and prioritise the national social and health policies of relevance to the AOD sector and the development of the next NDS.
- Ensure the NDS is aligned with identified social and health policies.
- Provide a rational, coordinated framework or action plan for the integration of identified policies into service practice.
- Ensure the new NDS complements and builds on, rather than replicates, alcohol-related policy directions and initiatives proposed by the National Preventative Health Taskforce.

Transparency

VAADA believes that transparency could be improved at various levels within the NDS advisory structures. There is limited understanding of the roles, responsibilities and functions of various NDS bodies within the AOD NGO sector and there seems to be limited documentation providing this information for those who seek it. The formal evaluation of the NDS found a lack of available documentation on policy discussions, processes and decisions made by bodies such as the IGCD and the MCDS (Siggins & Miller 2009).

Similarly, in their recent study on the coordination of illicit drug policy in Australia, the Drug Policy Modelling Program (DPMP) summarised the issues as follows:

> One area we would argue that is worthy of immediate attention concerns the transparency of Australian illicit drug policy coordination. Transparency was deemed one of the most important aspects of good governance for Australian illicit drug policy coordination, yet between 28% and 42% of stakeholders indicated uncertainty about the application of aspects of transparency, particularly whether roles and responsibilities were clearly specified, whether there was a free flow of information and whether limits, if any, on access to information were well defined and justified (Hughes, Lodge & Ritter 2010, p.71).

VAADA believes that reforming NDS governance and accountability mechanisms and improving the transparency of decision making processes would augment the wider Australian drug policy and practice community's ownership of our national strategy. Drawing on the work of the DPMP Monograph 18 and the findings of the Siggins Miller evaluation together with feedback from AOD service providers, VAADA recommends the NDS should:

Recommendations

- Clearly articulate the various roles, responsibilities and aims of NDS bodies and make this information publicly available via the NDS website.
- Provide information on the various working groups of the IGCD and ANCD and make this publicly available via the NDS website.
- Publish documents on the governance of the NDS and its advisory bodies to enhance AOD sector and wider community understanding of how the structures supporting the NDS operate.
- Improve documentation of policy discussions, processes and decision-making by the NDS bodies.

Consumer and service provider participation

VAADA believes that, while difficult to achieve, participation by all relevant stakeholders is fundamental to the development and realisation of good policy. Participation should be a key principle underpinning the work of the NDS and its advisory structures. We therefore argue for broader stakeholder engagement in the development and implementation of the next NDS. Specifically, VAADA believes there is a need to incorporate service delivery and consumers views into the NDS.

The significant knowledge base and expertise on service delivery within the AOD NGO sector could be better utilised and incorporated into the work of the NDS and sub-strategies. At the present time, there is limited communication between NDS bodies such as the MCDS and IGCD and AOD service providers. For instance, VAADA understands there is no formal mechanism within the IGCD to receive advice and feedback from the sector (Siggins Miller 2009). While we acknowledge the role of the ANCD in providing a voice for the AOD NGO sector to date, this is not a prescribed role of the ANCD, and it may not be best placed to continue the necessary work. We argue for more direct communication and engagement between the IGCD and AOD NGO

service providers, and for the adoption of structured, formal processes to gather serve provider views and incorporate these into the development and implementation of the new NDS.

As a means of achieving this, VAADA suggests the IGCD could consider adopting a formal consultation mechanism for engagement with the AOD sector similar to that utilised by the ANCD (ie. yearly jurisdictional meetings with service providers to elicit their views and concerns). This could go some way towards addressing the perceived lack of 'real content expertise' within the current NDS (Siggins Miller 2009, p.63). We stress the importance of utilising state and territory as well as national peak bodies to obtain advice and information from the AOD sector. This would allow for identification of local trends and patterns and needs.

Similarly, the voice of service users/consumers is sorely lacking from the current NDS. VAADA would like to see greater service user involvement throughout the next phase of the NDS. This could perhaps best be facilitated through representation by consumer and drug user organisations such as AIVL; Harm Reduction Victoria and APSU.

Further, we believe that as part of a commitment to enhanced transparency and accountability, the NDS should establish mechanisms to provide feedback on the implementation of NDS initiatives to all stakeholders, including AOD service providers and consumer groups. We note the Siggins Miller evaluation made a similar recommendation.

Recommendations

- Enhance engagement and direct dialogue with the AOD NGO sector.
- Develop formal mechanisms to gather views of service providers and incorporate these into the development and implementation of the new NDS. This could be done through state/territory and national peak bodies.
- Incorporate consumer representation and views into the NDS, potentially through national, state and territory consumer organisations.
- Provide regular updates on the implementation of NDS initiatives to all stakeholders.

Performance measures and reporting

The Siggins Miller evaluation found that the NDS has 'not been as effective as it could be in either monitoring drug trends or evaluating the impact of the NDS' (2009, p.84). Major components of the NDS have been developed with limited monitoring and evaluation, making it difficult to assess the effectiveness and efficiency of various programs and initiatives. There is a need to build monitoring and evaluation processes into the new NDS and sub-strategies.

Recommendations

- Define responsibility for the further development and implementation of NDS performance measures, monitoring and evaluation within the NDS structures.
- Build monitoring and evaluation processes into the new NDS and sub-strategies from the outset as recommended in the Siggins Miller evaluation.

Appendix 1

Recommendations from the *Evaluation and Monitoring of the National Drug Strategy 2004-2009*, Final Report, Volume 1 (Siggins Miller, April 2009)

Recommendation 1

Highlight and further develop a shared public understanding of the causes and consequences of drug-related harm and the need to retain the three pillars of supply reduction , demand reduction, and harm reduction; and consider replacing the term 'harm minimisation' with words which better communicate the need for prevention of drug use and drug-related harm.

Recommendation 2

Review investment among law enforcement, health and education sectors; supply, demand and harm reduction strategies; and licit and illicit drugs, and develop and apply funding mechanisms, jointly planned at Commonwealth and State and Territory levels, to make allocations that reflect the relative seriousness of the harms and costs addressed, and the availability of evidence-informed strategies and beneficial interventions across drug types and sectors.

Recommendation 3

Progress the development and implementation of a national prevention agenda, for example by:

1) Using NDRI's work in documenting the evidence base for a prevention agenda, including the roles of law enforcement in prevention (Loxley et al 2004), as a point of departure for developing a formal prevention strategy and action
2) Developing links between NDS and related sectors and fields to address the social determinants of health
3) Working to implement contemporary understandings of the social determinants of harmful drug use intersectorally, between drug strategies and other areas of social programming

Recommendation 4

Encourage broader stakeholder engagement in policy processes, in particular, engagement with consumer groups, service providers, and local government, for example by:

1) Building stronger engagement of the NDS with the education and corrections sectors, and enhancing links with related national strategies and policies (welfare reforms, taxation policy) and sectors (mental health, employment, discrimination)
2) Identifying and developing structured processes for assessing the views of the broader public through public consultations, providing greater transparency in public policy development and involving more people in shaping the next NDS
3) Disseminating policy-relevant evidence to the public to bridge the gap in public understanding of the evidence, and ensure that community consultation involves a better informed public and is more likely to meet the ideals of deliberative democracy
4) Establishing mechanisms to provide feedback on continuing implementation and outcomes to stakeholders such as consumer groups, NGOs, and professional organisations

Recommendation 5

Further integrate treatment services and pathways across the government, non-government and private sectors, and encourage increased investment in comprehensive models of evidence-based interventions, for example by:

1) Working collaboratively across sectors to develop referral pathways and integration of care, through government and non-government providers co-location, coordinated referral pathways, and shared care arrangements to meet the clinical and non-clinical needs of clients

2) Increasing capacity across State and Territory, non-government, and private sectors for more collaborative needs-based planning, funding allocation, performance monitoring and review processes

Recommendation 6

Develop a strategic approach to AOD workforce development to meet current and future needs, for example by:

1) Addressing structural issues of national concern such as more competitive employment conditions in the AOD sector, better clinical supervision and mentoring, incentives, continuity of entitlements across government, non-government and private providers, and funding for medical, nursing and allied health specialist training in AOD-related conditions

2) Indentifying strategies to ensure a supply of appropriately skilled and qualified workers (such as enhancing their scope of practice, and providing Medical Benefit Schedule (MBS) for allied health professionals engaged in the AOD sector)

3) Identifying strategies to ensure a supply of appropriately skilled and qualified Aboriginal and Torres Strait Islander and CALD AOD workforces

4) Using NCETA's central role to focus on strategic workforce development and modelling to estimate future needs, in collaboration with other bodies, including some of the State AOD peaks and State and Territory AOD agencies

Recommendation 7

Acknowledging the significant volume and quantity of Australian AOD research output, further enhance national drug research capacity, for example by:

1) Developing a coherent national drug research strategy and implementation program (perhaps based on the report of the former National Drug Research Strategy Committee)

2) Addressing the lack of NDS-supported infrastructure for drug law enforcement research (including dedicated researchers and research centres)

3) Enhancing collaboration between NDS national research centres and other drug research groups and projects

Recommendation 8

Increase capacity for performance monitoring, review and evaluation to inform future investment, for example by:

1) Developing an evaluation framework (literature review of existing evidence, program logic, contextual factors, performance indicators, data items and mechanisms for collecting them) as an integral part of the design of new programs

2) Identifying and developing data collection mechanisms

3) Training staff to collect and use data to monitor the performance of programs, to ensure that programs remain evidence-based and are in a position to improve the quality of their services

4) Undertaking regular program review and improvement processes based on performance data

Recommendation 9

Establish an integrative mechanism to address current limitations of the diverse relationships among the IGCD, ANCD, NEAP, the working groups, and relevant NGOs/peaks. Its functions could include:

- Providing a channel of advice that places identified needs and emerging issues on appropriate agendas, and disseminate the responses
- Defining the relationship of ANCD to the NGO sector in encouraging inputs from the non-government and private sectors into policy, program design, implementation, and evaluation
- Enhancing the role of the NEAP by creating an accessible, stratified database of preferred suppliers of expertise for the use of all advisory structures as needed

Recommendation 10

Expand the IGCD's access to expertise and streamline its operations by:

- Providing a funding mechanism for IGCD activity
- Ensuring a balance of discussion of health and law enforcement issues during meetings
- Engaging with challenging agenda items in a timely way
- Strategically commissioning research from experts inside and outside the IGCD
- Ensuring its recommendations to the MCDS are supported by evidence-based advice
- Adopting decision-making processes that are fully documented and transparent to the field

Recommendation 11

Build monitoring and evaluation into the design of all NDS sub-strategies from the outset.

Recommendation 12

Fill key gaps in Australia's AOD data systems by undertaking a strategic review of AOD data collection systems to prioritise where resources should be applied, including but not confined to:

- Developing a process for reviewing, and implementing as appropriate, the findings and recommendations for the 2006 AIHW investigation into data on drug use, drug-related and drug interventions among Aboriginal and Torres Strait Islander peoples
- Developing a data collection system that provides data on drug-related mortality covering all drugs, at least annually, with minimal delays
- Developing a nationally consistent monitoring system regarding the purity of illicit drugs, which includes a national cannabis potency monitoring program

Recommendation 13

Establish an expert committee to develop a national drug information system, including recommendations on contents, structures, resourcing and processes. Its starting point would be this report, the report of the former National Drug Research Strategy Committee and the report of the NDS Data Analysis Project. It could include developing a system for converting the products of core data collections into policy and action within the framework of the NDS.

Recommendation 14

Establish an ongoing system for monitoring drug issues and trends in Australia, based on a further refinement of the Headline Indicators used in this report.

Recommendation 15

Review the validity and reliability of the NDSHS and the Australian School Student Alcohol and Drug Survey (ASSAD) as they increasingly being questioned. Reviews are needed to assure users that these data collections are sound, or alternatively, to identify problems and suggest remedies.

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