# CHAPTER FIVE

# HEALTH AND AGED CARE RESPONSIBILITIES TO ADDRESS DRUG USE AND HARM

The Department of Health and Aged Care undertakes a range of activities which seek to address the harms to the Australian community caused by the use of drugs such as tobacco, alcohol, illicit drugs and the intentional misuse of pharmaceutical products. Departmental activities may:

- be directly targeted at reducing drug related harm, such as those undertaken by the Department's Drug Strategy and Population Health Social Marketing Branch; or

- have another focus, but still serve to address these issues, for example, initiatives in respect of injury prevention, mental health, therapeutic goods administration, pharmaceutical benefits etc.

Departmental responsibilities of relevance to drug use and drug-related harm are wide ranging and include:

- administration of Commonwealth Government funding to State and Territory Governments to contribute towards State based drug prevention, treatment, research and education activities, for example, funding under the Public Health Outcome Funding Agreements (PHOFA's);

- mechanisms to assess pharmaceutical products, both for registration on the Australian Register of Therapeutic Goods and for subsidisation under the Pharmaceutical Benefits Scheme. This includes assessment of emerging pharmacotherapies for the treatment of alcohol and other drug dependence and taking into account the abuse potential of products during assessment for PBS subsidy;

- administration of Commonwealth Government funding of peak organisations;

- administration of Commonwealth Government funding to primary prevention initiatives. Such initiatives may be directly aimed at preventing or deferring uptake to drug use, for example, the Community Partnerships Initiative, or may be in related areas, for example, activities under the National Suicide Prevention Strategy and the National Mental Health Strategy;

- activities to promote health and wellbeing, for example, through the provision of education and information;

- improving access to treatment services through both the provision of funding to the States and Territories and direct funding of Non-Government Organisation (NGO) treatment services;

- improved service delivery through the development of best practice guidelines and training packages for a range of workers who come into contact with drug users;

- administration of Commonwealth Government funding for a range of research and monitoring activities to inform policy and practice;

- programs designed to reduce the transmission of blood borne viruses among people who inject drugs;

- programs promoting the diversion of illicit drug users away from the criminal justice system and into treatment; and

- participation in international forums to address alcohol and other drug use and related harms.

Examples of specific activities undertaken and or administered by the Department of Health and Aged Care that have the capacity to prevent and/or reduce drug use and harm are outlined below. Activities have been listed against nine categories, namely:

1. Funding to State and Territory Governments and Peak Bodies under the National Drug Strategy
2. Prevention and Early Intervention;
3. National Responses to HIV/AIDS, Hepatitis C and Related Diseases;
4. Treatment, including Diversion to Treatment;
5. Education and Promotion of Best Practice;
6. Research, Monitoring and Evaluation;
7. Addressing the Needs of Specific Populations;
8. Registration, Availability and Quality Use of Pharmaceutical Products; and
9. International Activities.

It should be noted however, that these activities are not mutually exclusive and that some cross over may occur. Rather than repeat related activities under each category they have generally been cited only once. It is important to recognise however, that activities listed under one category may also contribute to outcomes in respect of another.

It is also important to note that the activities undertaken by the Commonwealth Government are consistent with the principle of harm minimisation upon which the National Drug Strategy is based. As detailed in the *National Drug Strategic Framework 1998-99 to 2002-03,* harm minimisation refers to policies and programs aimed at reducing drug-related harm. Such policies and programs aim to improve health, social and economic outcomes for both the community and the individual and encompass a wide range of integrated approaches including:

- supply-reduction strategies designed to disrupt the production and supply of illicit drugs;

- demand reduction strategies designed to prevent the uptake of harmful drug use, including abstinence-oriented strategies to reduce drug use; and

- a range of targeted harm reduction strategies designed to reduce drug-related harm for particular individuals and communities.

As detailed in Chapter 4, supply reduction strategies are generally the responsibility of the law-enforcement sector, including Commonwealth and State and Territory police agencies and Attorney General's Departments, and Commonwealth agencies including the Australian Customs Service and the National Crime Authority.

This chapter details a range of demand reduction and harm reduction initiatives administered by the Department of Health and Aged Care.

## 5.1 FUNDING TO STATE AND TERRITORY GOVERNMENTS AND PEAK BODIES UNDER THE NATIONAL DRUG STRATEGY

### 5.1.1 State and Territory Governments

**Public Health Outcome Funding Agreements.**

Commonwealth financial assistance to States and Territories for the National Drug Strategy is now provided through a broadbanded funding mechanism, the bilateral Public Health Outcome Funding Agreements (PHOFA's). The first round of PHOFA's covered the period 1997-98 to 1998-1999. All Commonwealth, State and Territory Ministers recently signed a second round of Agreements for the five years, 1999-2000 to 2003-2004. Total Commonwealth assistance on offer over the life of these Agreements is expected to exceed $900 million in current prices.

The Commonwealth is providing $118 million in broadbanded base funding in the PHOFA's for 1999-2000. In addition it provides Commonwealth assistance to all jurisdictions for the purchase of vaccines under the National Immunisation Program and quarantined funding for Family Planning activities in South Australia and Victoria, and for certain Non-Government Organisation Treatment Grants under the National Illicit Drugs Strategy Second Instalment in Victoria and South Australia. The monies for the NIDS NGO Treatment Grants paid through the PHOFA's will total $0.86 million in 1999-2000.

Under the PHOFA's Commonwealth assistance for the following eight (8) Commonwealth/State programs has been broadbanded into a single Agreement with each State and Territory. Previously the funding arrangements for these programs were the subject of eight separate agreements between the Commonwealth and each State and Territory:

- National Drug Strategy
- HIV/AIDS Matched Funding Program
- BreastScreen Australia
- National Cervical Screening Program
- National Childhood Immunisation Program
- National Women's Health Program
- Alternative Birthing Program
- National Education Program on Female Genital Mutilation.

The PHOFA's do not replace any of these national initiatives. Rather they have been designed to promote administrative consistency and efficiency across public health initiatives through a single funding and reporting process. The programs in the PHOFA's generally have their own national strategies which, in turn, have a range of performance indicators and evaluation processes in place.

Performance monitoring under the PHOFA's is a joint Commonwealth/State responsibility. Nationally agreed population health indicators are used wherever these are available, including specific measures for monitoring indigenous health.

This standardised approach to Commonwealth/State funding and reporting provisions for public health was introduced in July 1997 as part of the Council of Australian Governments

(COAG) 'whole of Government' approach to health system reform. It took account of the 1995 recommendations of the Joint Council of Public Accounts of the Parliament of the Commonwealth of Australia for the administration of Commonwealth assistance to States and Territories through Special Purpose Payments (SPPs).

The health system reform processes sought to:

- provide quality care responsive to people's needs;
- provide incentives for preventive health and cost effective care;
- give better value for tax payers' dollars;
- more clearly delineate Commonwealth and State/Territory roles and responsibilities;
- give State and Territory Governments the flexibility to utilise Commonwealth assistance according to local needs and priorities;
- move towards a stronger focus nationally on health outcomes for the Australian people.

The Commonwealth and the States and Territories are cognisant of the importance of obtaining expenditure information on each of the strategies covered by the PHOFA's in order to assist in understanding and improving the cost-effectiveness of public health activities and improving overall public health outcomes. As part of the provisions of the current PHOFA's all jurisdictions are participating in the National Public Health Expenditure Project to develop agreed national definitions and reporting procedures for public health expenditure at the State/Territory and Commonwealth levels.

The Australian Institute of Health and Welfare (AIHW) is undertaking this Project in accordance with its Memorandum of Understanding with the Department of Health and Aged Care. The Commonwealth also provided one-off funding in 1998-99 to all States and Territories to advance nationwide implementation of the Project. The Commonwealth, along with all the States and Territories, is represented on the Technical Advisory Group which advises on definitional and methodological issues relating to the measurement of public health expenditure.

Stage 1 of the project commenced in 1997. It focused on collecting descriptive information about public health activity across the whole of government in each jurisdiction. Stage 2 is now in progress. It involves the collection of public health expenditure information for 1998-99, including for:

- communicable disease control - including HIV/AIDS and hepatitis C, needle and syringe programs, other communicable disease control initiatives;and

- health promotion - including drugs of dependence health education/promotion (eg anti-smoking, safe alcohol consumption).

The Australian Institute of Health and Welfare is undertaking annual publication of the information from the National Public Health Expenditure Project, with publication of the 1998-99 data from Stage 2 scheduled for August 2000.

### 5.1.2 Peak Bodies

**Australian National Council on Drugs**

In 1999-2000, funding of $740,000 was provided to the Australian National Council on Drugs to meet commitments under its terms of reference, through the implementation of an annual workplan, and to fund secretariat support. (The role of the Council is set out at 3.3.3).

**Alcohol and other Drugs Council of Australia**

The Department of Health and Aged Care's Community Sector Support Scheme (CSSS) provides funding to community based organisations through specific outputs-based contracts which ensure that organisations focus their efforts on activities which respond to the health and aged care needs of the Australian community.

In 1999-2000, funding of $304,000 was provided under the CSSS to the Alcohol and Other Drugs Council of Australia (ADCA), which is the national peak body representing the NGO sector in the alcohol and other drugs field. ADCA's stated aims are to:

- develop and promote evidence based alcohol and other drug policies to the government, private and community sectors;

- support and foster the valuable role of non government organisation in alcohol and other drug service provision and in policy development; and

- utilise the collective wisdom and expertise of their broad and diverse membership base.

In addition, the Department of Health and Aged Care provides funding to the ADCA for the provision of an alcohol and other drugs library and information service. In 1999-2000 $342,000 was provided to ADCA for this service.

## 5.2 PREVENTION AND EARLY INTERVENTION

Single and Rohl's *Mapping the Future* (1997) was strongly supportive of the continuation and expansion of prevention programs under the National Drug Strategic Framework. Prevention can be defined in many ways and take many forms, for example, targeted media campaigns, legislative controls, distribution of information products, community development projects, peer education, skills building, etc.

Because of this diversity, it is useful to consider prevention as a vehicle that focuses attention and takes action on a wide range of cross cutting issues, such as the social determinants of health, common risk factors, encouragement of new partnerships and on collaborative inter-sectoral action (Sindall, 2000) against a range of drug supply, demand and harm issues.

Examples of prevention activities currently being undertaken by the Department of Health and Aged Care are provided below. This list is not definitive, but rather seeks to give an overview of the broad range of activities that are undertaken across the department and to focus on major initiatives.

### 5.2.1 National Drug Strategy

At its meeting of 17-18 February 2000, the Intergovernmental Committee on Drugs agreed that the Commonwealth Department of Health and Aged Care should further advance the development of a prevention agenda to more sharply focus the National Drug Strategy on preventing the uptake of harmful drug use. The proposed elements of the prevention agenda include:

- a monograph arising out of a literature review of prevention strategies worldwide;
- a prevention resource kit; and
- a workshop on prevention strategies.

The Department is progressing preparation of a monograph through a selective tender process. It is anticipated that once contracts are signed, the monograph will take approximatley twelve months to reach final presentation. Following on from the monograph, and depending on its recommendations, the next stage is anticipated to include identifying policy directions for a whole-of-government approach.

### 5.2.2 National Illicit Drug Strategy

- *Community Partnerships Initiative* (CPI). As part of the National Illicit Drug Strategy $8.8 million (over four years) has been allocated to the CPI. The Initiative is modelled on the World Health Organisation's *Global Initiative on Primary Prevention of Substance Abuse* and aims to encourage quality practice in community action to prevent illicit drug use and to build on existing activity occurring across Australia.

  It is anticipated that the Initiative will contribute to the prevention and reduction of illicit substance use by young people, by mobilising communities and fostering relationships between governments and the broader community. The focus of the Initiative is young people, however it includes other individuals and groups in the community who interact with young people in their social environments.

The Initiative has a number of components including grant funding, state based workshops and the development of self directed learning kits for communities on how to develop and implement community based primary prevention initiatives. To date 87 community based projects have been funded under the Initiative, to a total value of approximately $5.9 million.

- *Australian Drug Information Network ($2.5 million over four years)*. The Australian Drug Foundation has been funded to establish an Australian Drug Information Network (ADIN) to disseminate information on alcohol and drugs to the community, including schools, teachers, and health care professionals. The ADIN, which is expected to launch later this year, is comprised of:

  - a Website which will allow users to undertake a simple search for web based information on alcohol and other drugs specific to their particular needs. The ADIN website will contain a range of information on licit and illicit drugs and information linked to, or contained on the site will go through an accreditation process to ensure the accuracy and credibility of the information available; and

  - a telephone information service which seeks to utilise existing services by creating telephone link lines to the Alcohol and Drug Information Service's (ADIS's) in each state and territory, via a 1300 telephone number.

- *National Illicit Drug Campaign (28.1 million)*. The National Illicit Drug Campaign aims to educate the community about the dangers of illicit drug use and raise awareness about primary prevention, treatment and rehabilitation. Details of the campaign are provided in section 5.2.7 'Social Marketing Activity'.

### 5.2.3 Suicide Prevention

Using alcohol and other drugs in a harmful manner is often a response to emotional and mental health problems. Research has demonstrated links between the misuse of alcohol and other drugs and suicide and self harming behaviour.

Under Commonwealth suicide prevention policy, a number of projects have been initiatied which use primary prevention and early intervention approaches for suicide prevention. These have the potential for reducing the harmful use of alcohol and other drugs.

Programs include those targeting the whole community which aim to build community capacity for preventing suicide by promoting general mental health and emotional wellbeing, and those which reduce access to the means of suicide, such as controls for motor vehicle exhaust gases.

Current initiatives include:

- school based approaches such as Mind Matters: a Mental Health Promotion Resource for Secondary Schools;

- removing the stigma and social isolation around mental illness and encouraging help seeking behaviours by working with the media and promoting mental health literacy; and

- developing and implementing curriculum for undergraduate training for a range of professions incorporating aspects of suicide prevention and mental health promotion.

Under the National Suicide Prevention Strategy (NSPS), Commonwealth policy emphasises establishing strategic partnerships with other agencies to effect coordinated intersectoral action on suicide prevention, including those in the drug and alcohol field. Within this Strategy, a framework is being developed to guide suicide prevention activity over the next four years which can be used by the whole community. Titled *LIFE (Living Is For Everyone)*, this framework identifies primary prevention strategies for reducing risk factors, enhancing protective factors, building community capacity and promoting well being and resilience across the whole community. It is likely that these strategies will contribute to reduced rates of substance abuse.

### 5.2.4 Mental Health

The *Second National Mental Health Plan* is a joint statement by the health ministers of the Commonwealth, State and Territory governments of Australia. It provides a clear national framework for mental health reform activity under the National Mental Health Strategy (NMHS) at the national and State/Territory levels for the period 1998-2003.

Mental health promotion and prevention is one of three priority areas identified for the *Second National Mental Health Plan*. This theme broadly includes mental health promotion, community education, prevention of mental illnesses, and early intervention.

The *Mental Health Promotion and Prevention National Action Plan* was released in February 1999. It provides a policy framework for mental health promotion and prevention under the *Second National Mental Health Plan.* Activities under the national action plan include:

- the development of a background monograph on promotion, prevention and early intervention for mental health;
- scoping study on the mental health needs of the perinatal and 0-2 year old age group;
- scoping study on services and the needs of children and parents with a mental illness.

Additionally, under the National Mental Health Strategy and the National Suicide Prevention Strategy various projects and organisations have been funded that focus on the mental health of children and young people. Many of these activities may ameliorate risk factors for mental illness and suicide in young people, for example, the harmful use of alcohol and other drugs. Projects include:

- AusEinet - The Australian Early Intervention Network for Mental Health in Young People is achieving systemic change through sharing and disseminating information on best practice;

- The Australian Infant, Child, Adolescent and Family Mental Health Association who are conducting the scoping studies identified above;

- MindMatters: - A Mental Health Promotion Resource for Secondary Schools will promote resilience, connectedness, encourage help seeking, provide accurate information on mental illness and skills for coping with change and stress, dealing with bullying, grief and loss;

- Media Strategy - whole of community approaches involving the media, to change community attitudes to mental illness and overcome barriers to help seeking;

- Lifeline and Kids Help Line offer free national telephone counselling services known as "Reach Out!";

- The National Early Psychosis Project that focuses on early intervention in psychosis with young people;

- The Griffith Early Intervention Program that focuses on early intervention in anxiety and depression in children and young people;

- The National Survey of Mental Health and Well-Being - child and adolescent component;

- Various parenting projects for enhancing family relationships and providing early intervention strategies for families identified as being at risk.;

- National University Curriculum Project – developing and disseminating curriculum in undergraduate training for professionals on suicide prevention and mental health promotion;

- *LIFE: A Framework for Prevention of Suicide and Self Harm in Australia 2000-20*04 is being developed for use by the whole community. LIFE identifies strategies aimed at young people using approaches for mental health promotion plus strategies for early intervention and treatment. One of the measures of success will be enhanced emotional well being among young people which may result in decreased rates of substance abuse.

### 5.2.5 National Tobacco Strategy

The National Tobacco Strategy (NTS) 1999 to 2002-03 was endorsed by the Ministerial Council on Drug Strategy (MCDS) in June 1999. This comprehensive strategy provides for national leadership while allowing flexibility for each jurisdiction and the NGO sector to ensure tobacco control action is responsive to their particular needs and priorities. The 1998-99 budget provided $6.1 million over three years for tobacco harm minimisation.

The Department of Health and Aged Care participates in national initiatives under the Strategy and also implements jurisdictional specific responses. Examples of prevention initiatives under the Strategy include:

- *Changing tobacco excise arrangements.* On 1 November 1999 the method for calculating excise on tobacco products changed from a weight based method to a per stick method. The change to a per stick system removed the price differential between budget (high volume packs) cigarettes and other more expensive cigarettes. As a result high volume, low weight cigarettes will rise in price. Legislative responses such as this can have an impact on tobacco related harm as increased price can act as a disincentive to uptake to tobacco use by young people, and also result in a reduction in consumption by those already using.

- *Review of current health warnings on tobacco products.* There have been numerous calls from health groups for the current health warnings on tobacco products to be replaced, claiming that the current warnings are becoming ineffective. In particular, health groups have referred to the Canadian proposal to use pictures of diseased tissues and organs on cigarette packets as incentive to quit.

  In February 2000 Minister Wooldridge announced a review of the current health warnings on tobacco packaging. The first stage of the review currently underway is a research project to evaluate the current Australian health warnings. Public consultation on options for change is anticipated later in 2000.

- *The phase out of all tobacco sponsorship at international sporting events by 2006.* The *Tobacco Advertising Prohibition Act 1992* (the Act) bans the publication or broadcast of tobacco advertisements unless one of the few limited exceptions under the Act can be applied.

  Section 18 of the Act provides one such exception. Under Section 18(2) of the Act, the Minister for Health and Aged Care may specify an event for the purposes of Subsection 18(1) if the Minister is satisfied that the event is of international significance and that failure to specify the event would be likely to result in the event not being held in Australia. Examples of events which have received an exemption under Section 18 include the: Australian Formula One Grand Prix held at Albert Park; Australian Motorcycle Grand Prix held at Phillip Island; IndyCar Australia held at the Gold Coast; Rally Australia event held in WA; and Australian Ladies' Masters Golf Tournament in Queensland.

  The Government has taken the policy position of more rigorously applying the criteria for assessing Section 18 applications and placing tighter restrictions on exempted events in terms of merchandising, promotional activities, and the length of time permitted for an exemption.

  Minister Wooldridge announced in September 1998 that all tobacco sponsorship at international sporting and cultural events will be phased out by 1 October 2006.

- *Disclosure of ingredients found in cigarettes.* Discussions with the Australian tobacco industry to develop an agreed voluntary disclosure protocol are currently under way. The standards of disclosure used in the province of British Columbia Canada have been suggested as a good model from which to develop an industry wide protocol.

  It is proposed that the agreement will facilitate disclosure of information on the ingredients and emissions in cigarettes manufactured and sold in Australia and ensure an unprecedented level of cigarette disclosure in Australia. The objective in developing and adopting this agreement is to ensure that information on ingredients and emissions of cigarettes is made available in a way that effectively informs the public about cigarettes. It is expected that a protocol for disclosure will be in place by late 2000.

- *Sales to Minors.* All governments in Australia have identified the need to develop strategies that will reduce young people's use and access to tobacco products. Work has commenced on developing, implementing and evaluating a national 'best practice' model in sales to minors programs. Programs may include community and retailer education,

legislative options, penalties, monitoring and effective compliance checks and enforcement.

Work on the best practice model to reduce sale and supply of tobacco to children will commence late 2000 after an extensive consultation process.

- *National response to passive smoking*. Environmental tobacco smoke (ETS) is now recognised as a major health hazard to non-smokers. Since the 1980's a succession of government reports released in Australia and other countries have identified ETS as a cause of cancer, respiratory ailments and heart disease (NHMRC 1995).

  The Government has announced that it is working with States and Territories to develop and implement a national response to passive smoking. In Australia, major aspects of passive smoking protection remain a State and Territory responsibility. However, given the recognition by all jurisdictions that people have the right to be free from the harmful effects of tobacco smoke exposure, the Commonwealth is providing national leadership on this issue.

The first component of the national response, which looks at Environmental Tobacco Smoke in enclosed public places and workplaces, is nearing completion.

### 5.2.6 Alcohol Budget Measure

The Government announced funding, in the 2000/01 Budget, of $4 million over 4 years for initiatives to reduce alcohol related harm in Australia.

The funding will support the Commonwealth contribution to the implementation of the National Alcohol Action Plan 2000 – 2003 under the National Drug Strategic Framework 1998-99 to 2002-03 and support the development and implementation of the Commonwealth's own Alcohol Action Plan.

This measure will:
- complement State and Territory initiatives under the National Alcohol Action Plan
- support collaborative projects with industry, community and other government agencies
- augment the National Alcohol Campaign, launched in February 2000
- provide a further developed evidence base for action and alcohol policy
- increase public awareness of responsible drinking behaviour
- promote evidence based prevention and treatment of alcohol dependence

Proposed activities include:

- The implementation of NHMRC Australian Drinking Guidelines to be released later this year using business and community partnerships where possible to disseminate the guidelines.

- The development and dissemination of evidence based clinical practice guidelines for the management of alcohol dependence.

Young people are identified in the National Alcohol Action Plan as one of the groups at particular risk of alcohol related harm. The funding will be used for a range of follow up initiatives that will build on the National Alcohol Campaign.

Indigenous Australians are identified in the National Alcohol Action Plan as one of the groups at particular risk of alcohol related harm. The funding will make a contribution to the development of culturally appropriate interventions and best practice approaches to reducing alcohol related harm amongst Indigenous people, in partnership with relevant government agencies and non-government organisations.

### 5.2.7 Social Marketing Activity

Social marketing is defined by Kotler (1982) as "the design, implementation, and control of programs seeking to increase the acceptability of a social idea or practice in the target group(s)" Social marketing approaches have been used with good results in respect of alcohol and other drug issues, and are underpinned by extensive research to ensure that the concepts and approaches used have salience for the target audience(s). Examples of activities currently underway or planned include:

- *National Alcohol Campaign.* The National Alcohol Campaign was launched by the Federal Minister for Health and Aged Care, Dr Michael Wooldridge on 20 February 2000. The Commonwealth Government's commitment to date to this campaign totals $5.4 million from development to implementation.

  The campaign specifically targets teenagers aged 15-17 years as well as parents of 12-17 year olds and young adults aged 18-24 years. The campaign focuses on young people's drinking and associated information for parents.

  Campaign materials include: 2 television commercials for youth (one targeting males and one targeting females), a print resource for youth, a print resource (brochure) for parents of teenagers 12-17, a newspaper advertisement targeting parents in major Sunday newspapers (on launch day) and regional and suburban newspapers, magazine advertisements for youth and parents, youth and parent/stakeholder websites, and information for parents of Non-English Speaking Backgrounds.

- *The Rock Eisteddfod*. In the form of a performing arts event for primary and secondary schools, the Rock Eisteddfod delivers drug and alcohol prevention messages to the target audience (teenagers aged 12-18). The Department has sponsored the event for the past 11 years and will be sponsoring the 2000 National Rock Eisteddfod TV Special under the banner of the tagline "Drinking. Where are your Choices Taking You?" from the National Alcohol Campaign.

- *The Croc Eisteddfod*. The Croc Eisteddfod Festivals are performing arts events for primary and secondary schools in remote areas of Australia whereby drug prevention messages and strategies can be delivered to youth, parents, teachers, schools and communities at large in a credible youth cultural environment.

  The Department is sponsoring the 2000 Croc Eisteddfod Festivals in conjunction with the Office of Aboriginal and Torres Strait Islander Health (OATSIH). The events will be held in Alice Springs, Moree and Weipa.

- *The National Tobacco Campaign.* The National Tobacco Campaign, launched nationally in June 1997, was initiated by the Commonwealth in association with State and Territory governments, QUIT Campaigns and Cancer Councils.

  The Campaign has achieved a reputation for being the most collaborative, intense and sustained anti tobacco campaign ever seen in Australia. It has recently entered its fourth year of activity and although mass media led, involves a number of other integrated strategy components.

  The current focus of the Campaign is adult cessation. The target group is smokers and recent quitters aged 18-40 years with an emphasis on those of low socio-economic status.

  The Campaign advertising is designed to elevate quitting on smokers' personal agendas by demonstrating new insights on the health effects of smoking. Consultation with medical experts, researchers and consumers identified key areas of health information that could be persuasive in encouraging smokers to quit.

  The campaign to date has had outstanding results with an estimated reduction in adult smoking prevalence of 1.4% in the first six months of the campaign which, by extrapolation, represents approximately 190, 000 fewer smokers in Australia. On a purely economic level, it is estimated that in the first six months of the campaign $24 million in health expenditure was averted. In addition, the campaign has shown potential in reaching high-risk groups such as youth.

  The Campaign utilises seven television commercials, radio, Internet site, print and outdoor advertising public relations, a non-English strategy and a service provider strategy. Considerable upgrading of the national Quitline telephone support service has taken place in conjunction with the Campaign.

  A new phase of campaign television advertising and supporting public relations activity was launched on 31 May 2000, to coincide with World No Tobacco Day. The new advertising will focus on the volume of tar that smokers inhale every year and the eye damage (macular degeneration) that can be caused by smoking.

  The National Tobacco Campaign has generated considerable international interest with adaptations of the television advertisements being utilised in the United States, New Zealand, Singapore, Cambodia, Iceland, Poland and British Columbia. The Campaign has received recognition through several industry awards both here in Australia and overseas.

- *National Illicit Drug Campaign*. A National Illicit Drug Campaign is currently under development and is expected to launch later this year. The National Illicit Drug Campaign will be an integrated campaign, involving television and print advertising, a parents booklet and public relations activities aimed at reaching the community at a grass roots level. The campaign will comprise of two parts:

  **Part 1**, a strategy to meet the information needs of parents, carers and the broader community, has a primary target audience of parents of 12-17 year olds and parents of 8-11 year olds. The secondary audience is other adults, and children aged 12-17. The

aim of part one of the campaign is to inform and support the community, particular parents, in preventing and reducing the harm associated with illicit drug use amongst young people.

**Part 2**, will follow part 1 and will be a series of specifically targeted strategies relating to particular drugs and/or routes of administration. This part will most likely include both primary and secondary prevention components to reach groups identified as being at high risk. The strategies utilised will be informed by a comprehensive research and consultation process.

Formative market research to determine levels of knowledge, attitudes and information needs was undertaken in early 1999 with parents and the broader community. This research has provided the evidence base to guide the development of Part 1 of the campaign. Formative research to guide the development of Part 2 of the campaign is currently underway.

*National Mental Health Strategy*. The Community Awareness Program (CAP) was initiated under the first phase of the National Mental Health Strategy. The Program aimed to increase community awareness about mental illness and reduce stigma and discrimination experienced by people with a mental illness and their family and carers. This included the development and distribution of extensive television, cinema and outdoor advertising. Brochures, posters and videos were also produced to address stigma and discrimination and provide information about mental illness.

As part of the CAP, six brochures designed to increase mental health literacy in the community were updated and distributed in 1999. These are entitled: Mental Illness-The Facts. What is Depression? What is an Eating Disorder? What is Schizophrenia? What is Bipolar Mood Disorder? and What are Anxiety Disorders? Two million brochures have been printed and distributed to general practitioners, pharmacists, schools and the general public since October 1999. There continues to be a strong demand for these resources.

## 5.3 NATIONAL RESPONSES TO HIV/AIDS, HEPATITIS C AND RELATED DISEASES

One of the major focuses of the Commonwealth's approach to preventing and reducing the harms caused by the use of drugs is to prevent the uptake of drug use and to support the provision of effective treatment. However, while not condoning illegal behaviours such as injecting drug use, strategies also need to be implemented which reduce the harm caused to individuals and the community by people who continue to use drugs. As detailed in the *National Drug Strategic Framework 1998-99 to 2002-03*, in these circumstances, harm reduction strategies specifically target the individual using drugs and promote initiatives that benefit the wider community.

Harm reduction has been a cornerstone of Australia's National Drug Strategy since its inception in 1985. The policy of harm reduction has been particularly important in the illicit drugs area, where special priority has been given to pragmatic measures that can prevent or minimise the transmission of HIV/AIDS and other blood borne viruses.

Experience in other countries has shown the potential for the rapid spread of HIV infection, hepatitis C and other blood borne diseases through injecting drug use. Australia's approach in this area has long been regarded as one of the best in the world. We have been particularly successful in controlling the incidence and prevalence of HIV among people who inject drugs. In Australia, the prevalence of HIV infection among people who inject drugs has remained below three per cent and the HIV incidence below one per cent (MacDonald et al., 1997).

In the United States, the Centers for Disease Control and Prevention estimate that almost half the 41,000 new HIV infections in the USA each year occur through people who inject drugs and their sexual partners and children (Lurie and Drucker, 1997). By comparison, in Australia, of the 660 new cases of HIV diagnosed in the 12 months to September 1999, only 6% (40 cases) were attributable to injecting drug use or to "sex with an injecting drug user"" (NCHECR, 2000).

In contrast to HIV infection, the prevalence and incidence of hepatitis C is relatively high among injecting drug users in Australia. This can be explained in part because the hepatitis C epidemic was already well established prior to the introduction of measures such as needle and syringe programs. The hepatitis C virus is also more infectious than HIV (Crofts et al., 1999, and Crofts & Aitkin, 1997).

Exposure to hepatitis C is not just confined to current injecting drug users but is also significant among former injecting drug users (Hepatitis C Virus Projections Working Group, 1998). Since the early 1970s, prevalence of hepatitis C among people who inject drugs has consistently been in the range of 50-70 per cent, while incidence has been estimated at about 15 per cent in the early 1990s (Hepatitis C Virus Projections Working Group, 1998).

Overall, there are about 11,000 new hepatitis C infections annually of which about 80-90% are thought to be due to injecting drug use (Hepatitis C Virus Projections Working Group, 1998). For every 1,000 new infections with hepatitis C, over $14 million (in 1994 terms) is added to Australia's health care costs (Brown & Crofts, 1998).

Despite the relatively high rate of hepatitis C infection, there is some evidence that the prevalence and incidence of hepatitis C infection is falling in Australia. Surveys of the prevalence of hepatitis C among injecting drug users attending Needle and Syringe Programs found a 22% decline between 1995 and 1998 (NCHECR, 1999). Similarly, the incidence of new cases has fallen in some Australian injecting drug user populations, from 18% prior to 1987 to about 12% since then (Crofts et al.,1997).

### 5.3.1 Role of the Department of Health and Aged Care

The Department of Health and Aged Care is the principal Commonwealth agency responsible for coordinating the national response to HIV/AIDS, hepatitis C and other related diseases within a 'whole-of-government' approach.

Australia's national strategic responses to blood borne viruses, such as HIV/AIDS and hepatitis C, have been framed since the late 1980s with 'harm minimisation' identified as an essential component of public health efforts to address these epidemics. These responses have been enunciated since 1989 in three national HIV/AIDS strategies and related documents. The *National HIV/AIDS Strategy 1999-2000 to 2003-2004* has recently been released by the Government (this will be the fourth in the series). A National Hepatitis C Strategy is also currently being developed and will be released shortly.

In practice, Australia's harm reduction approach to the risks of transmission of blood borne viruses among people who inject drugs have translated into two broad groups of initiatives:

- Education/information on safer methods of using drugs, principally provided by peer-based users groups and networks; and

- Provision of sterile injecting equipment through Needle and Syringe Programs (NSPs) established in all jurisdictions.

The principal focus of these harm reduction interventions is to reduce transmission of illness, and thereby to reduce the burden of disease both for individuals and for the broader community.

### 5.3.2 Success of Harm Reduction Approaches

There is a substantial body of evidence that Australia's approach has been successful. This success is demonstrated by:

- maintenance of consistently low levels of HIV transmission among people who inject drugs**.** Needle and Syringe Program surveys show that HIV prevalence among people who inject drugs fell from 2.0% in 1995 to 1.5% in 1998 (NCHECR, 1999);

- less than 5% of total AIDS cases reported in Australia, are attributable solely to injecting drug use, compared with nearly 40% of AIDS cases in the USA where harm minimisation measures are generally not available nor widespread (NCHECR, 2000 & US Department of Health and Human Services, 1998);

- consistently low levels of mother-to-child transmission of HIV have been maintained where one or other parent injects drugs. In New York City (comparable population to

NSW) there were 17,000 paediatric cases of AIDS in 1997, compared with 42 in NSW (cited in Wodak & Penny, 1997);

- a 22% reduction in the prevalence of hepatitis C among injecting drug users attending Needle and Syringe Programs from 1995 to 1998 (from 63% in 1995 to 49% in 1998) (NCHECR, 1999);

- a 23% reduction in hepatitis C prevalence among injecting drug users who have been injecting for less than 3 years – from 22% in 1995 to 17% in 1998 (NCHECR, 1999). This indicates that prevention efforts among those recently initiated into injecting practices are having a significant impact; and

- a 52% reduction in rates of sharing injecting equipment among people who inject drugs - from 31% in 1995 to 15% in 1997 (MacDonald, M. *et al,* 2000). This suggests a significant reduction in this extremely high risk for BBV transmission.

### 5.3.3 Needle and Syringe Programs

Needle and Syringe Programs (NSPs) are recognised nationally and internationally as an important part of Australia's success in controlling and reducing HIV transmission particularly transmission that may occur via injecting drug use.

While the Commonwealth plays an indirect role in the operation of NSPs, the Government, through the Department of Health and Aged Care, supports the continuation and enhancement of NSPs (including through the provision of indirect funding support – outlined below).

This commitment is consistent with the support given for NSPs in the *National Drug Strategic Framework 1998-99 – 2002-03* and the recently released *HIV/AIDS Strategy 1999-2000 to 2003-2004*.

Australia's Needle and Syringe Programs are also strongly supported by the Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD) and the Australian National Council on Drugs (ANCD). In September 1999, the Chairman of the ANCD, Major Brian Watters, called for "an expansion of and enhancement of needle exchange services in Australia". He is quoted as saying:

> *"The role of needle exchange programs in minimising the rate of HIV and other blood borne viral infections in Australia is well documented and acknowledged around the world. It is now time for all governments to consider expanding the role of the needle exchange programs they have established to assist in increasing client access to treatment services."* (ANCD, 1999)

#### 5.3.3.1 Funding of Needle and Syringe Programs

State and Territory governments are responsible for directly funding and administering Needle and Syringe Programs and for ensuring that there exists an appropriate balance in education and prevention activities within their jurisdiction. For the past ten years all State and Territory governments have provided Needle and Syringe Programs.

Since 1997/98 the Department of Health and Aged Care has provided broad-banded funding to States and Territories through the Public Health Outcome Funding Agreements (PHOFAs). In line with the broadbanded funding arrangements, the quantum of funding applied to NSPs is no longer reported to the Department. State and Territory Governments now provide public health expenditure data to the Australian Institute of Health and Welfare as part of the National Public Health Expenditure Project (more details at 5.1)

In April 1999, the Council of Australian Governments (COAG) approved a $221 million package of measures under the 'Tough On Drugs' initiative. Within this package, funding of $30.6 million is being provided over four years for the support of Needle and Syringe Programs, through: (1) the provision of additional education, counselling and referral services directed at users through community based Needle and Syringe Programs, and; (2) the diversification of existing Needle and Syringe Programs through pharmacies and other outlets.

Of the $30.6 million allocated for the support of NSPs, $27 million is being provided to States and Territories with the balance supporting a range of national activities. The Department of Health and Aged Care (Population Health Division) is responsible for administering this funding.

The aims of these initiatives are to increase the number of clients accessing education and treatment services and to increase the availability of sterile needles and syringes, including through pharmacies. These initiatives are being developed in close consultation with State/Territory authorities and other key stakeholders, including community groups.

#### 5.3.3.2 Evidence for the Success of Needle and Syringe Programs

There is abundant evidence from Australia and other countries of the public health benefits of Needle and Syringe Programs (Varmus, 1998). In 1998, the United States Secretary for Health and Human Services, Donna Shalala announced that:

> *"this nation is fighting two deadly epidemics – AIDS and drug abuse. They are robbing us of far too many of our citizens and weakening our future. A meticulous scientific review has now proven that needle exchange programs can reduce the transmission of HIV and save lives without losing ground in the battle against illegal drugs. It offers communities that decide to pursue needle exchange programs yet another weapon in their fight against AIDS."* (US Health and Human Services Press Office, 1998)

In Australia, evidence demonstrates very clearly that Needle and Syringe Programs have reduced the transmission of HIV, hepatitis B and hepatitis C and that this has been achieved without increasing injecting drug use or the number of discarded needles and syringes. The size of the reduction of HIV transmission due to NSPs has been estimated to be at least 30%. (derived from Hurley & Butler, 1996 – 3,000 HIV cases prevented in 1991.)

There has been a marked decline in reported sharing of syringes in Australia since 1984, when more than 90% of respondents reported having done so in the month before interview (cited in MacDonald et al., 2000). Among injecting drug users attending Needle and Syringe Programs, reported use of a needle and syringe after someone else in the preceding month declined significantly from 31% in 1995 to 15% in 1997 (MacDonald et al., 2000).

While rates of infection of hepatitis C among injecting drug users remain high, there is some evidence that both the prevalence and incidence of hepatitis C infection among injecting drug users is falling and that rates would be markedly higher in the absence of Needle and Syringe Programs. Reasons for the relatively high rate of hepatitis C infection (compared with HIV infection) among injecting drug users include:

- hepatitis C was already well established among injecting drug users before the introduction of harm minimisation interventions such as NSPs (this was not the case with HIV);

- hepatitis C is more efficiently transmitted through blood-to-blood contact than HIV, and is now known to be more infectious than HIV with smaller amounts of blood needed for transmission. Risks of transmission arise not just from sharing needles and syringes, but also from sharing other equipment such as spoons, water, tourniquets and swabs; and

- despite the efforts of NSPs and peer-based education programs, some people who inject drugs continue to engage in high risk behaviours, such as sharing injecting equipment.

Needle and Syringe Programs in Australia have been shown to be highly cost-effective. The evaluation of the 2nd National HIV/AIDS Strategy conducted by Professor Richard Feachem (Head of the Health Division, World Bank) found that NSPs prevented at least 3,000 cases of HIV in 1991, producing a saving of about $266 million in that year alone (Feachem, 1995). Professor Feachem concluded that "the savings in treatment costs due to the prevention of HIV infection more than offset the operating costs of the [needle and syringe] programs… even under the worst case assumptions" (Feachem, 1995).

It is important to note that NSPs are not simply programs for distributing and receiving needles; they also offer an opportunity for health promotion and referral interventions to other health and treatment services. This is particularly true for hard-to-reach populations such as people in geographically isolated regions, as well as people from culturally and linguistically diverse backgrounds whose own cultural organisations may not acknowledge the presence of BBV risk behaviours, such as injecting drug use, within their community.

Research suggests that Needle and Syringe Programs tend to attract injecting drug users who are homeless, inject more frequently, use shooting galleries or engage in sex work (Hahn et al.,1997, and Schechter et al., 1999). Many of these clients have never been in contact with other drug services (Klee & Morris, 1995, and Stimpson, 1989). Therefore NSPs are an

important point of first contact for high risk injecting drug users and can act as "gateways" to more traditional treatment for drug dependence (Heimer, 1997).

#### 5.3.3.3 Unsafe Disposal of Needles and Syringes

There is substantial public concern over the unsafe disposal of needles and syringes, and the concomitant risk of needle stick injury to members of the public. Much of this concern is focused on the operation of NSPs and is based on the belief that NSPs are responsible for exacerbating the problem.

State and Territory governments are responsible for providing facilities to ensure the continued high rates of return and safe disposal of used injecting equipment. All injecting drug users are encouraged through a number of incentive programs, which vary in each State and Territory, to return their used needles. The efforts of State and Territory governments to improve the safe disposal of used injecting equipment will be enhanced by the funding being provided under the COAG measures for the support of NSPs.

The Department of Health and Aged Care has an interest in the population health aspects of needle disposal as well as in the implications of public concern over this issue for the operation of NSPs. The Department's Therapeutic Goods Administration also has a role to play in relation to the development of retractable needles suitable for use by injecting drug users (see below).

Despite public perceptions, there is no evidence that NSPs increase the number of needles and syringes discarded in public areas (Oliver et al., 1994). Indeed the incidences of inappropriately disposed injecting equipment are low relative to the numbers of needles and syringes supplied. During a twenty–month period in Brisbane, 1.4 million pieces of injecting equipment were distributed and only 871 pieces (0.1%) were found to have been inappropriately discarded (Queensland Department of Health, 1999).

In addition, there have been no recorded cases in Australia of people who have experienced a non-occupational needle stick injury, contracting diseases such as HIV/AIDS or hepatitis C.

NSPs not only provide disposal for used needles and syringes but they aim to reduce the number of improperly discarded needles and syringes by providing information to clients about safe disposal, and by collecting and cleaning up discarded injecting equipment on a regular basis.

Retractable needles may offer a partial solution to the risk of needle stick injury although the devices currently available are not adequate or appropriate for use in Needle and Syringe Programs (eg, because they can be modified for re-use and they are relatively expensive). The development of a retractable needle suitable for use in NSPs is being pursued by the Joint Working Group of the Intergovernmental Committee on Drugs (IGCD) and the Intergovernmental Committee on AIDS, Hepatitis C and Related Diseases (IGCAHRD).

To facilitate this process, the Minister for Health Dr Wooldridge has directed the Therapeutic Goods Administration to provide advice on evaluation guidelines for retractable needles and syringes.

### 5.3.4 Other Programs

In addition to funding for Needle and Syringe Programs, other activities undertaken by the Department of Health and Aged Care to reduce the transmission of blood borne viruses and ameliorate the harm and suffering caused by infection (including among injecting drug users) include:

- coordination and implementation of national strategies on communicable diseases issues, including, the National Communicable Diseases Surveillance Strategy, the National Indigenous Australian's Sexual Health Strategy and four national strategies on HIV/AIDS. The *National HIV/AIDS Strategy 1999-2000 to 2002-2003* has recently been released by the Government;

- development of a *National Hepatitis C Strategy* (the first of its type in the world), in collaboration with State and Territory Health Departments, key community based organisations and other stakeholders. This Strategy is expected to be launched in the near future;

- funding of $12.4 million over 4 years for improved education, prevention and health maintenance initiatives for those currently infected with hepatitis C, and for those at risk of becoming infected, to lower the current rate of transmission of hepatitis C in Australia;

- funding to the Australian IV League (AIVL) for two years to undertake the National Hepatitis C Education and Prevention Program for people who use drugs illicitly. Under this program AIVL has thus far published the *AIVL Guide to cleaning fits* and the *AIVL Guide to safer injecting*; engaged a contractor to develop a targeted campaign about safer injecting; and commenced revising educational resources for national distribution. A regular newsletter, *Hepatitis See*, is also published;

- funding of $700,000 for priority hepatitis C education and prevention initiatives (including a forum on Blood Borne Virus Prevention among Aboriginal and Torres Strait Islander Injecting Drug Users, and a hepatitis C 'Incident Case Register'); and

- funding to the Australian Hepatitis Council for education initiatives targeting people living with hepatitis C, people affected by hepatitis C and the general community. Part of this work involves the development of an education strategy for people living with hepatitis.

## 5.4 TREATMENT, AND DIVERSION TO TREATMENT

The availability of treatment services for users of both licit and illicit drugs is a cornerstone of the National Drug Strategy. Treatment can provide a pathway out of drug dependence, prevent, reduce or mitigate ill-health and other harms associated with alcohol and other drug use, reduce demand and have flow-on effects on the health and well being of users' families, others in the community and the next generation, through improved parenting of recovering and recovered drug dependent people.

People with drug problems should be encouraged and helped to enter drug treatment at every opportunity, given the benefits that can accrue for them as individuals and for the community generally. Drug treatment is cost-effective when evaluated by a range of criteria, including health, social well being, economic prosperity, and incidence of crime. The most comprehensive examination of the economic benefits and costs of drug treatment related to methadone maintenance and were performed with data from the US Treatment Outcome Prospective Study (TOPS) (Harwood et al, 1988). This study estimated the benefit/cost ratio of methadone maintenance treatment to be 4:1. A much more conservative cost-benefit model, which valued only limited increases in employment rather than the much larger reductions in goods stolen, found a cost/benefit ratio of about 1:1. Gerstein & Harwood (1990) concluded that, using either of these models, methadone maintenance pays for itself on the day it is delivered, and post-treatment effects are an economic bonus.

As is the case with many health conditions, there is no 'one size fits all' treatment for alcohol and other drug dependence. Treatment services can be delivered on an in-patient basis or in the community, including the persons home. They can be delivered by generalist health workers, such as General Practitioners, who have been shown to deliver effective brief and early interventions, or by specialist alcohol and other drug professionals. The duration of treatment can range from short term through to long term stays in residential rehabilitation units or on substitution therapies such as methadone. The type of treatment provided will be informed by a range of factors including the presence of dependence and the individuals life situation and preferences.

The goals of drug treatment services can include complete abstinence from all drugs or reduced or controlled use. In addition to assisting people to reduce their drug use or become drug free, such services should assist the client to address other issues which can impact on the persons drug use, health and wellbeing. This might include the provision of information on reducing risky drug taking and sexual practices, and may also involve referral to, or liaison with, a wide range of agencies to assist the client to address issues such as unemployment, legal difficulties, financial difficulties, parenting, and sexual abuse.

### 5.4.1 Who Accesses Drug Treatment Services in Australia?

The 1995 Census of clients of treatment service agencies (Torres et al., 1995) provides some information on clients accessing treatment in Australia at that time. The census found that:

The principal drug problems of substance users accessing (non-methadone) services were:

- alcohol (49.3%);
- opiates (26.2%);
- Opiates/polydrug (7.4%);
- tobacco (4.8%);
- benzodiazepines and other tranquilizers (4.5%);
- cannabis (6.7%);
- amphetamines (6.5%);
- polydrugs, excluding opiates (3.5%);
- barbiturates (0.3%); and
- other (1.8%).

If the people participating in methadone maintenance programs are included, opiates were the main drug problem being treated on the day of the census.

In addition, in respect of those in treatment (excluding methadone) on the day of the census:

- the mean age was 33.8 years;
- the majority were male (70.6%);
- 18.4% were in paid employment, 43.4% were unemployed and a further 23.2% were pensioners;
- 46% accessed a residential treatment service on the day of the census, with the remaining 54% accessing non-residential treatment services (note however that methadone services were **not** included in the census); and
- 74.1% were Australian born (non-indigenous), 11.6 % were indigenous people and 13.3% were overseas born.

In respect of methadone services, at 30 June 1999, approximately 26,676 people were receiving methadone maintenance therapy in Australia.

### 5.4.2 Role of the Department of Health and Aged Care

While the Department of Health and Aged Care does not directly provide treatment services, it facilitates access to such services through the following mechanisms:

#### 5.4.2.1 <u>Pharmaceutical Benefits Scheme</u>

Methadone treatment is recognised nationally and internationally as an appropriate modality for treating opioid dependence. National guidelines for methadone treatment were first endorsed by the Australian Health Ministers' Conference is 1985. The aims of methadone

treatment are to reduce the individual and social harm associated with illicit opioid use. There is a strong evidence base to support methadone maintenance. A 1999 review of the national and international medical and scientific literature , conducted by the National Drug and Alcohol Research Centre, found that, amongst other things:

- methadone maintenance treatment has been demonstrated to be more effective than either no-treatment, drug-free counselling and rehabilitation, placebo medication, and detoxification/withdrawal in randomised controlled trials;

- the evidence shows that methadone maintenance therapy is associated with a lower risk of death compared to that associated with no treatment, drug free treatment or detoxification/withdrawal; and

- methadone maintenance treatment has been repeatedly shown to be associated with lower HIV infection.

The Commonwealth Government funds the cost of methadone syrup under Section 100 of the Pharmaceutical Benefits Scheme and payments are made directly to the supplier on a monthly basis. In 1998/99 the Commonwealth expended $3.959 million on the provision of methadone syrup.

In addition, a range of other pharmaceutical products used in the management of dependence are available at subsidised rates under the Pharmaceutical Benefits Scheme. For example, acamprosate and naltrexone for use within a comprehensive treatment program for alcohol dependence, with the goal of maintaining abstinence.

Similarly, a range of pharmaceutical products used in the management of diseases related to the use of alcohol and other drugs are subsidised under the PBS.

Further information on the registration and approval for listing of pharmaceutical drugs is provided in section 5.8 “Registration, Availability and Quality Use of Pharmaceutical Products”.

#### 5.4.2.2 National Illicit Drug Strategy – NGO Treatment Grants Program

Funding under the NGO Treatment Grants Program is for:

- establishing and operating new services for treating illicit drug problems with a particular emphasis on filling geographic and target group gaps in the coverage of existing treatment services; and/or

- expanding and upgrading new and existing NGO treatment services.

Funding under the Program of approximately $57 million over four years has been fully allocated to 133 drug treatment programs across Australia. A diverse range of initiatives have been funded, including outpatient counselling, peer support, home detoxification, medicated and non-medicated detoxification, therapeutic communities and long term residential rehabilitation. The program has also provided funding to a number of organisations for programs responding to the sniffing of petrol and other inhalants in Aboriginal and Torres Strait Islander communities. Examples of these grants include:

- The Ngaanyatjarra Pitjanjatjara Yankunytjajara (NPY) Women's Council Aboriginal Corporation, cross-border NT, WA, SA has received $810,307 over four years for a community based petrol sniffing project in member communities utilising a case management community development model to work with petrol sniffers and their families.

- The Aboriginal Drug and Alcohol Council SA Inc, SA has received $855,652 over four years to develop treatment strategies to address and reduce petrol sniffing and other drug use in remote Aboriginal communities.

- The Warburton Community in Western Australia has received $264,816 over four years for a petrol sniffing treatment and rehabilitation facility, within the Ngaanyatjarra Lands, followed by intensive support on return to the community. The program is targeted at ATSI youth.

#### 5.4.2.3 Illicit Drug Diversion Initiative

The Commonwealth Government has committed $111 million over 4 years to the Illicit Drug Diversion Initiative, which sets a national approach whereby minor drug offenders will be diverted to compulsory assessment, and then referred to treatment and/or education aimed at keeping them out of the criminal justice system.

In November 1999, the Council of Australian Governments (COAG) endorsed a national framework for this initiative to ensure a consistent approach to the diversion of offenders across Australia. The framework (see Appendix 5) outlines a clear pathway for individuals from detection to assessment, education, treatment and post treatment support. It also establishes the responsibilities of the police and other services involved in diversion.

The diversion initiative strengthens the "Tough on Drugs" policy by providing a new early intervention focus, which aims to achieve benefits for both drug users and the community. It aims to prevent people entering into long term drug abuse, where the consequences are serious health problems, financial destitution, a criminal record and, in some cases, acts of violence and property crime.

The diversion initiative will result in:

- people being given early incentives to address their drug use problems, in many cases before incurring a criminal record;

- more illicit drug users diverted into demand reduction programs; and

- fewer people appearing before the courts for use and possession of small quantities of illicit drugs.

Offenders diverted under this initiative will have access to appropriate drug education or a range of clinically acceptable drug treatment, such as counselling, withdrawal and, where necessary, residential rehabilitation and pharmacotherapies. Wherever possible, family involvement will be encouraged and education and treatment services will be culturally, linguistically and gender sensitive. Those who fail to attend the initial assessment, or fail to

participate in treatment or education, risk being sent back to the criminal justice system where they face the possibility of gaol.

Australia's approach targets individuals who have little or no past contact with the criminal justice system for drug offences and are apprehended for use or possession of any illicit drug. Persistent or violent offenders can expect the criminal justice system to continue to be tough on drug related crime and will not be eligible for diversion. In addition, the diversion scheme will not apply to offenders apprehended at the international border.

The success of this program will be contingent on a strong working relationship between the criminal justice and health sectors. The initiative will be subject to a major national evaluation, with the final evaluation report due in September 2002.

By the end of May 2000, two states (New South Wales and Tasmania) had signed funding agreements with the Commonwealth and had commenced the diversion initiative. Negotiations were nearing completion with most other jurisdictions.

#### 5.4.2.4 Medicare

Treatments for many drug problems occur through generalist health services, including General Practitioners and Public Hospitals. Similarly, generalist health services, such as GP's, hospitals and community health services, are responsible for the management of the myriad of health consequences associated with the misuse of alcohol and other drugs, for example, cancers, cardiovascular problems, and gastrointestinal problems associated with the use of tobacco and/or alcohol, diseases such as HIV and hepatitis B and C related to injecting drug use, and injury resulting from alcohol or other drug related road trauma or violence.

Commonwealth funding for these interventions is provided under Medicare, mainly in the form of:

- subsidies for prescribed medicines and private medical expenses;
- substantial grants to State and Territory governments to contribute to the costs of providing access to public hospitals, at no cost to patients, and other health services; and
- specific purpose grants to State/Territory governments and other bodies.

Additionally, the Enhanced Primary Care items under the Medical Benefits Schedule, which commenced on 1 November 1999, contain items for care planning and case conferencing for patients with chronic conditions. These new items may aid in the management of clients who are experiencing chronic mental health conditions, including substance abuse problems, through the development and regular review of comprehensive care plans.

## 5.5 EDUCATION AND PROMOTION OF BEST PRACTICE

According to the Australian Institute of Health and Welfare (1999) in 1997 there were approximately 22,000 deaths associated with alcohol and tobacco and almost 250,000 hospital episodes. In 1997 there were 832 deaths attributable to illicit drug use. Many more individuals, their family and friends, will consult their General Practitioner, community nurse, pharmacists or other community workers about the harms arising from the use of tobacco, alcohol, pharmaceuticals and illicit drugs. Others will come into contact with police, ambulance officers, and youth and corrections workers. In short, there are few people working in the health, welfare, law enforcement or justice sectors who will not be confronted with people experiencing alcohol and other drug related problems. As such, the provision of appropriate education and training to a range of professional groups, and the production and dissemination of best practice guidelines, are an essential component of any strategy to address drug related harm in Australia.

### 5.5.1 National Illicit Drug Strategy

Funding has been made available under the National Illicit Drug Strategy for a range of initiatives aimed at informing best practice and developing quality educational resources for a range of frontline workers, including General Practitioners, youth workers and police. Initiatives include the:

- development, piloting and dissemination, via a 'train the trainer' package of models of 'shared care' of illicit drug users;
- development of 'best practice' guidelines, methodologies and instruments for evaluating the impact of alcohol and other drug education and training initiatives;
- development of illicit drug training resources targeted at youth workers and Indigenous Health Workers;
- updating the *Handbook for Medical Practitioners and other Health Care Workers on Alcohol and Other Drug Problems* and linking it with a package of training materials for General Practitioners;
- development of core competencies and related training materials for the management of people suffering from a comorbid mental health and drug and alcohol problem;
- development and dissemination of information for pharmacists on illicit drug issues and on their role in Needle and Syringe Programs;
- development of a core curriculum on the police role in harm minimisation;
- development of consumer and prescriber information on naltrexone and of clinical guidelines for all pharmacotherapies for the treatment of opioid dependence, including naltrexone, methadone and buprenorphine;
- funding for the continued publication of the Drug and Alcohol Review journal;

- provision of core funding to the National Centre for Education and Training on Addictions;

- development of best practice guidelines for the management of cocaine toxicity and dependence; and

- supplementary funding for an Australian Treatment Outcomes Study, which will inform the development of best practice in respect of treatment for opioid dependence.

### 5.5.2 Communicable Diseases Strategies

The Communicable Diseases and Environmental Health Branch manages a wide range of education and training initiatives aimed at minimising the transmission of blood borne viruses (including among injecting drug users). The Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD) also plays a significant role in the production of education and training materials for national distribution. The Council was appointed by the Minister for Health and Aged Care, Dr Wooldridge, to provide expert advice on issues relating to HIV/AIDS and hepatitis C. Many of these initiatives were detailed in section 5.3, 'Reducing Harms'.

### 5.5.3 National Tobacco Strategy

An education and training agenda for the National Tobacco Strategy, spanning the Strategy's six key result areas, is currently under development. The primary dimensions of the agenda include workforce, school and community education initiatives. The majority of initiatives proposed will be taken forward under the first two Key Result Areas (Strengthening Community Action and Promoting Cessation).

Under *Promoting Cessation*, particular workforce initiatives designed to increase the number and range of health professionals and allied workers with skills and resources to help smokers quit, is currently under development in partnership with the Public Health Education and Research Program (PHERP). Anticipated outcomes of the PHERP partnership include:

- best practice guidelines on tobacco control for health professionals and allied workers;

- new or (strengthening of existing) education and training courses and materials in undergraduate, postgraduate and inservice or ongoing training settings; and

- a national dissemination strategy for tobacco control education and training.

Attention to best practice is a hallmark of the NTS. Particular initiatives underway include:

- a review of best practice in the provision, ongoing management and operation of the National Quitline service to generate and promote improvements to the Quitline infrastructure;

- development of a national best practice model for reducing sale and supply of tobacco to children. This is anticipated to result in a resource for States and Territories to enhance national consistency in the areas of compliance monitoring and enforcement, prosecution, training, community education and community action around the sale and supply of tobacco to children;

- a national response to passive smoking which includes a legislative component to address smoking in enclosed public places and workplaces. This component of the overall national response to passive smoking is intended to provide a suite of resources that facilitates best practice legislation in this area; and

- development of a best practice approach to smoking cessation for urban and remote Indigenous communities. It is anticipated to inform the suitability of nicotine replacement therapy for Aboriginal and Torres Strait Islander People in urban and remote settings.

### 5.5.4 National Alcohol Action Plan

The draft National Alcohol Action Plan identifies a number of key strategies designed to minimise alcohol-related harm to individuals, family and the community. Education and best practice initiatives underway or under development include:

- the development of revised *Responsible Drinking Guidelines* under the National Health and Medical Research Council. Second stage public consultation on the Guidelines is proposed for the later half of 2000. Widespread promotion and dissemination the guidelines will occur under the NAAP 2000-2003; and

- clinical Practice Guidelines for the Management of Alcohol Dependence/Problem Drinking are proposed for 2001. It is anticipated that this project will yield a range of evidence-based and targeted materials for a range of health professionals, including general practitioners.

## 5.6 RESEARCH, MONITORING AND EVALUATION

Research and monitoring are important to ensure that policies and programs are informed by the best available evidence. An overview of research infrastructure under the National Drug Strategic Framework, including the three national alcohol and other drug research centres, has been provided in Chapter 3 of this submission. Examples of other departmental activities include:

### 5.6.1 National Tobacco Strategy

- *Research to inform effective nicotine regulation policy.* The Australian Cancer Society (ACS) in partnership with the Department of Health and Aged Care is scoping a research agenda to inform future policy development for nicotine regulation. The ACS will also oversee part of the resulting research agenda program.

- *National Quitline service review.* A review of best practice in the provision, ongoing management and evaluation of the National Quitline service is currently being undertaken.

### 5.6.2 National Injury Prevention Action Plan

Alcohol and other drug use are related to three of the four priority areas identified in the Draft National Injury Prevention Action Plan: Priorities for 2000-2002; namely poisoning in children; drowning and near drowning; and falls in the elderly.

#### 5.6.2.1 Poisoning in Children

About 3,560 cases of poisoning at ages 0 to 4 years in Australia in 1996/97 required hospital admission. Of these, 71 percent were due to poisoning by pharmaceutical substances. The direct cost to the Australian health system due to poisoning sustained in children aged 4 years and younger in 1995/6 has been estimated to be $36 million. Poisoning in children is the result of misuse rather than the abuse of pharmaceuticals. The Department:

- has commissioned research into issues of childhood poisoning and the identification of medications that would benefit from the addition of child resistant closures. Further research is needed into poisonings that occur from drugs which already have child resistant packaging;

- is participating in a trial of the National Public Health Partnership Performance Planning Framework, to determine the cost effectiveness of interventions in poisoning for children and youth aged 0 to 20 years. Various risk factors are being examined to determine future prevention strategies.

#### 5.6.2.2 Drowning and Near Drowning

Alcohol plays a significant causative role in drownings, particularly among males, and young males (15-24 years) are the highest risk group for diving into shallow water. Accidental drowning accounted for 3.6% of all injury deaths in 1997. Research initiatives include:

- a project being undertaken in partnership with the Australian Water Safety Council and the Royal Life Saving Society of Australia which will provide a clear picture of the demographics and aetiology of drowning and near drowning in Australia; and

- a study of the feasibility of using the National Coronial Information System to capture improved data on drowning and water related deaths.

#### 5.6.2.3 Falls in the Elderly

Falls account for the largest proportion of all injury related deaths and hospitalisations for people aged over 65. The use and misuse of over the counter medications, prescriptions and alcohol are risk factors associated with falls in the elderly.

Funding was provided in the 1999/2000 Federal Budget for a National Falls Prevention in Older People Initiative. Work under this initiative includes a project being undertaken by the Royal Australian College of General Practitioners. The project aims to develop an assessment tool and other material for use by GPs in community health care settings. The assessment tool will include a range of variables such as physical health, mental health, drugs including alcohol and medications, and other lifestyle issues.

### 5.6.3 National Illicit Drug Strategy

Funding for a range of research and monitoring activities was provided under the National Illicit Drug Strategy (see 4.1.1.1 'Demand Reduction Measures).

#### 5.6.3.1 National Health and Medical Research Council (NHMRC)

Funding of approximately $4 million under the National Illicit Drug Strategy was provided to the NHMRC to allow them to undertake an expanded program of interdisciplinary research to achieve innovation in the prevention and treatment of illicit drug use.

Initially two grants and one fellowship were funded from applications previously received by the NHMRC:

- The prediction of emotional and behavioural problems: Infancy to adolescence;
- Investigation of cocaine induced changes in brain function; and
- Parenting in the Socio-Cultural context of illicit drug and harmful alcohol use.

In June 1998 an Expert Committee was established to manage the development of the research agenda. Following a review of funded research in the area of illicit drugs and a national workshop, the NHMRC called for expressions of interest for research relevant to the following strategic research focus areas:

- development of an action plan to design and fund a large-scale longitudinal study of illicit drug usage;
- secondary analysis of primary illicit drug data sets;
- research on population impact and client outcomes of different treatment models;
- comparative analysis of treatment models for service systems;
- heroin overdose;

- evaluation of diversion treatment; and
- evaluation of family-based approaches.

Funding for sixteen projects (refer to Appendix 6 for details) was approved in January 2000. In addition the Minister for Health and Aged Care approved the Committee's recommendation that they:

- commission a literature review which will focus on the links between families and illicit drug use; and

- advertise a second grant round which will focus on:

    - the treatment and prevention of illicit drug use by Aboriginal and Torres Strait Islander peoples and Communities; and

    - treatment of drug dependencies.

#### 5.6.3.2 Cannabis Cessation Strategies and Barriers to Treatment

Funding under the National Illicit Drug Strategy has been provided for the development of cannabis cessation strategies for adults and for adolescents.

The Cannabis Cessation Strategy for Adults (18 years and over) builds upon research previously undertaken by the National Drug and Alcohol Research Centre. The project involves the development and dissemination of a clinical practitioner guide which will utilise an intervention package for use by health practitioners during patient consultations. The clinical guide will be accompanied by a complementary self-help handbook for patients to take home.

The Cannabis Cessation Strategy for Adolescents aims to reduce the use of cannabis among young Australians. There is a gap in existing treatment services for young people, and development of an intervention package will help to bridge that gap. The proposed intervention strategy has several components, including involvement of the young person's family and an intervention session or "Cannabis Check-up".

Following development, the intervention strategy will undergo clinical trialing, involving 300 participants, in New South Wales, Victoria and South Australia. It is anticipated that at the conclusion of the trial a resource package and training module for health care workers, such as drug and alcohol workers, general practitioners, youth outreach workers and clinical nurse specialists, will be developed and distributed through a national training program.

Funding has also been provided under NIDS for research into factors that act as barriers or incentives to people entering, and being retained in treatment.

#### 5.6.3.3 National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD)

Funding was allocated under the National Illicit Drug Strategy for the national evaluation, monitoring and subsequent dissemination of the outcomes of the trials of alternative treatment modalities for opioid dependence, with a view to developing models of best practice and disseminating outcomes. Following agreement by the Ministerial Council on

Drug Strategy, the National Drug and Alcohol Research Centre was contracted to develop and implement a nationally consistent evaluation and monitoring framework for the alternative pharmacotherapy trials across the nation.

This project will contribute to a national effort to develop a range of effective, evidence based best practice pharmacotherapy treatment options for people who are opioid dependent. The project involves a number of pharmacotherapy trials that have been specifically nominated and supported by the States and Territories. The project includes 11 randomised trials and 9 observational studies. These trials involve a range of new therapeutic drugs, including naltrexone, buprenorphine, LAAM, and slow release oral morphine, with methadone as a comparator in some instances.

NEPOD commenced in July 1998 and a final report is expected to be available by June 2001.

#### 5.6.3.4 Quality Assurance and Best Practice

Research projects under this component of NIDS include:

- development of an evaluation framework for the health components of the National Illicit Drug Strategy;
- an evaluation of therapeutic communities and the development of a best practice manual;
- a study of the effectiveness of social support for methadone clients; and
- a study of the management of dual dependency on benzodiazepines and opioids.

#### 5.6.3.5 Illicit Drug Reporting and Information

Funding has been allocated to establish a system for monitoring the demand for and usage of illicit drugs in Australia and the harms arising from use. Activities under this initiative include:

- funding for an illicit drugs module of the National Coroners' Information System, to provide improved information on drug related deaths and standardisation of reporting across jurisdictions;
- conduct of the National Drug Strategy Household Survey. The surveys provide time series data on prevalence of both licit and illicit drug use in Australia;
- funding of the National Illicit Drug Reporting System, which monitors the price, purity, availability and use of the major illicit drug types (opioids, amphetamines, cocaine and cannabis) and acts as an early warning system for illicit drug use trends;
- a study to estimate the number of heroin users, in particular dependent users, in Australia; and
- the development of a national minimum data set for alcohol and other drug treatment services, to provide standardised client data across jurisdictions and treatment modalities.

## 5.7 ADDRESSING THE NEEDS OF SPECIFIC POPULATIONS

As indicated in Chapter 1 of this submission, there are differences in respect of both prevalence and harms associated with alcohol and other drug use across specific sectors of the population. The Department of Health and Aged Care administer a range of programs and initiatives designed to address use and harm in specific populations. Examples of such programs and initiatives are provided below.

### 5.7.1 Aboriginal and Torres Strait Islander People

#### 5.7.1.1 Office for Aboriginal and Torres Strait Islander Health

The Office for Aboriginal and Torres Strait Islander Health (OATSIH) administers the Aboriginal and Torres Strait Islander Substance Misuse Program which, during the current year (1999-00), will provide funding of $18.4m towards the operation of sixty-nine (69) community controlled health and substance misuse services nationally. These services are located across urban, rural and remote locations and provide a range of services, including education and prevention programs, early intervention strategies, and treatment and rehabilitation within non-custodial settings. In addition, some of the community controlled health services funded by OATSIH also provide substance misuse services as part of their overall service, although not specifically funded by the Substance Misuse Program.

Twenty-six (26) of these services provide residential rehabilitation and treatment for acute and chronic alcohol problems. However, this is not to the total exclusion of other substances (ie. marijuana, injecting drug use, petrol sniffing) or treatment approaches.

Many of these services have adopted, and in some cases developed, varying approaches and models to addressing changing trends in their communities. 'Models' range from tertiary level care and interventions, such as promoting abstinence based on the Alcoholics Anonymous 12 Steps, to secondary and primary level interventions and services ('sobering-up' shelters, detoxification and promotion and prevention strategies).

In administration of the Substance Misuse Program the OATSIH has taken a holistic approach with strategies concerning substance misuse developed within a framework comprising:

- control of supply and diversion;
- prevention and early intervention; and
- provision of specialist treatment and rehabilitation.

In addition to the above, the OATSIH has established the 'Comgas Scheme' to ensure that those remote Aboriginal communities using aviation fuel or 'Avgas', as part of a broader strategy to prevent petrol sniffing, can continue to do so at no additional cost. The scheme was established in response to a decision of the Australian Customs Service to enforce the legal excise applicable to aviation fuel for non-aviation purposes. The OATSIH has negotiated agreements with suppliers of aviation fuel, namely Mobil Oil Australia Ltd, BP Australia Ltd and Shell, to subsidise supply to some twenty-eight (28) communities. Funding totalling $1m is available during 1999/00 to support this initiative.

### 5.7.1.2 Review of the Commonwealth's Aboriginal and Torres Strait Islander Substance Misuse Program

Following the transfer of the Aboriginal and Torres Strait Islander Health and Substance Misuse Programs from the Aboriginal and Torres Strait Islander Commission (ATSIC) to the Department on 1 July 1995, the OATSIH decided to undertake a review of the Substance Misuse Program. This review was to focus on the design and context of the Program as well as its relationship to broader mainstream health and substance misuse programs. The aim of the review was to identify key strategies for an integrated national approach to substance misuse. The immediate goal was to improve program development and policy formulation and identify where the OATSIH needed to focus efforts in improving substance misuse services funded by the Program.

The OATSIH has completed the review with distribution of the Final Report commencing in June 2000 (a copy is provided at Appendix 7). The major findings of the review include the need for an increased emphasis on prevention and early intervention and a shift in the balance of the Program from one based primarily on treatment and rehabilitation to one more reflective of the continuum of harm associated with substance misuse.

***Prevention and Early Intervention***

The review identified the need for an increased emphasis on prevention and early intervention and highlighted the potential of primary health care services and clinicians in addressing substance misuse, particularly through:

- early identification in primary health care settings;
- population health programs;
- screening; and
- brief interventions.

The OATSIH has commenced work, in partnership with the National Aboriginal Community Controlled Health Organisation (NACCHO), aimed at promoting the role of community controlled health services in relation to substance misuse. A number of Project Officer positions have been funded within NACCHO and its State and Territory-based affiliates to support this work.

In conjunction with the review, OATSIH convened a Working Group to develop a set of consensually-derived recommendations for the clinical management of alcohol related problems in Indigenous primary health and related (eg. custodial) settings. The recommendations reflect information from systematic studies and practitioner experience and provide primary care clinicians with:

- a better understanding of the social context and natural history of alcohol use in Indigenous communities;

- strategies for the management of alcohol use disorders; and

- recommendations regarding the clinical management of common medical problems in which alcohol is a complicating factor.

In addition, the recommendations discuss preventative interventions, early identification, treatment and continuing care.

The OATSIH will shortly commence national implementation of the recommendations through distribution of the document and the staging of 'train the trainer' style workshops in regional centres across the country. The implementation strategy is designed to promote uptake and dissemination of the document among practitioners and relevant primary health care sites.

***Specialist Treatment and Rehabilitation***

The review of the Commonwealth's Aboriginal and Torres Strait Islander Substance Misuse Program highlighted a number of areas for improvement within specialist substance misuse treatment and rehabilitation services, including the development of quality assurance processes. The OATSIH, in partnership with the Aboriginal Drug and Alcohol Council of South Australia, has established a pilot of the Quality Improvement Council (QIC) *Standards for Alcohol, Tobacco and Other Drugs* in substance misuse services in South Australia. This trial will establish the appropriateness of the QIC process and standards when applied to Aboriginal and Torres Strait Islander substance misuse services and inform the development of a quality assurance framework for the program.

***Measures to Control Supply***

The review found that measures to control the supply of alcohol and other drugs, for example, drug and alcohol free events, restrictions on the sale of alcohol, and the use of Avgas as a petrol substitute, can provide a valuable window of opportunity for communities to develop more sustainable prevention and intervention strategies. The review also found that other interventions, such as night patrols and out-station programs, greatly enhance these measures.

***Violence and Injury***

The review also highlighted the link between alcohol and injury. A study of injury in five communities in Cape York Peninsula found that alcohol is a major contributor to injury events, with at least 50% of all injuries and 88% of assault injuries being directly associated with the consumption of alcohol.

#### 5.7.1.3 National Action Plan

The review also provides a "National Action Plan for the Aboriginal and Torres Strait Islander Substance Misuse Program", which identifies and brings together those priorities identified by the review into a framework for action.

***Policy Framework***

The proposed policy framework, which is currently under development, is built on the principles of community participation, community partnerships and collaboration at all levels of the system. Regional planning underpins the whole approach to achieving improved access to services and better service networks across all regions.

Key elements of the policy framework include:

- Integrated primary health care services

  The policy framework for the development of Indigenous substance misuse services at the national level needs to be strongly centred around a network of comprehensive primary health care services. These services are able to provide integrated health promotion, population health and clinical care services.

  A key priority is to strengthen the role of State/Territory run clinics and general practitioners, through the Divisions of General Practice, in the provision of comprehensive primary health care approaches, as part of the wider system of primary health care which Indigenous people access.

- Integrated strategies

  In the wider substance misuse field separate strategies are often developed for alcohol, tobacco, illicit drugs and other substances. However, in the Indigenous sector, the point of delivery of these programs and services is often the primary health care service and, as such it is important to ensure interventions are integrated across a range of strategies. Similarly, the extent of multiple drug use and co-morbidities mean that strategies must be integrated on the ground.

- Broader social programs

  Substance misuse strategies can not be isolated from broader health issues of emotional and social well being, nor from issues of injury and violence in communities. Access to trained counsellors and other specialist services is facilitated through a focus on primary health care and can lead to improved management of clients with co-existing mental health and drug problems. It also recognises that alcohol and other drug problems affect not just the individual but also their families and communities and, as such, wider supports and services are needed.

- Community based education programs to reduce risks and change behaviour

  Within the context of a comprehensive approach to primary health care, health promotion and education programs have a key role in preventing substance misuse. Education programs need to target specific groups in the community and be developed locally. Specific programs to address the needs of young people, together with broader community development programs, are emphasised. To prevent the risks associated with foetal alcohol syndrome, programs specifically targeting young women and pregnant women are also important, as is raising awareness of the risks of Sudden Infant Death Syndrome (SIDS) from smoking in pregnancy and/or smoking around babies.

- Use of early and brief interventions

  The provision of brief and early interventions for substance misuse, delivered by primary health care services, is seen to have great potential, although their use is limited at the present time.

The use of patient information and recall systems, screening and adoption of care plans for clients will facilitate brief interventions. Strengthening access to counselling services is an important part of the service infrastructure and networks that are needed to support these interventions.

Clinical care guidelines for the management and treatment of alcohol and other drug problems, including management of clients who suffer from both a mental health and alcohol or other drug problem, together with proper training for health workers and clinicians, are identified as a priority.

- Improving specialist treatment and rehabilitation services

Developing effective quality residential services is an immediate policy goal. Services need to be reviewed against criteria of:

- choice of treatment;
- care plans agreed with clients;
- referrals to other specialist services including linkages to primary health care services;
- client/staff ratios;
- after care and support arrangements;
- quality of physical buildings and infrastructure; and
- linkages to forensic system, sobering up shelters, etc.

Establishing a service reporting mechanism for residential rehabilitation services, along the lines of the Service Activity Reporting instrument now in place for primary health care services, is a high priority.

Similarly, the future development/expansion of such services is an issue for consideration, as is the future role of the OATSIH in such expansion. The multiple funding sources of these services and their close links to housing, residential disability services, supported accommodation and home care services suggest that, in the longer term, substance misuse rehabilitation services are best managed and developed in the context and frameworks of these other programs.

- A skilled workforce

For Aboriginal Health Workers and others working in the Indigenous substance misuse area, there are few educational/training opportunities. Many mainstream education programs are based on theories and/or learning styles which may not be appropriate for, or easily transferable to, Aboriginal Health Workers.

There is a need for qualified specialist and generalist staff to provide the range of service responses and interventions needed to address substance misuse in Indigenous communities. Core competencies for health workers need to encompass skills and knowledge in alcohol and other drug issues. The 'Emotional and Social Well Being Training Centres, which have recently been established, are ideally placed to develop specialist training in respect of alcohol and other drug issues.

- Improving the evidence base

  Many strategies to address substance misuse in Indigenous communities have not worked. Frequently they have not been developed in partnership with communities and have not been comprehensive and sustainable. Currently there is little data and evidence on the effectiveness of different interventions and treatments in Indigenous communities. Additionally, there is a need for research which looks at the wider social impacts and economic costs to Indigenous communities resulting from substance misuse.

***Implementation of the Policy Framework***

- National Level

  At the national level, mechanisms are needed to provide advice and input to policy and planning processes. Many organisations, both government and non-government, are involved directly or indirectly in substance misuse issues and no one mechanism will deliver national co-ordination. Considerable effort and willingness on the part of all organisations is required to identify opportunities for collaboration and cooperation. Key players at the national level include:

  - *Ministerial Council on Drug Strategy and Related Structures*

    As reported earlier, the MCDS has overall responsibility for the broad policy direction and operation of the National Drug Strategic Framework and comprises both health and law enforcement Ministers from each State and Territory and the Commonwealth. The MCDS is supported by a range of advisory committees, including the IGCD and the ANCD.

    It is essential that Indigenous substance misuse issues are considered holistically under the NDSF. This is partly because of the need to give emphasis to broader prevention strategies but also to place the issues within a more holistic framework, which is more relevant to how Indigenous communities approach health issues.

    To ensure Aboriginal and Torres Strait Islander issues feed into the agenda of the Ministerial Council on Drug Strategy (MCDS), the MCDS has approved the establishment of the National Drug Strategy Reference Group for Aboriginal and Torres Strait Islander Peoples which will provide advice to the various expert advisory committee, the IGCD and the ANCD.

  - *Aboriginal and Torres Strait Islander Health Council*

    The Aboriginal and Torres Strait Islander Health Council advises the Minister for Health and Aged Care on Indigenous health issues. This is a key forum for policy and strategic advice to the Minister, across all health programs which impact on Aboriginal and Torres Strait Islander people.

    The role of the Council has recently been reviewed. It is timely therefore to focus on social health issues and ensure that there is a more integrated and coordinated approach to substance misuse, mental health and other related issues such as injury and violence.

- *National Aboriginal Controlled Community Health Organisation (NACCHO)*

  NACCHO is a peak organisation representing a large number of community controlled health organisations. It has affiliate bodies in all States and Territories and was a signatory to the Aboriginal and Torres Strait Islander Health Framework agreements. NACCHO and its State/Territory affiliates can play a key role in:

  - guiding and assisting member services to develop and/or implement substance misuse prevention and early intervention programs, as part of a comprehensive primary health care approach; and

  - ensuring linkages with other key national non-government bodies such as the Alcohol and other Drugs Council of Australia, which is ideally placed to support and enhance the work of NACCHO.

- State and Territory Level

  At the State and Territory level, State/Territory health agencies need to review the roles and functions of their community health clinics and examine how these services can take on a more active role in this area of substance misuse.

  State/Territory forums under the Aboriginal and Torres Strait Islander Framework Agreements need to give a particular focus to substance misuse issues in the development of statewide policies and programs. In addition, regional plans need to incorporate substance misuse issues and identify gaps in the range of services needed.

  The Department has funded a number of positions within the State/Territory affiliates of NACCHO to assist in this planning process and in the establishment of better networks across services and between NACCHO State/Territory affiliates.

- At the Regional Level

  Regional plans, developed by key stakeholders, provide an opportunity to develop service plans which take into account all the resources available within a region and which reflect the local environment and priorities. In this way, regional plans provide an opportunity to look across the region at what services are in place, both mainstream and Indigenous specific, what is needed, and where the gaps are. The planning process can assist intersectoral linkages and co-ordination of services on the ground. Completion of regional plans for all States and Territories, which include substance misuse issues and services, are considered a high priority.

- At the Service Level

  The framework proposes that local networks of services be established to improve local co-ordination and referral processes. Local level service agreements should be considered.

  In addition, it is proposed that quality assurance assessments be conducted of all Aboriginal and Torres Strait Islander substance misuse services funded under the

Commonwealth Aboriginal and Torres Strait Islander Substance Misuse Program, including those substance misuse service components located in Aboriginal and Torres Strait Islander primary health care services. These assessments would recognise that each service has different needs and priorities and that different levels of development will be required to ensure quality assurance standards. Some services will need minimal assistance and support to achieve effective ongoing quality assurance standards while other services may require more structured and ongoing support.

The key outcome from the individual service assessment process will be the development of specific service plans - the first stage - which will set a working framework for each service, in close collaboration with OATSIH, to achieve quality assurance standards. In addition, to ensure full and formal participation for Aboriginal and Torres Strait Islander substance misuse services, it is proposed that local level workshops be conducted in each State and Territory.

#### 5.7.1.4 Examples of other Departmental Initiatives

In addition to initiatives targeting Indigenous communities which occur under the auspices of OATSIH, a number of other program areas have specific initiatives addressing alcohol and other drug related issues in Indigenous communities. For example

***National Tobacco Strategy***

The Commonwealth is working in conjunction with the National Expert Advisory Committee on Tobacco and other experts to:

- develop best practice approached to smoking cessation among Aboriginal and Torres Strait Islander Communities; and

- conduct an audit of the levels of awareness of the harms associated with tobacco smoking and of the range of existing effective tobacco control responses in Aboriginal and Torres Strait Islander communities. This represents the development phase in tobacco control strategy for this population, to cover those activities in those areas that are not sufficiently addressed in the National Tobacco Strategy.

***National Illicit Drug Strategy***

A number of initiatives under the NIDS have elements focusing on Aboriginal and Torres Strait Islander communities. For example:

- Aboriginal and Torres Strait Islander people were identified as a priority group under the NGO Treatment Grants Program;

- a training package on illicit drug issues is being developed for Aboriginal Health Workers under the Training Frontline Worker Initiative;

- primary prevention resources for Aboriginal and Torres Strait Islander communities will be developed under the Community Partnerships Initiative; and

- research into the treatment and prevention of illicit drug use by Aboriginal and Torres Strait Islander peoples and communities has been identified as a priority for the next round of funding under the NHMRC NIDS research program.

### 5.7.2 Young People

Many of the initiatives and responsibilities outlined in section 5.2 'Prevention and Early Intervention' are targeted at young people. However there are a number of initiatives that particularly focus on young people which warrant specific mention.

#### 5.7.2.1 Non-Government Organisation Treatment Grants Program

As previously described, under the Non-Government Organisation Treatment Grants Program of the National Illicit Drug Strategy, funding is provided to non-government organisations (NGOs) to establish and operate new treatment services for users of illicit drugs. The Program has a particular emphasis on filling geographic and target group gaps in the coverage of existing treatment services. Funding has also been allocated for expanding and upgrading existing non-government treatment services to strengthen the capacity of NGOs to achieve improved service outcomes and to increase the number of treatment places available. One of the identified target groups of the program are young people.

Of the 133 projects funded under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Program, 45 projects have been funded specifically targetting youth. Some examples of these projects are:

- **The Ted Noffs Foundation, NSW - $1,465,000 over four years.** A comprehensive, non-residential treatment service has been established in the Wentworth area for 12-18 year olds. The Ted Noffs Foundation has also received funding under this Program for two more projects in Sydney totalling $848,746 over four years, and one based in the ACT for $2.5 million over four years which also services the surrounding regions of NSW. All these projects are targetted at youth.

- **Jesuit Social Services - Connexions, Vic - $447,000 over four years.** A dual diagnosis (mental health/alcohol and drug) service for young people with serious mental illness and problematic substance abuse has been established in Melbourne.

- **Youth Empowered Towards Independence, Qld - $577,000 over four years.** An adolescent drug treatment program servicing the Cairns region based on a Cognitive Behavioural Therapy model has been established for people under 25 years of age.

- **Hindmarsh Youth Centre, SA - $663,756 over four years.** A non-medical detoxification centre has been established in Adelaide for young people who are homeless or at risk of homelessness and who are affected by drugs.

#### 5.7.2.2. Community Partnerships Initiative

As previously detailed, the Community Partnerships Initiative aims to encourage quality practice in community action to prevent illicit drug use and to build on existing activity occurring across Australia. It is expected that the Initiative will contribute to the prevention

and reduction of illicit substance use by young people by mobilising communities and fostering relationships between governments and the broader community.

The focus of the Initiative is young people, however it includes other individuals and groups in the community who interact with young people in their social environments. Examples of projects under the CPI include:

- **Manly Drug Education and Counselling Centre.** The Manly Drug Education and Counselling Centre has received funding of $32,500 over 1 year for the "Drugs Stop" project which forms part of a community health promotion action plan to address adolescent drug use in the Manly-Warringah area of Sydney. The project utilised peer education as a strategy to educate young people (12-18 year olds) about the harms of both licit and illicit drug use. The primary aim of the project was to arm peer leaders with the knowledge and skills to make safer choices about their own, and to influence their peers, use of both legal and illegal drugs. It utilised both primary and secondary prevention strategies to empower and encourage young people who were non-users to remain non-users; and for those who were already using to adopt modes of consumption that were less harmful to themselves and the community. This objective was achieved through the provision of accurate and credible information about the harms of drugs as well as training in decision-making, confidence building, communication and listening skills, rapport and team building strategies.

- **Local Drug Action Group Incorporated.** The Local Drug Action Group Inc, which has received fuding of $48,000 over 2 years, is the incorporated umbrella organisation for a network of 57 Local Drug Action Groups established across Western Australia. The Groups are made up of community members who volunteer their time to implement activities in their local area to prevent and reduce drug abuse. They have received funding for the "Helping Empower Local Parents" project which aims to establish a network of training volunteer parent educators to provide peer-based interventions to other parents in local communities across Western Australia. The project will focus on prevention and early intervention of youth drug abuse, targeting those parents in the community with children in upper primary and lower secondary school. It will support families to develop effective communication about drug use issues and provide parents with factual drug information and practical strategies to assist young people to make good choices.

- **Macarthur Drug and Alcohol Youth Project**. The Macarthur Drug and Alcohol Youth Project, which has received funding of $54,000 over 2 years, has been established for several years in the local region, and has undertaken various primary prevention activities in the past, including party-safe pamphlets and resources, and recreational activities designed to promote a drug-free environment, and has targeted youth, and indigenous communities in particular. They have received funding for the "Parent Links Project" which aims to link parents, community members and young people to the local Alcohol and Other Drug information services, as well as mobilising the community to take a more active role in drug prevention and education. Activities proposed include a training workshop for the establishment of community educators, which will target parents, and increase awareness of drugs in the community through the development of informative resources such as pamphlets and promotional events.

### 5.7.3 People with Mental Illness and Drug Dependency

The Second National Mental Health Plan (1998-2003) and the National Drug Strategic Framework (1998-99 to 2002-3) both recognise the importance of addressing issues around coexisting mental health and substance use disorders, including both licit and illicit drugs, and other substances such as petrol.

The National Comorbidity Project is a joint initiative under both strategies and aims to identify and develop appropriate services, policy and treatment at all levels of the health care system (Commonwealth, State and local) to address comorbidity in mental illness and substance use.

The first stage of the project was the National Comorbidity Workshop that was held in March 2000. A broad range of participants attended the Workshop. These included consumers, carers, policy makers, service providers, clinicians and researchers from the mental health and drug and alcohol sectors, General Practitioners and rural and remote representatives. Representatives from other relevant sectors including Aboriginal and Torres Strait Islander health, criminal justice, youth and homelessness also attended.

The workshop identified a number of priority areas, goals and strategies that will form the basis of future activity in this area and the workshop report is currently being finalised. Another workshop is planned to be held to specifically address indigenous comorbidity issues.

### 5.7.4 Pregnant Women and their Partners

#### 5.7.4.1 National Tobacco Strategy

Pregnant women and their partners are a specific high-risk priority population that has been identified under the National Tobacco Strategy. Recent Commonwealth initiatives include:

- partially funding the Australian Medical Association (AMA) to undertake a smoking and pregnancy campaign in 1998. The project was an AMA initiative in partnership with the Royal Australian College of Obstetricians and Gynaecologists, Royal Australian College of General Practitioners, QUIT Victoria and the Department of Health and Aged Care.

    - Activities undertaken during this campaign included a National Consensus Conference on Smoking and Pregnancy held in Melbourne in 1998, and the development of a smoking and pregnancy kit for obstetricians, general practitioners and their patients.

- funding a pilot project to be conducted by the Royal Australasian College of Physicians that will provide passive smoking information and advice to patients and their families, encouraging them to provide a smoke-free environment for children.

#### 5.7.4.2 Alcohol

Consumption of alcohol during pregnancy and the potential effects of alcohol on the unborn have been the subject of debate over the past decade. Although research in this area is not extensive, the weight of evidence shows that high peaks in blood alcohol concentration are

more dangerous than sustained but moderate levels of consumption. The damage done to unborn babies from heavy drinking episodes remains an important preventable risk factor for congenital abnormalities in Australia.

For this reason the National Expert Advisory Committee on Alcohol have identified pregnant women as one of the groups at particular risk of alcohol related harm in the draft National Alcohol Action Plan 2000 –2003, which is expected to be endorsed by Ministerial Council on Drug Strategy in late 2000, following a period of public consultation. The draft Plan identifies a range of strategies to reduce alcohol related harm, including workforce/education and training initiatives and interventions by health professionals. The need to educate pregnant women and women likely to become pregnant about the risk of foetal alcohol syndrome and foetal alcohol effects is specifically acknowledged in the Plan.

In addition, the National Health and Medical Research Council (NHMRC) is currently revising the 1992 Australian Drinking Guidelines to take account of the latest scientific evidence in regard to harmful levels of alcohol consumption. The new guidelines will provide specific advice for different groups in the population such as pregnant women and young people. Once the revised Australian Drinking Guidelines are finalised later this year, and endorsed by the NHMRC, a range of communication strategies will promote the guidelines to Australians and, in particular, to groups at particular risk of harm such as pregnant women and women likely to become pregnant.

### 5.7.5 Rural and Regional Populations

The Regional Health Services Program incorporates the existing initiatives of Multipurpose Centres and Multipurpose Services; and the 1999-2000 budget initiative of Regional Health Services. The range of the Program means that it can provide a comprehensive response to both primary health and aged care needs.

Recognising that no two communities are exactly alike there is no single solution for service mix or activity under the Program. Community consultation, including with existing health professionals in a region, is a fundamental aspect of the Program.

Where substance abuse is identified as a health priority by a community, it can be included as part of the wider service delivery in their application for a Regional Health Service.

In considering the right mix of, and interaction of services, to improve health and wellbeing, a community will most likely consider an expanded range of services such as rural health promotion, general practitioners services, illness and injury prevention, substance abuse and misuse, women's health, children's services, community nursing, aged care, community based palliative care, mental health, podiatry, radiology and immunisation. Some communities might also consider ways of reorganising and thereby making better use of existing services.

This important Program has been further expanded in the recent 2000-2001 Budget.

### 5.7.6 People from Culturally and Linguistically Diverse Backgrounds

#### 5.7.6.1 Women's Health

Working Women's Health, a Victorian organisation previously known as Women in Industry and Community Health aims to ensure that working women, particularly those from culturally and linguistically diverse backgrounds, have access to knowledge and information they require to control their health and well-being. The Commonwealth Government provides funding by direct grant to Working Women's Health as a contribution to costs of a range of services and activities. These activities include health promotion activities with a focus on sexual and reproductive health for women at their workplace, for newly arrived and for isolated women in the community. The activities include education and information around drugs and alcohol.

Working Women's Health offers services in many languages including Arabic, Cantonese, Croatian, Greek, Italian, Khmer, Kurdish, Macedonian, Mandarin, Serbian, Spanish, Tagalog, Tigre, Tigrenya, Turkish and Vietnamese.

#### 5.7.6.2 National Alcohol Campaign

Developmental Research conducted in 1998 by Elliott & Shanahan for the Development of the National Alcohol Campaign suggested that 15-17 year old youth from non-English speaking backgrounds were drinking in ways which were similar to, or less harmful than, those adopted by English speaking youth. In general they are less likely to have ever consumed alcohol, to have consumed more than 10 drinks in their life, to have drunk in the last week or to have ever drunk too much alcohol.

In addition, although there may be specific media opportunities for communicating with NESB youth, these teenagers are primarily accessing mainstream English media.

Developmental research for the Non-English speaking background parent strategy, conducted by Cultural Perspectives in 1999 among parents from 16 language groups and key informants, confirmed that all that parents required was information on youth alcohol consumption. They also recommended that materials developed for English speaking parents would be appropriate for use, in translated form, for non-English speaking parents.

Based on this research, and given the nature of the mainstream English campaign, the parent strategy for non-English communities has been executed through:

- Press
- Radio
- Internet

The appropriate translation of the press advertisements, for use in non-English press, allows for complex information to be delivered as well as linking these advertisements to the rest of the campaign through the use of branding elements of the campaign and the TVC images. The press advertisement appeared in newspapers during the week of the launch, (week commencing 20 February 2000) and the following two weeks. The newspaper ads were translated into the following sixteen languages: Arabic, Bosnian, Cambodian, Chinese,

Croation, Greek, Indonesian, Italian, Korean, Macedonian, Polish, Russian, Serbian, Spanish, Turkish, and Vietnamese.

Radio was used to strengthen the campaign's delivery to key communities. Radio was limited to those communities identified in the research as having a significant rating (higher risk category) and only in those languages where it is known that they have:

- Poor level of English competence; and
- Low literacy skills.

These communities were identified by Cultural Perspectives as: Vietnamese, Khmer, Korean, Cantonese, Mandarin, Turkish, Russian and Serbian.

The mainstream parent brochure text was translated into 16 languages and is available on the campaign website. The press ad translated into 16 languages is also available on the website. The address is www.nationalalcoholcampaign.health.gov.au. Research indicates that the problem of youth alcohol does exist but is not so prevalent amongst NESB communities. The use of the internet is a re-active strategy which provides a response and a sense of fulfilment for those parents who want to find out more.

#### 5.7.6.3 National Tobacco Campaign

As part of the National Tobacco Campaign, a communication strategy specifically targeting people from non-English speaking backgrounds (NESB) was launched in February 1998. This strategy was developed in recognition of the particular characteristics of smoking prevalence among different ethnic groups, as well as their varying levels of English language proficiency, length of time since migration and their use of mainstream and ethnic communication media.

The target audience for the strategy was male and female smokers and recent quitters aged 18–40. Demographic and smoking prevalence data amongst people from culturally and linguistically diverse backgrounds informed the language groups to be targeted. These were: Italian, Greek, Arabic, Vietnamese, Chinese (Mandarin and Cantonese), Spanish, Korean, and Turkish.

The components of the strategy were ethnic radio and press advertising; publicity; initiatives with workplaces; general practitioners and bilingual health and medical community members. Further phases of non-English advertising were implemented in September 1999. This phase of advertising involved further screening of the (translated) television commercials on SBS television and Channel 31 and (translated) radio commercials on SBS Radio and other ethnic radio stations in Sydney and Melbourne. The TV and radio commercials, specifically targeting the six most relevant languages (Greek, Italian, Vietnamese, Cantonese, Mandarin and Arabic) all featured the Quit number tagline.

The Quit Book is also available in thirteen languages.

#### 5.7.6.4 National Illicit Drugs Campaign

A strategy to reach parents and other adults from a non-English speaking background will be developed and integrated with the mainstream campaign, and where appropriate continue the existing creative images, while addressing the issues that are specific to these communities.

The tender process for development and implementation of the strategy has commenced after recent approval from the Ministerial Committee on Government Communications.

### 5.7.7 Men's Health

The Commonwealth has allocated $4 million over 4 years to establish the Centre of Excellence in Male Reproductive Health. It is a collaborative centre-without-walls for research and education in male reproductive health. The hub of the Centre is the Institute of Reproduction and Development at Monash University. Consensus by a broad range of stakeholders is that androgens, or steroids, is the highest priority issue for the Centre. Other priorities are sexual dysfunction, sub fertility, lower urinary tract problems and benign prostatic disease, and prostate and testicular cancer. Androgens are readily available, particularly at gymnasiums. Androgens pose significant health problems for men, including impacting on male fertility.

## 5.8 REGISTRATION, AVAILABILITY AND QUALITY USE OF PHARMACEUTICAL PRODUCTS

### 5.8.1 Therapeutic Goods Administration

The Therapeutic Goods Administration (TGA) is a division of the Commonwealth Department of Health and Aged Care and is the Australian drug regulatory authority responsible for carrying out a range of assessment and monitoring activities to ensure that all therapeutic goods available in Australia are of an acceptable standard. At the same time, the TGA aims to ensure that the Australian community has access, within a reasonable time, to therapeutic advances. Overall control of the supply of therapeutic goods is exerted through four main processes:

- pre-market evaluation and approval of registered products intended for supply in Australia;
- a system for listing lower risk products including many medical devices, many herbal medicines and vitamin products;
- licensing of manufacturers in accordance with international standards under Good Manufacturing Practice;
- post-market monitoring through sampling, adverse reaction and incident reporting, surveillance activities, and response to public enquiries.

#### 5.8.1.1 Registration and Listing of Medicines

Therapeutic goods included in the Australian Register of Therapeutic Goods (ARTG) are divided into two categories – "registrable" goods which include prescription and non-prescription medicines (such as new chemical entities, new treatments or new generic products) and "listable" goods which include low risk non-prescription medicines (such as some over the counter medicines and herbal products). Listable goods do NOT contain substances that are scheduled in the Standard for the Uniform Scheduling of Drugs and Poisons (SUSDP).

Registrable goods undergo a more rigorous evaluation of their safety, quality and efficacy before being included in the ARTG, than listable goods. Listable goods are not normally subject to a comprehensive review of information. However, they need to comply with relevant statutory standards. They must also meet other requirements, advertising regulations and compliance of the manufacturing process with a recognised code of Good Manufacturing Practice.

Currently, in Australia, there is substantial research being done on the use of pharmacological treatments for the treatment of drug dependence. Some of these products are yet to be made widely available in Australia. The following information outlines the process a product must go through to be included in the ARTG, and also the mechanisms under which an unregistered product can be used.

***The Registration Process for Prescription Medicines***

An application to register a product is received from a sponsor (usually a pharmaceutical company) by the TGA and is checked for compliance with formatting requirements (largely the same as for the European Union), the type of application and whether a priority evaluation is requested.

An initial assessment of the application is undertaken by both administrative and professional areas in the Drug Safety and Evaluation Branch (DSEB) and a decision is made whether to accept the application for evaluation. The initial assessment must be completed within 40 working days.

The data submitted by a sponsor is evaluated by the three professional evaluation areas (see below) which assess the submitted information for quality, safety and efficacy for the proposed usage:

1. Chemical, Pharmaceutical and Biological
2. Pharmaco-toxicological
3. Clinical

On completion of each of the three evaluation reports, a copy is sent to the sponsor for comment as is a proposed decision prepared by the head of the clinical section responsible for that therapeutic class.

The completed evaluation reports, proposed decision and sponsor comments are referred to the Australian Drug Evaluation Committee (ADEC). ADEC considers these documents, together with any other relevant material, and makes a recommendation in relation to the application. Once the ADEC resolutions are ratified (currently about 5 working days), the advice is sent to the Minister for Health and the Secretary of the Department.

A Delegate of the Secretary at the TGA then makes a decision, taking into account ADEC's advice, and proceeds to finalise the application by either granting approval to include the product on the ARTG or rejecting the application.

***Who can register a product?***

Under the *Therapeutic Goods Act 1989*, a sponsor is some one who:

- imports therapeutic goods;
- manufactures therapeutic goods;
- has therapeutic goods imported or manufactured on their behalf; and
- exports therapeutic goods from Australia.

The sponsor of a medicine is the person or company responsible for applying to the TGA to have their medicine included in the ARTG. The sponsor must be a resident of Australia or carrying on business in Australia.

***Registration Timeframes for Prescription Medicines***

Regulation 16D of the *Therapeutic Goods Regulations* specifies the amount of time allowed for the TGA to evaluate and make a decision on an application relating to a prescription medicine, depending on the type of application. The specified time does not include the time taken for a sponsor to respond to questions asked by the TGA during the evaluation process. Applications are classified as Category 1, Category 2 or Category 3.

A Category 1 application may be for a new chemical entity or a new use for a registered prescription product. These applications are allowed 255 TGA working days for evaluation and finalisation of the decision. The average total turn around time for a new chemical entity to be registered for marketing in Australia is around 14 months.

Category 2 applications are for the same purpose as Category 1 applications except that the application relates to a drug which has been approved in two countries in which TGA has mutual agreement for the exchange of evaluation reports. A Category 2 application is allowed 175 working days for evaluation and decision.

Category 3 applications involve a change to a product that is already registered, where the change does not require clinical, toxicological or bioavailability data to support the change. A Category 3 application is allowed 45 working days for evaluation and decision.

### 5.8.1.2 Use of unregistered products

Commonwealth legislation provides several mechanisms by which individuals may gain access to unregistered therapeutic goods:

- participation in a clinical trial: Clinical Trial Notification (CTN) and Clinical Trial Exemption (CTX) schemes
- Special Access Scheme (SAS)
- Personal importation

***Clinical Trial Schemes***

Clinical trials should be conducted solely to answer valid scientific questions.

Clinical trials should not be used by medical practitioners as a means for obtaining an unapproved product for a particular patient.

There are two options for conducting a clinical trial in Australia. Under the CTN scheme the sponsor of an unregistered medicine notifies the TGA of a proposed clinical trial once the trial has been approved by an Institutional Ethics Committee (IEC). In this case, the TGA does not review the safety of the drug or any aspect of the trial protocol.

Under the CTX scheme the TGA assesses information submitted by a sponsor about the safety issues associated with an unregistered drug and then makes a decision whether the trial should commence.

***Special Access Scheme (SAS)***

A medical practitioner treating a seriously ill patient with a life-threatening condition may obtain an unregistered medicine from either an Australian source or from overseas. Depending on the severity of the illness, access may be achieved by notification to the TGA (life-threatening illnesses) or may require approval by a TGA doctor (other illnesses).

***Personal Importation***

Generally, an unregistered product may be personally imported provided that the quantity imported in one importation is not more than 3 months supply at the maximum recommended dose. Restrictions apply, however, to certain classes of medicines.

### 5.8.1.3 Unapproved Uses of Registered Products

The Commonwealth does not regulate the way in which an individual doctor prescribes a medication for an individual patient. This is a clinical judgement made by the practitioner for the individual patient.

There may be medical practice and medico-legal implications associated with prescribing a medication outside its approved indications. Such matters are generally within the responsibility of State and Territory authorities including Medical Boards and Departments of Health.

### 5.8.1.4 Scheduling of Medicines

Some medicines contain substances that are not available directly to consumers. Access to these substances, listed in schedules contained in the Standard for the Uniform Scheduling of Drugs and Poisons (SUSDP), is usually restricted for a number of reasons, including: toxicity, safety, and the risks and benefits associated with the use of the product.

The schedules in the SUSDP list drugs and poisons according to the recommended restrictions on their availability to the public.

The categories of the SUSDP which are most relevant to medicines on the ARTG and/or contain commonly abused substances are:

- Schedule 9 (S9) – prohibited substances
- Schedule 8 (S8) - controlled drugs;
- Schedule 4 (S4) - prescription only medicines;
- Schedule 3 (S3) - non-prescription medicines for supply by pharmacists only; and
- Schedule 2 (S2) - non-prescription pharmacy medicines.

Medicines which are not scheduled in the SUSDP can be sold through any distribution outlet, such as a supermarket or health food store. Examples of medicines which are unscheduled include: small packs of simple pain relievers, and most vitamins and minerals.

Schedule 9, contains, for example heroin and cannabis. It includes substances which may be abused or misused, the manufacture, possession, sale or use of which should be prohibited by law except when required for medical or scientific research, or for analytical, teaching or

training purposes with approval of Commonwealth and/or State or Territory Health Authorities.

Schedule 8 contains, for example morphine, dexamphetamine. Schedule 8 substances are substances which should be made available for use, but which require restrictions to reduce abuse, misuse and physical and psychological dependence. Restrictions are placed on manufacture (manufacturers must apply for a license from both the Commonwealth and State/Territory Governments) and supply (supply via prescription for long-term use requires approval from most State/Territory Health Departments).

The SUSDP is either adopted in or by reference to, State/Territory poisons and drugs legislation for its legal operation.

### 5.8.2 Pharmaceutical Benefits Branch

Medicinal drugs, when they are of good quality, accessible to patients, and used wisely, are arguably one of the major contributors to good health and the general well being of society.

Medicinal drugs also represent a major challenge in achieving the desirable standards of quality, level of accessibility, and quality of use. Often this involves apparently competing interests.

These challenges, and the roles and responsibilities of partners engaged in meeting these challenges, are documented in the *National Medicines Policy 2000* (NMP), launched in late 1999 by the Parliamentary Secretary to the Minister for Health and Aged Care, Senator the Hon Grant Tambling.

A principal objective of the NMP is quality use of medicines, which involves, *inter alia*, the safe use of medicines by promoting practices which minimise misuse, overuse and underuse.

Another principal objective of the policy is timely access to the medicines that Australians need, at a cost individuals and the community can afford. The Federal Government ensures access to necessary prescription medicines through the Pharmaceutical Benefits Scheme (PBS).

#### 5.8.2.1 Potential for Abuse of New Medicinal Preparations – PBS Listing

The PBS Schedule includes medications suitable for the treatment of the majority of conditions which afflict community patients.

Before a drug or medicinal preparation may be subsidised under the PBS, it needs a recommendation to this effect from the Pharmaceutical Benefits Advisory Committee (PBAC). The PBAC is a statutory committee and the legislation under which it operates requires it to take account of the safety, effectiveness and cost effectiveness of a new drug, compared to currently available therapy, when considering new listing applications.

The PBAC operates under an evidence-based process and applicants (drugs' sponsors) have available a detailed set of guidelines to assist them in the presentation of their applications. The PBAC is at the forefront of the use of cost effectiveness in its consideration of subsidy applications.

The PBAC, being composed mainly of members from the medical and pharmacy professions, is fully aware of other aspects relating to appropriate use of medications, including matters relating to abuse, overuse, development of dependence and development of resistance (antibiotics) and takes such matters into consideration in its deliberations. One of the Committee's principles is that it is unlikely to recommend listing of a new drug where this may increase problems of abuse or dependence.

Under the *National Health Act 1953*, the Minister for Health and Aged Care is unable to declare a drug to be a pharmaceutical benefit unless the PBAC has so recommended.

When a drug is listed in the PBS Schedule, it is able to be listed for certain conditions only, and it is also common to place limits on the quantities which should be available per prescription. Thus in relation to the benzodiazepines, the hypnotics are listed with a maximum quantity of 25 (per prescription) and there is no repeat available. This is because the PBAC believes that the correct use of hypnotics is short-term use to establish a sleep pattern. Further short courses may be used at infrequent intervals should the need arise but long-term continuous use is not appropriate. There have been many requests to increase the quantity available but the PBAC has not been prepared to alter its stance on the issue. The Committee has agreed to the use of larger quantities for patients with late stage cancers; and for those receiving long-term nursing care, providing they have been proven to be benzodiazepine-dependent and an attempt at drug withdrawal has been tried but been unsuccessful.

The PBAC has considered several requests to list alternatives to the benzodiazepines but to date the PBAC has not been prepared to recommend. Although the products have been presented along with the claims that the newer agents result in less abuse and dependence, the data presented have not supported this and the PBAC has not been convinced that the claims would be substantiated in practice. The Committee has indicated that unless a new agent is proven to have a substantial advantage in the areas of abuse and dependence, recommendation for PBS subsidy is unlikely.

Likewise with the listing of the narcotic analgesics, most of these are listed in the PBS Schedule with limited quantities for 'severe disabling pain not responding to non-narcotic analgesics'. Furthermore, increased quantities and repeats are only available for severe disabling pain associated with proven malignant neoplasia, or for patients with chronic severe disabling pain where treatment has been initiated in a hospital.

In relation to the combination formulations of codeine phosphate with paracetamol or aspirin, the 30 mg codeine combinations are available in a maximum quantity of 20 and increased quantities and repeats are only available for severe disabling pain associated with proven malignant neoplasia, or for patients with chronic severe disabling pain where treatment has been initiated in a hospital. The 8 mg codeine formulations are not subsidised, as the PBAC believes that the 8 mg dose is sub-therapeutic.

The Committee has been concerned at the apparent overuse of the 30 mg codeine combinations for some years, and has proposed to the States that the combination products be brought into line with plain 30 mg codeine phosphate and be included in schedule 8 of the uniform scheduling codes. The States have not agreed to this suggestion. At one stage the

PBAC recommended that the 30 mg codeine combination products be deleted from the PBS Schedule. This recommendation was not accepted by the then Government.

In 1994 the PBAC recommended the PBS listing of nicotine patches to assist in the cessation of smoking. The then Government rejected this recommendation because it considered that smoking cessation programs were a State/Territory responsibility.

Following recommendations by the PBAC, acamprosate and naltrexone have recently been added to the PBS Schedule as adjunctive treatment for alcohol dependence. The use of naltrexone in opioid dependence was not recommended due to a lack of data in support of significant effectiveness in that patient population.

#### 5.8.2.2 Quality Use of Medicines Initiatives

***Australian Pharmaceutical Advisory Council***

APAC was created in 1991 as a consultative forum to advise the Commonwealth Government on a wide range of pharmaceutical policy issues. The Council identifies and considers issues and needs in health care with particular reference to pharmaceuticals.

A subcommittee of APAC was formed in late 1999 to examine issues around the intentional misuse of pharmaceuticals.

This subcommittee forms part of the advisory structures for the National Drug Strategic Framework (NDSF). Members are appointed by the Minister for Health and Aged Care, the Hon Dr Michael Wooldridge (see Appendix 3).

The subcommittee is building on previous work in the area and complementing work being done in the area of unintentional misuse of pharmaceuticals. The following issues, identified at earlier stakeholder meetings, will form the basis for the group's activities:

- target drugs (opioids, stimulants, benzodiazepines, and performance and image-enhancing drugs) and data comprehensiveness;
- privacy;
- communication best practice (targets include community and professionals);
- risk analysis;
- legislative reform;
- education (includes clinical guidelines);
- stakeholder mobilisation;
- partnership development;
- management of data sets; and
- removal of structural barriers to good practice.

The group has met once. Target substances of abuse have been identified as opioids, benzodiazepines, stimulants, and performance and image-enhancing drugs. Initial discussions have signalled significant data gaps in this area and it is likely that initial recommendations from the committee will suggest ways of addressing this problem.

***Health Insurance Commission***

Use of existing PBS claims data has led to success by the Health Insurance Commission in addressing the problem of 'doctor shopping'. The HIC identifies doctor shoppers as those who, in a given year, see 15 or more different general practitioners, have 30 or more Medicare consultations, and obtain more PBS prescriptions than appear to be clinically necessary. Doctor shoppers seeking PBS medicines for abuse mainly obtain prescriptions for benzodiazepines, narcotic analgesics, and codeine compound analgesics.

Through a range of HIC interventions, the numbers of identified 'doctor shoppers' has fallen from over 13,000 in 1995-6 to just over 8600 in 1998-9. These initiatives include counselling, education and information strategies directed at both medical practitioners and doctor shoppers themselves.

***National Prescribing Service***

The Government has provided funding for this service, an independent incorporated organisation providing leadership and coordination for quality prescribing in Australia. The service aims to improve health outcomes for consumers through appropriate (judicious, safe, effective) and cost-effective prescribing.

The NPS has identified appropriate use of benzodiazepines amongst its priority areas. Educational material was provided to doctors in 1999 which provided strategies for:

(a) refusing to prescribe benzodiazepines when experiencing patient pressure; and
(b) how to help patients to withdraw from benzodiazepines.

A limited media campaign and production of materials to be used by patients (eg sleep diary) complemented the education materials aimed at prescribers.

***Pharmaceutical Health and Rational Use of Medicines (PHARM) Committee***

The Pharmaceutical Health and Rational Use of Medicines Committee (PHARM), an expert committee which advises the government on Quality Use of Medicines, formed a working party in 1999 to systematically examine inappropriate prescribing and use of benzodiazepines.

The working party comprises PHARM members with expertise in general practice, pharmacy, nursing, as well as members from the consumer and community sectors, and officers from the Health Insurance Commission and the Commonwealth Department of Health and Aged Care.

The Working Party has devised an Implementation Plan that seeks to integrate current initiatives with new measures to further address inappropriate prescribing and use.

One area targeted by the Benzodiazepine Working Party for attention is the abuse of benzodiazepines in conjunction with illicit drugs. This issue will be addressed through the work of the APAC subcommittee on the intentional misuse of pharmaceuticals.

The Benzodiazepine Working Party's Implementation Plan has:

1. commissioned an evidence based systematic review to provide an overview of the current situation, and

2. argues for a national program for health services and health professionals that will
   - provide a framework for reduced benzodiazepine prescribing and for the promotion of positive alternatives,
   - encourage a range of health services and health professionals (GPs, divisions, hospitals, community health services, and pharmacists) and other community agencies to be involved in support and education programs, and
   - provide materials to support the above objectives.

## 5.9 INTERNATIONAL INITIATIVES

Australia is a signatory to several international conventions and agreements that involve the assumption of certain responsibilities and have implications for domestic policy formulation. The purpose of Australia's participation in international drug forums is to contribute to global stability and regional cooperation, drawing on our extensive expertise and experience in effective law enforcement strategies, regulatory mechanisms and demand and harm reduction initiatives. Australia will continue to participate in the international drug policy arena.

Australia is a major donor to the United Nations International Drug Control Programme and has been a member of the Commission on Narcotic Drugs since 1973. The Commission is the central policy making body within the United Nations System for dealing with drug issues. Australia participates in the annual meetings of the Commission and is an active and well-respected member.

The International Narcotics Control Board undertook a periodic visit to Australia on 8-15 April 2000 to develop an understanding of the environment in which Australian policies are being developed, and the rationale behind those policies. The last visit by the Board was in 1991.

- The INCB is the independent and quasi-judicial control organ for the implementation of the United Nations drug conventions. It is responsible for the promotion of government compliance with the provision of the drug control treaties and for assisting them in this effort. Broadly speaking, the Board deals with two aspects of drug control:

    - Licit manufacture, commerce and sale of drugs; and
    - Illicit manufacture and trafficking of drugs.

Australia is one of the world's major suppliers of licit opiates. Australia produces high quality concentrate of poppy straw for both domestic use and export. The Australian industry has been operating for over thirty-five years and is recognised internationally as being highly secure, efficient and tightly controlled by government. The poppy industry, which is based in Tasmania, is regulated in accordance with Australia's obligations under the United Nations Single Convention on Narcotic Drugs, 1961 as amended by the 1972 Protocol. The International Narcotics Control Board was established by the Single Convention to limit the cultivation, production, manufacture and utilisation of drugs, and at the same time, to ensure the availability of drugs for medical and scientific purposes. Australia fully co-operates with the Board in its endeavours to achieve the balance between supply and demand. The licit opiate industry in Australia is subject to various controls by both Commonwealth and State and Territory Governments.

- The Commonwealth is responsible for controlling the manufacture, import and export of all controlled substances. This responsibility is executed by the Department of Health and Aged Care through a system of licenses and permits.

- The growing of controlled substances is regulated by State and Territory Governments. In Tasmania this comes under the jurisdiction of the Department of Justice, Poppy Advisory and Control Board (PACB).

Australia's efforts in international drug cooperation are coordinated by the Standing Interdepartmental Committee in International Narcotics Issues, which is made up of representatives of all Commonwealth agencies with an interest in international drug matters. The National Drug Strategy Unit coordinates links between the Committee's activities and the National Drug Strategic Framework.

### 5.9.1 Responsibilities for Precursor Controls

Australia is a signatory to the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988. This Convention seeks to implement international controls on precursor substances that are frequently used in the illicit manufacture of narcotic drugs and psychotropic substances.

Australia's obligations under this treaty require certain controls to be imposed on the possession of, access to and supply of these substances. The necessary controls on imports are imposed under the *Customs (Prohibited Imports) Regulations* while controls on possession, supply and access are generally applied by relevant State and Territory legislation. The Therapeutic Goods Administration is responsible for issuing import licences and permits under the Customs Regulations and is the national competent authority for the purposes of the Convention.

There is considerable variation in the legislative controls the States and Territories use to control these substances and other substances of potential misuse or abuse. The "National Competition Review of Drugs, Poisons and Controlled Substances Legislation Options Paper" considers the need for a national approach to these controls in order to improve uniformity and increase efficiency.

### 5.9.2 Commonwealth participation in the World Health Organisation's Framework Convention in Tobacco Control.

Tobacco use is a global health concern, underlined by the World Health Organisation's (WHO) decision in 1998 to make tobacco control a priority for global health. Foremost in WHO's tobacco control initiatives is support for the Framework Convention on Tobacco Control (FCTC). The FCTC will be an international legal instrument intended to circumscribe the global spread of tobacco and tobacco products. The FCTC forms the cornerstone of the WHO Tobacco Free Initiative (TFI). The TFI is a project established in 1998 by the Director-General of WHO to assign priority to reinvigorate work on tobacco control. WHO are working towards facilitating the completion of the FCTC by May 2003.

### 5.9.3 The Western Pacific Region

Australia is a Member State in the Western Pacific region of WHO and is involved at a regional level with the Tobacco Free Initiative and associated activity concerning the FCTC.

The Department of Health and Aged Care is looking to participate in and assist with regional consultations on the FCTC over the life of the negotiations.