Australian Government

Department of Health and Ageing

Supplementary submission to the Parliamentary Joint Committee on the Australian Crime Commission's Inquiry into Amphetamines and Other Synthetic Drugs

Since the Department of Health and Ageing (the Department) provided its submission on 13 March 2006 to the Parliamentary Joint Committee on the Australian Crime Commission in relation to the Committee's Inquiry into Amphetamines and Other Synthetic Drugs (AOSD)[1], there have been a number of significant events of relevance to the Committee's work. These include the 2006-07 Budget, the May 2006 meeting of the Ministerial Council on Drug Strategy (MCDS) at which announced the development of a National Amphetamine Type Stimulant (ATS) Strategy, and the publication of a discussion paper on drug testing kits. Information on these matters is provided below together with responses to the questions raised by the Committee following the 5 June 2006 public hearing and at the 19 June 2006 public hearing.

2006-07 Budget

The Australian Government announced a total of $214 million for new drug and alcohol measures in the 2006-07 Budget which includes the following measures of particular relevance to Amphetamine Type Stimulant (ATS) problems:

- The *Illicit Drug Use – Combating Emerging Trends* measure allocates $34.4 million in new funding over 4 years for research, workforce training and treatment for people with psychostimulant problems in Australia – particularly ecstasy and amphetamines.

  The measure also includes funding for a third phase of the *National Illicit Drugs Campaign.* Phase three of this campaign will target young Australians' use of cannabis as well as psychostimulants such as ecstasy and methamphetamine, and will also increase community awareness of associated harms.

- The *Alerting the Community to the links between drug use and mental health* measure ($21.6 million over 4 years) will fund an information campaign to give people a better understanding of the connections between drug abuse and the development of mental illness as well as the importance of seeking help early. There will also be targeted information to raise awareness in the clinical setting. It is expected that links between ATS use and psychosis will be included.

1 AOSD is a term used by the Committee. ATS – or Amphetamine Type Stimulants is a term more commonly used by the Australian Government and the MCDS. Both terms are similar in intent and are used interchangeably in the questions from the Committee. Answers provided by the The Department refer to ATS.

- The *Improved services for people with drug and alcohol problems and mental illness* measure ($73.9 million over 5 years) will ensure that non-government treatment organisations are better resourced and skilled to provide this treatment. This initiative includes dissemination of research findings on best practice treatment options, and general improvement of skills within the treatment sector.

- The *Improving the Capacity of Workers in Indigenous Communities* measure ($20.8 million over 5 years) will ensure that health workers are trained to identify and address mental illness and associated substance use issues in Indigenous communities and to recognise the early signs of mental illness and made referrals for treatment where appropriate.

- The *Counsellors for University Campuses* measure**,** with an allocation of $19.8 million over 4 year, will fund a network of counsellors on university campuses to identify early onset psychosis, substance abuse, and family support needs (including for sole parents) and arrange referral to appropriate specialist and mainstream community services.

National Amphetamine Type Stimulant Strategy

In May 2006, the Ministerial Council on Drug Strategy (MCDS) agreed to develop a National Amphetamines Type Stimulants Strategy to coordinate effort to reduce the harms of amphetamines and other dangerous psychostimulants. This national strategy is to be developed as a priority, based on a similar methodology to the formulation of *National Alcohol Strategy* and *National Cannabis Strategy* models.

The Strategy will give priority to helping workers at the front line deal more effectively with these issues. This should include a review and assessment of treatment and counselling options, including both pharmacotherapies and behaviourally-based approaches. In making this decision, Ministers also noted that all jurisdictions have already instigated initiatives to target ATS such as crystal methamphetamine or 'ice' as well as 'speed'.

Pill Testing

At the public hearing of 5 June 2006, the Committee raised the issue of pill testing. At its meeting in May 2005, MCDS agreed not to endorse the development or use of drug testing kits for personal use at the point of consumption. This decision reflects the agreement of all State, Territory and Australian Government law enforcement and health Ministers.

In accordance with the MCDS resolution, the Department is not pursuing any further activity in relation to pill testing.

Further information on pill testing has been made available since the Department's submission. A paper entitled *Drug testing kits: Detailed discussion paper on social, health and legal issues* was published on the National Drug Strategy website in May 2006 (see www.nationaldrugstrategy.gov.au). A copy of the paper is provided at Attachment A for the Committee's information.

National Illicit Drugs Campaign

The Department will continue to focus its efforts on prevention, education and treatment responses, and through the 2006-07 Budget announcement of $34.4 million in new funding to combat emerging trends, the Department is well placed to build upon already existing projects and programs, including to continue the National Illicit Drugs Campaign.

At the Committee hearing of Monday, 5 June, Mr Andrew Stuart, First Assistant Secretary, Population Health Division, informed the Committee that the evaluation of Phase Two of the National Illicit Drugs Campaign had demonstrated very positive results. Further information on the evaluation is provided below.

Phase Two of the National Illicit Drugs Campaign targeted young people and advertisements were run on marijuana, speed and ecstasy from April 2005 to July 2005.

The Evaluation Survey[2] was based on a nationally representative sample of 1490 young people aged 13-20 years. A copy of the full report is at Attachment B for the Committee's information.

Of those interviewed as part of the Evaluation, 84% recognised advertisements pertaining to speed and 81% recognised advertisements about ecstasy. Of those that recognised the advertisements for ecstasy and speed, 97% of the interviewees stated that the advertisement was believable.

Questions on Notice

Following the public hearing on 5 June 2006, the Department received 25 written and 3 verbal questions on notice. Responses to these questions are provided below.

2 The *National Drugs Campaign: Evaluation of Phase Two* report is at Attachment B. Refer to page 84 cited statistics.

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Question Number	Question on Notice
1	In the public hearing on 5 June 2006 Mr Stuart mentioned the adoption of a National Amphetamine Type Stimulant (ATS) Strategy. a. Is this the same National ATS Strategy mentioned in the submission from the Attorney-General's Department (Sub. 15)? b. This appears to be a very major development. Why didn't the DOHA submission refer to it? c. Is DOHA responsible for coordinating this new strategy? d. What are the key elements of the Strategy? The current strategies have not resulted in a significant drop in demand or supply – what new action plans will be included under the National ATS Strategy to achieve that? e. When will the strategy be made public? ***(Written Question on Notice)***
2	The Australian Institute of Health and Welfare Household Surveys show that the period of fastest growth of AOSD use was between 1995 and 1998. In that period recent use of amphetamines increased from 2.1% to 3.7%, and use of ecstasy increased from 0.9% to 2.4%. a. Why has it taken the National Drug Strategy so long to focus on AOSDs? Why has it taken 8 years for a specific ATS Strategy to be developed? b. How flexible is the NDS in reflecting changing trends in the use of drugs? ***(Written Question on Notice)***
3	According to United Nations figures, Australia has the highest per capita consumption of AOSDs in the world – about twice the rate in the UK and USA and even more when compared with the Netherlands and Canada. To date the Committee has not heard any convincing explanations as to why Australia leads the world in the consumption of these drugs. Your submission suggests that different data collection systems might be the answer, but the AIHW at Monday's public hearing seemed to indicate that these countries all have sound statistical collection methods. a. Even allowing for different data collection systems, what do your analysts think are the reasons of the relatively high rate of consumption of AOSDs here? (Ecstasy is allegedly more expensive here than in other markets, which would if anything be expected to have a dampening effect on demand.) b. If DOHA doesn't have a satisfactory explanation, can you suggest where the Committee could go for such an analysis? ***(Written Question on Notice)***
4	The Committee has heard that the National Drug Strategy is based on three pillars: supply reduction, demand reduction, and harm reduction. a. In round figures, what is the annual budget of the National Drug Strategy? b. Roughly how much of the National Drugs Strategy is spent on supply reduction (law enforcement), how much on demand reduction (treatment and prevention), and how much on harm minimisation? c. How successful do you think each of the elements of the NDS have been in achieving its goals? ***(Written Question on Notice)***

5	Some commentators argue that drug use should be seen as a health rather than a legal issue. They say that addicts and other users are sufferers of a medical and social problem that cannot be solved through the criminal justice system. Prohibition and law enforcement have clearly failed to eradicate demand and supply, and prevention and treatment should be the focus. a. What is your response to such statements? b. Does the current bureaucratic structure, with the Department of Health & Ageing having carriage of the National Drug Strategy, indicate that drugs are, in fact, seen as primarily a health issue? c. Is it possible to make treatment and prevention the main focus, with law enforcement acting in a support role only? ***(Written Question on Notice)***
6	The Committee has been told that New Zealand has legalised some lower-grade amphetamines such as BZP. a. Please provide background to New Zealand's approach to AOSD: b. When did their program start? c. Why was it introduced (what were seen as the costs and benefits)? d. What is the regime? e. What drugs are included? f. How has it worked? g. Has anything similar been considered under the ATS Strategy? If not, why not? ***(Written Question on Notice)***
7	The Committee has held hearings for this Inquiry in NSW, Queensland, South Australia and Western Australia. All these jurisdictions indicated that AOSDs are their major drugs-of-concern. a. Looking 'over-the-horizon', what key developments do you see in illicit drugs over the next five years? b. What are the foreseeable major threats? c. What are the foreseeable opportunities? ***(Written Question on Notice)***
8	The Committee was told that there are now twice as many 'ice' addicts as heroin addicts, and that ice addicts often suffer from mental health problems such as psychosis and violence and so place much greater stress on support systems. a. Do you agree with those statements? b. What treatment options are there for AOSD addicts, and particularly for ice addicts? c. How can you help medical staff cope with violent behaviour? d. Were these issues taken into account in the Mental Health Package announced in April and the Budget in May? ***(Written Question on Notice)***

9	Professor Mattick of the National Drug and Alcohol Research Centre told the Committee at a public hearing in Sydney on 16 May that cognitive behavioural therapy was an effective treatment for dependent users and that in 2003 DOHA funded the development of a treatment guide by the University of Newcastle. a. The Committee was told that very few treatment centres have taken it up. Why? b. What treatment options are currently available to AOSD users? c. Are other treatment approaches under consideration (eg dexaphetamine has been mentioned to the Committee)? d. What treatment for AOSD users has worked best overseas? ***(Written Question on Notice)***
10	Ecstasy use in Australia continues to increase, which suggests that previous and current supply reduction and demand reduction strategies have not worked. a. Why have they failed, and what needs to be done differently? b. Do we just have to accept that young people will experiment and that at least some AOSD use is inevitable? c. Is their reputation as 'party drugs' and the fact that they are easily taken in tablet form, part of the problem? d. Is the real challenge how to prevent occasional use from becoming regular and dependent use? ***(Written Question on Notice)***
11	The Committee received evidence from the Triple J program and other witnesses which suggests that many young people do not believe advertising that demonises recreational drug use. a. What is the best way of communicating with young people about the harms which can be associated with drug use? b. How will that be reflected in the National ATS Strategy? ***(Written Question on Notice)***
12	The issue of pill testing was raised briefly at the public hearing on 5 June and the Committee would welcome further comments from the Department. Given the variable quality of AOSDs, pill testing has been recommended by some commentators. a. Why is pill testing not permitted in Australia? b. Is there any evidence that pill testing encourages drug use? c. Is accurate testing equipment now available? At what cost? d. What is the Department's view on pill testing? e. Should there be a properly designed and supervised trial to determine the effects of pill testing? f. Do you agree with witnesses from Enlighten Harm Reduction who expressed concern that local manufacturers could switch to other far more dangerous drugs, such as PMA? g. Do you have contingency plans if that should happen?
13	The DOHA submission refers to an estimated 102,000 regular users of methamphetamines of which 73,000 are dependent users. a. What is the definition of 'regular'? b. By 'dependent' do you mean addicted? How often would a dependent user take AOSD? ***(Written Question on Notice)***
14	The DOHA submission notes that 11% (14,208) of people getting treatment for

	drugs are dependent on amphetamines. a. Do you agree with commentators who say that AOSD users are generally reluctant to seek treatment? b. Why are AOSD users reluctant to seek treatment? c. What can be done to change that? How does the new National ATS Strategy address this issue? ***(Written Question on Notice)***
15	The DOHA submission states that 'Injecting accounted for 79% of closed treatment episodes within this group [amphetamine users] compared to all other drugs of concern, where injecting accounted for only 22%'. a. Why do amphetamine users inject themselves so much more than other drug users? b. Is it just ice addicts who inject, or are other forms of amphetamines also involved? ***(Written Question on Notice)***
16	The DOHA submission notes that National Drugs Campaign (NDC) has a budget of $30 million over two phases. Phase I commenced in March 2001 and targeted parents of 8 to 17 year olds. a. Is the National Drugs Campaign run by the Department of Health and Ageing? b. What assessment was done of Phase 1 of that campaign? How successful was it? c. What key lessons emerged from Phase 1, especially in relation to AOSDs? d. Have other countries tried campaigns which specifically targeted parents? ***(Written Question on Notice)***
17	Phase 2 of the NDC commenced in April 2005. Your submission notes that its primary focus is youth aged 13 to 17 years, while parents are now secondary targets. a. What are the key elements of Phase 2 of the National Drugs Campaign? b. How will it differ from Phase 1, especially in relation to AOSDs? c. Why the reduced focus on parents? ***(Written Question on Notice)***
18	The DOHA submission notes that under *Tough on Drugs*, $5.1 million has been allocated to the National Psychostimulants Initiative from 2003-04 to 2007-08. a. What are the key elements of this Initiative? b. We are now into the third year of this Initiative. What results have been achieved so far? c. What lessons have been learnt? d. Will this become part of the National ATS Strategy? ***(Written Question on Notice)***
19	The DOHA submission mentions the National Co-morbidity Initiative, which has funding of $9.7 million over 5 years from 2003-04. a. Please describe the key elements of this Initiative? b. Which elements are specifically related to AOSDs? c. What progress has been achieved so far? ***(Written Question on Notice)***

20	The DOHA submission mentions that $340 million has been allocated to the Illicit Drug Diversion Initiative from 1999-00 to 2007–08. a. Please describe the key elements of this Initiative? b. Which elements are specifically related to AOSDs? c. Will these be incorporated into the new National ATS Strategy? d. What progress has been achieved so far? ***(Written Question on Notice)***
21	The DOHA submission notes that DOHA's Office of Chemical Safety is a member of the National Working Group (NWG) for the Prevention of the Diversion of Precursor Chemicals. The Office has received funding under the National Drug Strategy to develop a national database on legitimate users of chemicals which could be used in the illicit manufacture of drugs. a. When did this project commence, and how long is it expected to take? b. What progress has been achieved? c. Will pseudoephedrine be included (now the subject of the Pharmacy Guild's Project STOP)? d. Have other countries developed similar databases? ***(Written Question on Notice)***
22	Can you provide an overview of the current programs under the Illicit Drug Diversion Initiative? In responding, can you provide information on a State Basis? ***(Written Question on Notice)***
23	The current name, no. and cost of each program under Illicit Drug Diversion Initiative for the last 12 months or nearest financial year? ***(Written Question on Notice)***
24	Can you provide a list of current programs or partnerships being undertaken with the AFP or ACC in relation to drug markets? ***(Written Question on Notice)***
25	In relation to the data you receive, do you assess the quality of that data, and if so, how? ***(Written Question on Notice)***
26	"…The survey that followed up on the recognition of the campaigns was sample based. We will take on notice what that sample was and we will provide that in our written response." ***(Hansard Reference: Page ACC 6, Mr STUART)***
27	"… If you are asking if there was any research as an input into the formation of the [diversion] program, I would have to take that on notice…" ***(Hansard Reference: Page ACC 8, Mr STUART)***
28	"… I wonder whether you might respond by a short note that basically goes through those elements that are said to be part of a harm minimisation strategy in relation to amphetamines and other synthetic drugs, and the budget over, say, the last three years and forward, so we can have a look at what actually has been done or planned. And, if you know of anything useful at the state level, because this is not just a Commonwealth issue—if there are intelligent harm minimisation things being done in this area by states…" ***(Hansard Reference: Page ACC 12, Mr KERR)***

Responses to Questions on Notice

Question 1:

In the public hearing on 5 June 2006 Mr Stuart mentioned the adoption of a National Amphetamine Type Stimulant (ATS) Strategy.

a. Is this the same National ATS Strategy mentioned in the submission from the Attorney-General's Department (Sub. 15)?
b. This appears to be a very major development. Why didn't the DOHA submission refer to it?
c. Is DOHA responsible for coordinating this new strategy?
d. What are the key elements of the Strategy? The current strategies have not resulted in a significant drop in demand or supply – what new action plans will be included under the National ATS Strategy to achieve that?
e. When will the strategy be made public?

Answer:

a. Yes.

b. On 15 May 2006, the Ministerial Council on Drug Strategy agreed to the development of a *National Amphetamine Type Stimulant (ATS) Strategy*. This decision was subsequent to the submission to the Inquiry from the Department of Health and Ageing (the Department).

c. Yes.

d. A proposal to develop Australia's first National ATS Strategy was endorsed on 15 May 2006 by the Ministerial Council on Drug Strategy (MCDS). Development of the Strategy is being undertaken in two stages with the law enforcement component due for completion in 2006.

   It is anticipated the strategy will parallel the *National Drug Strategy 2004-2009*. The strategy will encompass a blend of supply reduction, demand reduction and harm reduction strategies. The mix of such strategies will be determined through stakeholder consultation and on the basis of evidence.

e. After the developmental phase, MCDS will need to consider the draft Strategy. Matters relating to the public release of the Strategy will be for the decision of the MCDS.

Question 2:

The Australian Institute of Health and Welfare Household Surveys show that the period of fastest growth of AOSD use was between 1995 and 1998. In that period recent use of amphetamines increased from 2.1% to 3.7%, and use of ecstasy increased from 0.9% to 2.4%.

a. Why has it taken the National Drug Strategy so long to focus on AOSDs? Why has it taken 8 years for a specific ATS Strategy to be developed?
b. How flexible is the NDS in reflecting changing trends in the use of drugs?

Answer:

a. Progressive iterations of the *National Drug Strategy* have built upon Australia's capacity to respond to all drug and alcohol problems, with significant emphasis on tobacco and alcohol harms. This is reasoned on estimates of up to a 90% contribution of the total costs of drug harm is attributable to these two substances.

   Whilst an increase in the use of ATS is concerning, the numbers of people using these drugs are still low compared with cannabis, tobacco and alcohol. A proportionate response is required and given the decline in overall illicit drug use – and most notably since 1999, in opiate based drug harms – an increasing emphasis on amphetamines and other synthetic drugs is appropriate in the current climate.

   More recent attention on ATS is also attributable to the use of the more potent forms of the drug, such as Crystal Methamphetamine (or 'ice'), which are being used in more dangerous ways (smoking and injecting) and which is also associated with increased health harms.

b. The current *National Drug Strategy 2004 – 2009* includes 'identification and response to emerging trends' as one of its 8 priority areas and provides a broad, integrated framework from which to respond flexibly to emerging drug problems.

   This priority area within the *National Drug Strategy* demonstrates a commitment to flexibility and responsiveness by State, Territory and the Australian Governments, which are equal partners under the Strategy.

Question 3:

According to United Nations figures, Australia has the highest per capita consumption of AOSDs in the world – about twice the rate in the UK and USA and even more when compared with the Netherlands and Canada. To date the Committee has not heard any convincing explanations as to why Australia leads the world in the consumption of these drugs. Your submission suggests that different data collection systems might be the answer, but the AIHW at Monday's public hearing seemed to indicate that these countries all have sound statistical collection methods.

a. Even allowing for different data collection systems, what do your analysts think are the reasons of the relatively high rate of consumption of AOSDs here? (Ecstasy is allegedly more expensive here than in other markets, which would if anything be expected to have a dampening effect on demand.)
b. If DOHA doesn't have a satisfactory explanation, can you suggest where the Committee could go for such an analysis?

Answer:

a. and b.

There are household surveys in other countries such as the United States, Canada, the United Kingdom and New Zealand. While these surveys are conducted with varying degrees of similarity to the Australian surveys, comparisons between countries should be treated with caution.[3] Household surveys are not always the best means of measuring low prevalence behaviours (such as illicit drug use) because of the willingness of people to respond accurately about these behaviours. Alterations to methodologies over time suggest that drawing firm conclusions about different consumption patterns between countries is difficult.

That said, too many Australians are using ATS. The factors that influence drug and alcohol use include structural factors, such as socioeconomic status and community attitudes about drug use; and individual factors, such as temperament and peer group influence[4]. Research also states that changes in youth culture are associated with changes in the use of illicit drugs, for example, the advent of the rave scene has been accompanied with an increase in the use of ecstasy[5]. Moreover, the transition to adulthood occurs much later than before, which results in a longer potential time for engaging in risk taking behaviours[6]. The increased availability of drugs and alcohol and perceptions of the low risk associated with drug taking further contribute to substance abuse.

3 AIHW Statistics on Drug Use 2004 p 35

4 Y Bonomo *Adolescent Substance Abuse* in M Hamilton, T King and A Ritter (ed) DRUG USE IN AUSTRALIA 2004 Oxford University Press

5 P Dietz, A Laslett, G Rumbold The Epidemiology of Drug Use in M Hamilton, T King and A Ritter (ed) DRUG USE IN AUSTRALIA 2004 Oxford University Press

6 Y Bonomo *Adolescent Substance Abuse* in M Hamilton, T King and A Ritter (ed) DRUG USE IN AUSTRALIA 2004 Oxford University Press

Question 4:

The Committee has heard that the National Drug Strategy is based on three pillars: supply reduction, demand reduction, and harm reduction.

a. In round figures, what is the annual budget of the National Drug Strategy?
b. Roughly how much of the National Drugs Strategy is spent on supply reduction (law enforcement), how much on demand reduction (treatment and prevention), and how much on harm minimisation?
c. How successful do you think each of the elements of the NDS have been in achieving its goals?

Answer:

a. and b.

The National Drug Strategy includes a mix of strategies that span education; family and community services; health, law enforcement; three levels of government; the non-government and community sectors, and there is considerable complexity when determining the funding balance between supply reduction, demand reduction and harm reduction. As an example, the *Illicit Drug Diversion Initiative,* which is administered by this Department, could be included in all three categories.

The Australian Government has allocated over $1.3 billion since 1997 under its *Tough on Drugs* initiative. Of this amount, an allocation of $899 million has been made to prevention, demand and harm reduction measures, and $416 million to supply reduction measures.

When considering that State, Territory Governments carry the major responsibility for providing drug and alcohol services, expenditure under the National Drug Strategy is considerable.

c. Illicit drug use has declined markedly, from 22% in 1998 to 15.3% in 2004[7]. There are approximately 810,000 fewer recent illicit drug users in Australia in 2004 when compared with 1998. Successive evaluations of the National Drug Strategy have also found the integrated, comprehensive and balanced approach to drug policy in this country to be a strength which has delivered positive outcomes.

7 The 2004 National Drug Strategy Household Survey: First Results, p.3

Question 5:

Some commentators argue that drug use should be seen as a health rather than a legal issue. They say that addicts and other users are sufferers of a medical and social problem that cannot be solved through the criminal justice system. Prohibition and law enforcement have clearly failed to eradicate demand and supply, and prevention and treatment should be the focus.

a. What is your response to such statements?
b. Does the current bureaucratic structure, with the Department of Health & Ageing having carriage of the National Drug Strategy, indicate that drugs are, in fact, seen as primarily a health issue?
c. Is it possible to make treatment and prevention the main focus, with law enforcement acting in a support role only?

Answer:

a. These statements overlook the complexity that is required of a comprehensive and integrated drug policy. No single approach works for all people with drug and alcohol problems.

   It is difficult to directly attribute benefit from an initiative to law enforcement or health. For instance, law enforcement deters drug use (either any drug use, or an escalation of low level drug use) which has health benefits. Some health-oriented approaches, such as attracting and retaining drug users in treatment, have law enforcement related benefits in terms of fewer people being engaged in the illicit drug market and lower rates of drug-related crime.

   Drug issues are diverse. People use varying amounts of differing illicit drugs and do so for a wide range of reasons. An emphasis on one or two strategies is unlikely to resonate with all groups of drug users. Supply and demand reduction strategies work in concert.

   A case in point is the reduction in heroin overdose deaths, from 1,116 in 1999 to 357 in 2004. Overall illicit drug use has declined since 1998, with the 2004 National Drug Strategy Household Survey indicating that Australian's recent use of any illicit drug dropping from 22% in 1998 to 15.3% in 2004.

b. The Health portfolio takes a leading role in both domestic and international drug policy. In carrying out this role, the Department works very closely with other Australian Government Departments, State and Territory Governments and the non-government sector.

c. The Australian Government's policy is a balance of supply, demand and harm reduction initiatives. At both the Australian Government, and the State and Territory Government level, strong partnerships exist with law enforcement, as well as family and community services and education sectors. The Government considers the balance and adequacy of such initiatives across all sectors and, from time to time, this results in new measures such as those delivered in the 2006-07 budget.

Question 6:

The Committee has been told that New Zealand has legalised some lower-grade amphetamines such as BZP.

a. Please provide background to New Zealand's approach to AOSD:
b. When did their program start?
c. Why was it introduced (what were seen as the costs and benefits)?
d. What is the regime?
e. What drugs are included?
f. How has it worked?
g. Has anything similar been considered under the ATS Strategy? If not, why not?

Answer:

a. New Zealand's National Drug Policy 1998-2003 aims to improve the health and well-being of New Zealanders by promoting the development of strategies and programs to prevent and reduce drug-related harm. The New Zealand Ministerial Committee on Drug Policy has requested that the New Zealand Ministry of Health review this policy and public submissions were requested on 9 June 2006. Further information on the current and review of New Zealand's National Drug Policy is available at www.ndp.govt.nz

b. The New Zealand Ministerial Action Group on Drugs endorsed a Methamphetamine Action Plan on 22 May 2003, which has the objective of developing cross agency approaches to deal with methamphetamine related problems. This Action Plan is publicly available at www.ndp.govt.nz/publications/methamphetamineactionplan.html

   In reference to New Zealand's legalisation of some lower grade amphetamines, only benzylpiperazine (BZP) has been made available as a Restricted Substance[8] via the New Zealand Misuse of Drugs Amendment Act 2005 which was passed by the New Zealand Parliament in June 2005.

c. The passing of the Misuse of Drugs Amendment Act 2005 resulted from a report by New Zealand's Expert Advisory Committee on Drugs in 2004, which assessed BZP and recommended government controls without prohibiting the substance. On 13 June 2006, Jim Anderton, Chair of New Zealand's Ministerial Committee on Drugs, announced that the Expert Advisory Group will be reviewing the status of BZP when more evidence on the danger, or otherwise, is know.

d. BZP is restricted to those 18 years and over and most forms of advertising are prohibited, as are promotions and 'give-aways'.

e. BZP is the only ATS drug that has been made available within New Zealand as a Restricted Substance.

f. There is no information readily available on an evaluation of this program. Any further enquiries can be directed to the New Zealand Ministry of Health.

g. The National ATS Strategy is yet to be developed.

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8 Under the Act, it is an offence to sell or supply a Restricted Substance to a person under the age of 18 years, but it is not an offence to be in possession of a Restricted Substance

Question 7:

The Committee has held hearings for this Inquiry in NSW, Queensland, South Australia and Western Australia. All these jurisdictions indicated that AOSDs are their major drugs-of-concern.

a. Looking 'over-the-horizon', what key developments do you see in illicit drugs over the next five years?
b. What are the foreseeable major threats?
c. What are the foreseeable opportunities?

Answer:

a. The next five years will see over $214 million in new funding being administered by the Department for programs to respond to problems associated with substance abuse in Australia. In particular, under the Combating Emerging Trends measure, specific treatment protocols and options will be identified to respond to the use of ATS, and drug and alcohol workers will be provided with up-to-date training resources to increase their capacity to respond to use of these drugs.

   Phase 3 of the National Drugs Campaign will be implemented, targeting young people and their parents, providing them with accurate information about the risks of drug use, particularly psychostimulants.

b. A possible threat is the uptake of the more potent forms of ATS by young people. Recent Government initiatives respond to this potential threat.

c. With the provision of funding in the most recent Budget, the Department has the opportunity to provide accurate and frank information about the risks of drug use, including ATS, and the choices available to young people in resisting using these drugs.

Question 8:

The Committee was told that there are now twice as many 'ice' addicts as heroin addicts, and that ice addicts often suffer from mental health problems such as psychosis and violence and so place much greater stress on support systems.

a. Do you agree with those statements?
b. What treatment options are there for AOSD addicts, and particularly for ice addicts?
c. How can you help medical staff cope with violent behaviour?
d. Were these issues taken into account in the Mental Health Package announced in April and the Budget in May?

Answer:

a. Estimates of the number of heroin and amphetamine users suggest there is a larger population of amphetamine users than there are heroin users. However, these estimates are based on users of amphetamines generally, rather than 'ice' users per se.

b. The increase in investment in all types of alcohol and other drug treatment over the past decade has improved capacity to respond to all drug problems, including ATS problems. Many of the current interventions used in drug and alcohol services are effective for ATS users. Refer to response 9b for an overview of treatment options.

   Initial work has been undertaken through the current National Psychostimulants Initiative to look at a range of interventions specifically for amphetamine users. Funding that has recently been announced in the 2006 Budget aims to strengthen the capacity of drug and alcohol workers to deal more effectively with psychostimulants, including further research into effective interventions for people using psychostimulants, including crystal methamphetamine.

   Under the COAG Mental Health Package announced in April, $73.9 million over 5 years will also be provided to build the capacity of non-government organisations to effectively address and treat co-existing drug and mental health issues.

c. There is a recognised need for medical and related staff to effectively and safely manage individuals who present with behaviours associated with psychostimulant toxicity. Such individuals pose a significant risk to themselves and others.

   In 2004, the Department funded the update of its Monograph: Models of intervention and care of psychostimulant users. Recommendations from this project included the production of national guidelines for GPs, Police, Emergency Departments and Ambulance Officers for the management of the symptoms of ATS use.

   Guidelines for GPs, Police, Emergency Department and Ambulance Services have since been produced. The GP and Police guidelines have been disseminated nationally and the Emergency Department and Ambulance guidelines will be printed and published in the near future.

d. Yes. See response to question 7 part (a).

Question 9:

Professor Mattick of the National Drug and Alcohol Research Centre told the Committee at a public hearing in Sydney on 16 May that cognitive behavioural therapy was an effective treatment for dependent users and that in 2003 DOHA funded the development of a treatment guide by the University of Newcastle.

a. The Committee was told that very few treatment centres have taken it up. Why?
b. What treatment options are currently available to AOSD users?
c. Are other treatment approaches under consideration (eg dexaphetamine has been mentioned to the Committee)?
d. What treatment for AOSD users has worked best overseas?

Answer:

a. One type of treatment does not suit all clients. A proportion of clients who present to treatment services with ATS problems are quite agitated and sometimes paranoid. Some treatment providers feel that cognitive behavioural therapy (CBT) is too hard for the client at this point, and prefer to use pharmaceutical treatments to calm and stabilise the patient before they embark on CBT.

   CBT is ideally suited for outpatient treatment services. The majority of drug treatment services are residential treatment services which do not necessarily suit the needs of ATS users.

b. There are a number of treatment options available to AOSD users. These include withdrawal management (detoxification), counselling, group therapy, medication (pharmacotherapy), 'out-patient' programs, controlled use interventions, maintenance of behaviour change programs (such as therapeutic communities, residential rehabilitation, motivational interviewing, cognitive-behavioural therapy, and psychotherapy) and self help and peer support groups.

c. A pilot randomized controlled study of dexamphetamine substitution for amphetamine dependence was undertaken by the National Drug and Alcohol Research Centre (NDARC) several years ago. The study was funded by the (then) Department of Health and Aged Care.

   The findings of the pilot study state that *"Substitution therapy deserves further consideration as one of the range of interventions for problematic amphetamine use. Rigorous controlled trials of amphetamine substitution with adequate sample sizes and follow-up are needed."*

   Accordingly the Drug and Alcohol Services South Australia is currently trialing dexamphetamine as part of its research trials to evaluate new treatments for users of amphetamines/stimulants.

Turning Point is currently conducting a study of the natural history of withdrawal and options for intervention. Phase 4 of this project includes prescription case studies to examine:

- the feasibility of using pharmacotherapies (eg. dexamphetamine and modafinil) as an approach to managing psychostimulant withdrawal;
- whether the use of these pharmacotherapies will assist amphetamine users into enhanced engagement with best practice psychosocial treatment;
- the pharmacodynamic profile of dexamphetamine and modafinil as withdrawal treatments (exploring symptom relief, effective duration of action of the medication and effects on the time course of amphetamine withdrawal); and
- the exploration of dexamphetamine and modafinil doses required for amphetamine users based in Melbourne.

The study will see dexamphetamine and modafinil being offered for short course withdrawal treatment in conjunction with withdrawal counselling, with the ultimate aim of amphetamine abstinence.

d. Psychosocial approaches have been trialled in the US and found to work. A study of treatment programs undertaken by the University of California found that those who reported methamphetamine abuse as their primary drug problem, had reduced the frequency of methamphetamine abuse nine months after the start of treatment.[9] Patients had received the addiction treatment services routinely provided by each program, which usually included group therapy on drug and alcohol related issues, sessions on dealing with mental health symptoms and sessions addressing psychosocial problems including family, parenting and employment.

9 Community-Based Treatment Benefits Methamphetamine Abusers, NIDA Notes Volume 20, Number 5

Question 10:

Ecstasy use in Australia continues to increase, which suggests that previous and current supply reduction and demand reduction strategies have not worked.

a. Why have they failed, and what needs to be done differently?
b. Do we just have to accept that young people will experiment and that at least some AOSD use is inevitable?
c. Is their reputation as 'party drugs' and the fact that they are easily taken in tablet form, part of the problem?
d. Is the real challenge how to prevent occasional use from becoming regular and dependent use?

Answer:

a. Supply reduction and demand reduction strategies have not been a failure. Results of the *National Drug Strategy Household Survey* show a decrease in illicit drug use from 22% in 1998 to 15.3% in 2004.

b. Young people, like other groups, require targeted prevention messages to provide education and enable informed decisions surrounding drug issues and drug use.

   Research indicates that some groups of young people are more likely to experiment with drugs than others. Research published in 2003 identified six attitudinal groups in the 12-24 age group that varied in their attitudes to and usage of drugs, and their motivations for behaviours in relation to drugs.

c. Terminology is often identified as an issue. The Ministerial Council on Drugs (MCDS) has noted the unhelpful language that sometimes accompanies ATS however it is difficult to identify the impact of terminology on young people's drug taking tendencies.

   In terms of the route of administration, it is true that taking a drug orally – by swallowing a pill – is an easy route of administration and is less confronting to potential users than injecting.

d. An important, fundamental aim of drug education and prevention strategies is to prevent or delay drug use, and most certainly, to stop drug use from escalating.

Question 11:

The Committee received evidence from the Triple J program and other witnesses which suggests that many young people do not believe advertising that demonises recreational drug use.

a. What is the best way of communicating with young people about the harms which can be associated with drug use?
b. How will that be reflected in the National ATS Strategy?

Answer:

a. The Department adopts a thorough evidence-based social marketing approach to the development, implementation and evaluation of its national drug prevention campaigns and messages to young people; including extensive research with young people themselves. Messages which are credible and targeted are the most effective means to communicate with a specific group of people.

Australia is recognised internationally for its effective use of mass media for social marketing that involve the use of television, radio and print media to contribute to improvements in health literacy and changes in health behaviour[10].

The Department's social marketing approach to the development of the National Drugs Campaign incorporated thorough formative research to gain a comprehensive understanding of knowledge, attitudes and motivations toward drug use amongst young Australians. This comprised a two stage qualitative-quantitative research study with young people aged 12-24 years and parents of 15-17 year olds[11]. The research provided important information upon which the campaign's development was based. In addition to providing a rich understanding of the views of young people toward drug use, quantitative applications of factor analysis and cluster analysis were undertaken to provide a psychographic segmentation of 15-24 year olds with respect to levels of risk of illicit drug use. Also, a comprehensive channel analysis of young people's media and lifestyle habits was undertaken to ensure the most effective and efficient delivery of the campaign.

A thorough evaluation of the campaign was undertaken with young people and parents, incorporating national representative surveys prior to the campaign and following its implementation[12]. The post-campaign research involved 1490 young people aged 13-20 in 2005. They were provided with specific questions to measure young people's response to the campaign. In this study the effectiveness of campaign planning and implementation was confirmed with 99% of young people recognising at least one component of the campaign.

Further the effectiveness of the campaign pre-testing and refinement of the campaign communication materials was confirmed by the findings that 97% of young people

10 M Wise Health Promotion Journal of Australia 2000:10 (2) pp 76-77

11 Clark G, Scott N and Cook S (2003) Formative Research with Young Australians to Assist in the Development of the National Illicit Drugs Campaign. Commonwealth Department of Health and Ageing.

12 Pennay D, Blackmore D, Milat AJ, Stewart C, Carroll T & Taylor J. (2006).*National Drugs Campaign: Evaluation of Phase Two*. Commonwealth of Australia: Canberra.

rated the amphetamines and the ecstasy television commercials as believable, with 96% rating the marijuana commercial as believable. Similarly 93% of young people rated the amphetamines and ecstasy commercials as effective, while 90% rated the marijuana commercial as effective.

In addition, significant increases in knowledge about negative consequences of drug use were found, as well as a significant reduction in the proportions of young people identified as 'at risk' of accepting an offer of amphetamines or cannabis. There was also a reduction in those 'at risk' of accepting an offer of ecstasy but this difference was not statistically significant.

The very positive results found in the campaign evaluation supports the evidence-based social marketing approach to campaign development, implementation and evaluation. The lessons learnt from this campaign will be applied in further social marketing strategies to reduce the use and harms associated with amphetamine type substances and other illicit drugs.

b. The Ministerial Council on Drug Strategy at its meeting on 15 May 2006 endorsed the development of a National ATS Strategy. The Strategy will be developed using a consultative approach with links made to existing strategies and initiatives, where appropriate to avoid duplication of effort. The evidence from the first two phases of the National Drugs Campaign will be expected to inform the development of communication elements in the National ATS Strategy.

During the 19 June 2006 hearing, the Department was asked to provide background as to why the findings of the National Drugs Campaign Phase 2 differed markedly from the response that Triple J received during its program on Amphetamines of 5 May 2006.

The Triple J program was effectively a talkback show, not an unbiased study, which received a small number of responses from listeners who were motivated to call Triple J by the program content. The methodology used could not result in any statistically representative or reliable data.

The Phase 2 of the National Drugs Campaign was conducted in accordance with stringent methodology and represented a comprehensive cross-section of the population. Refer to Question 26 for further information. Accordingly, the findings of the Triple J program differ to those of the National Drugs Campaign Phase 2.

Question 12:

The issue of pill testing was raised briefly at the public hearing on 5 June and the Committee would welcome further comments from the Department. Given the variable quality of AOSDs, pill testing has been recommended by some commentators.

a. Why is pill testing not permitted in Australia?
b. Is there any evidence that pill testing encourages drug use?
c. Is accurate testing equipment now available? At what cost?
d. What is the Department's view on pill testing?
e. Should there be a properly designed and supervised trial to determine the effects of pill testing?
f. Do you agree with witnesses from Enlighten Harm Reduction who expressed concern that local manufacturers could switch to other far more dangerous drugs, such as PMA?
g. Do you have contingency plans if that should happen?

Answer:

a. Australian, State and Territory health and law enforcement Ministers agreed at the Ministerial Council on Drug Strategy meeting in May 2005 that they could not endorse the development or use of drug testing kits for personal use.

b. There is little evidence relating to testing and how associated information provided affects the behaviour of users, other than anecdotal comments from users and organisations conducting testing.

   A UK survey of 1,200 clubbers asked what they did when they thought the quality of pills got better or worse (Winstock and Vingoe 2000). In this group, 40% said that when the quality gets better, they take more, and 12% were put off taking more of the pills. When quality of pills reduces, up to 40% said it would not make any difference and 20% said they would take more because the pills were not very strong. A limitation of this study is that the meaning of quality was not defined and may not refer to pill contents.

c. The Department is not aware of any fully accurate testing equipment.

d. The Department is guided by current Government policy in relation to pill testing (see answer to part (a) above).

e. Given the position of the State and Territory and Australian Governments on this matter, available resources are focussed on other prevention, education, demand and supply reduction measures.

f. All illicit drugs are dangerous and the Department cannot speculate about what local drug manufacturers may or may not produce. There are many toxic chemicals that may be used in the manufacture of illicit drugs.

g. The Department continues to fund research that monitors the drug market. The *Illicit Drug Reporting System 2005* publication is an example of this.

Question 13:

The DOHA submission refers to an estimated 102,000 regular users of methamphetamines of which 73,000 are dependent users.

a. What is the definition of 'regular'?
b. By 'dependent' do you mean addicted? How often would a dependent user take AOSD?

Answer:

a. Estimates of the number of regular and dependent methamphetamine users in Australia are based on surveys of 310 regular methamphetamine users aged 15-49 years, who were recruited from across Sydney between December 2003 and July 2004.

   According to this study conducted by McKetin and colleagues[13] a 'regular' user is defined as someone who had used methamphetamine at least monthly in the past year.

   Findings from face-to-face interviews with 310 regular methamphetamine users indicated that, in addition to all participants having used methamphetamine at least once a month in the past year (as per the definition of 'regular'), the majority (82%) had used the drug weekly.

b. The terms 'dependent' and 'addicted' are often used interchangeably.

   To be diagnosed as dependent ('addicted') in Australia - as is generally the case internationally – it is generally accepted that you need to fulfil the criteria as articulated in the "Diagnostic and Statistical Manual of Mental Disorders" (DSM-IV is the most current version). Due to the medical nature of such a diagnosis (and related privacy issues), estimates of the number of people receiving this diagnosis are not available.

   However, in a study conducted by McKetin and colleagues[14] participants were asked questions from the Severity of Dependence Scale (SDS) for the use of methamphetamine. Previous research has suggested that a cut- off of four is indicative of dependence for users of methamphetamine[15]. It is suggested that methamphetamine users who scored four or above on the SDS were likely to meet the DSM-IV criteria for severe dependence.

   Of the 310 regular methamphetamine users (upon which estimates were based) surveyed, 56% were severely dependent on methamphetamine (score of four or greater on the SDS).

13 McKetin, R., McLaren, J., Kelly, E., Hall, W., & Hickman, M. (2005). Estimating the number of regular and dependent methamphetamine users in Australia. National Drug and Alcohol Research Centre, Technical Report No. 230.

14 McKetin, R., McLaren, J., & Kelly, E. (2005). The Sydney methamphetamine market: Patterns of supply, use personal harms and social consequences. Monograph Series No. 13. NDARC: Sydney.

15 Topp, L., and Mattick, R. (1997). Choosing a cut-off on the Severity of Dependence Scale (SDS) for amphetamine users. Addiction, 92 (7), 839-845.

The frequency of drug taking behaviour by regular users can be affected by a number of factors such as the availability of the drug, money to purchase the drug and other health related factors.

Based on the interviews conducted by McKetin (mentioned above) regular methamphetamine users typically took the drug two to four times per week (49%), however the frequency of use varied from less than weekly (18%) to daily or almost daily use (13%).

Question 14:

The DOHA submission notes that 11% (14,208) of people getting treatment for drugs are dependent on amphetamines.

a. Do you agree with commentators who say that AOSD users are generally reluctant to seek treatment?
b. Why are AOSD users reluctant to seek treatment?
c. What can be done to change that? How does the new National ATS Strategy address this issue?

Answer:

a. There may be some reluctance on AOSD users to seek treatment. Refer to 'b' below for a discussion of reasons.

b. A study[16] on the utilisation of health services by methamphetamine users noted that ATS users may feel less impetus to seek treatment than heroin users for example, because ATS use is less debilitating in terms of physical withdrawal and impact on day-to-day functioning, and is less costly than heroin (therefore there may not be the same financial incentive to stop use).

   It is important to also acknowledge that there are barriers to treatment for methamphetamine as there are for all drugs, such as gender, culture and stigma. It is also important to consider the way treatment is marketed to methamphetamine users. In particular, outpatient treatment that is easily accessible may be more suited for the treatment of methamphetamine users than other drug treatment services. Further research is needed to examine the treatment needs of ATS users.

c. A number of issues will need to be addressed in development of a National ATS Strategy, including treatment issues. The development of the Strategy has only just been endorsed by the MCDS.

16 National Drug and Alcohol Research Centre, *Health Service Utilisation among Regular Methamphetamine User*, p.20

Question 15:

The DOHA submission states that 'Injecting accounted for 79% of closed treatment episodes within this group [amphetamine users] compared to all other drugs of concern, where injecting accounted for only 22%'.

a. Why do amphetamine users inject themselves so much more than other drug users?
b. Is it just ice addicts who inject, or are other forms of amphetamines also involved?

Answer:

a. These figures come from the Alcohol and Other Drug Treatment National Minimum Data Set (AODTS-NMDS). The AODTS-NMDS is a nationally agreed set of common data items collected by government-funded service providers for clients registered for alcohol and other drug treatment.

   These statistics do not suggest that 79% of all methamphetamine users inject. The data mentioned above need to be interpreted narrowly as the NMDS only collects data on those people who are seeking treatment for their drug use from government agencies. It does not provide any information on methamphetamine users outside of the treatment setting.

   Injecting is associated with heavier use of methamphetamine, dependence, and more severe health problems. It is these people that are more likely to be seeking treatment.

   Therefore, the AODTS, NMDS statistics that report that 79% of people who sought treatment for methamphetamine use were injecting, is in keeping with our understanding that injecting methamphetamine users are the ones most likely to be seeking treatment.

b. All forms of methamphetamine can be injected. Methamphetamine ‘base’ and ‘ice’ are more commonly injected, compared to methamphetamine powder or ‘speed’ which is often taken orally or snorted.

Question 16:

The DOHA submission notes that National Drugs Campaign (NDC) has a budget of $30 million over two phases. Phase I commenced in March 2001 and targeted parents of 8 to 17 year olds.

a. Is the National Drugs Campaign run by the Department of Health and Ageing?
b. What assessment was done of Phase 1 of that campaign? How successful was it?
c. What key lessons emerged from Phase 1, especially in relation to AOSDs?
d. Have other countries tried campaigns which specifically targeted parents?

Answer:

a. The National Drugs Campaign is a prevention focussed public health campaign run by the Department of Health and Ageing, aimed at increasing awareness of the harms done by illicit drugs.

b. The target groups of Phase 1 of the National Drugs Campaign were:
   - Primary – Parents of 8 – 17 year olds
   - Secondary – Young people aged 12-17 years and adult community members without children.

   Phase 1 of the campaign was evaluated in June – July 2001. This research consisted of pre-campaign and post-campaign telephone interviews with parents of 8-17 year olds, members of the community, 15-17 year olds, and parents of a non-English speaking background. Additionally, continuous tracking interviews were conducted over the six weeks of campaign activity.

   Results from these surveys indicated that the campaign was effective in reaching parents and encouraging them to engage in discussions with their children and about illicit drugs.

   The evaluation also indicated that the campaign increased the number of conversations between young people and parents about illicit drugs. Both parents and young people reported that the campaign had also made these conversations easier. Further, there appeared to be an increase in young people's confidence in their parents' ability to source information about illicit drugs and their credibility in being aware of drug-related issues to which youth may be exposed.

   Overall, the key results from Phase 1 showed that three in five parents who were surveyed during the evaluation of the campaign felt that the campaign made it easier for them to talk to their children about drugs. Three in four surveyed did actually talk to their children about drugs, and the majority of these said they intended to discuss illicit drugs with their children in the future. In addition, the evaluation found the campaign had a significant impact amongst teenagers, with one in two finding that it helped them to talk to their parents about drugs.

   Evaluation of the youth post-campaign survey indicates that the campaign had a positive impact in achieving its objectives with the Phase 1 secondary target audience.

In relation to amphetamines and other synthetic drugs, the post-campaign survey found that three in five young people reported that the conversations they had with their parents (prompted by the campaign) made it less likely they would use ecstasy or speed, heroin or cocaine, or LSD.

Young people aged 15 were significantly more likely than those aged 16 or 17 years to state that they were less likely to use any illicit drugs as a result of conversations with their parents.

c. The success of Phase 1 helped informed the development of Phase 2 of the Campaign. The evaluation indicated that the strategic approach was correct and further reinforcement amongst parents would strengthen their capacity to talk to their children about illicit drugs.

The evaluation of Phase 1 of the campaign indicated that parents of a non-English speaking background (NESB) were less likely to feel confident about discussing the subject of illegal drugs with their children. Results suggested that NESB parents are possibly at an earlier stage of awareness with regard to illegal drugs issues, and that through the campaign they have begun to engage more with the issues. This is an area that the Australian Government continues to focus on improving.

d. Yes, although an extensive review of campaigns from other countries has not been undertaken. At the time of developing Phase One of the National Drugs Campaign, the Department was aware of similar campaigns being run in the United States of America and the United Kingdom. The US campaign was driven by the Office of National Drug Control Policy (1999) and the UK campaign by the Health Education Authority (1998).

Question 17:

Phase 2 of the NDC commenced in April 2005. Your submission notes that its primary focus is youth aged 13 to 17 years, while parents are now secondary targets.

a. What are the key elements of Phase 2 of the National Drugs Campaign?
b. How will it differ from Phase 1, especially in relation to AOSDs?
c. Why the reduced focus on parents?

Answer:

a. Phase Two of the National Drugs Campaign was aimed at preventing young people from using drugs. It highlighted the harmful effects of illicit drug use, with particular attention to the three most commonly used illicit drugs: marijuana; ecstasy; and speed.

   It offered positive alternatives to drug use, provided information on counselling services for drug users and their families, and reinforced the message that parents should talk to their children about drugs.

   Phase 2 was developed in close consultation with key non-government experts. A substantial research program informed the development of Phase 2 using research into young people's knowledge of and motives for using illicit drugs. This research identified the need to target distinct sub-groups of teenagers and young adults.

   The aim of this youth prevention campaign was to contribute to a reduction in the proportion of young Australians using illicit drugs.

   The campaign consisted of: print, television and cinema advertisements targeting young people and their parents; youth marketing activities to promote credible alternatives to drug use and encourage positive lifestyles; resource materials with practical information for parents, information materials for service providers and stakeholders; and communication activities to address the specific needs of people from non-English speaking backgrounds and Indigenous Australians.

b. Phase 2 highlighted the harmful effects of illicit drug use, with particular attention to the three most commonly used illicit drugs: marijuana; ecstasy; and speed.

   These drugs were targeted because of their prevalence of use and the range of significant negative health consequences they can cause.

   Primary Target Audience for Phase 2 was young people aged 13-24 years. Within this target group, three complementary strategies were designed to address the different needs of youth sub groups.

   The secondary audience for Phase 2 included –
   - Parents and carers of 8-17 year olds;
   - Service providers including school counselors, youth workers, GPS, and alcohol and drug agencies; and
   - Stakeholders in the fields of alcohol and other drugs, health, welfare and community support, education and law enforcement.

In Phase 2 of the campaign, three youth-targeted television commercials – 'Marijuana', 'Speed' and 'Ecstasy' ran nationally on all commercial free-to-air television channels, SBS, subscription TV and cinema for nine weeks in the period April - July 2005. All three drugs are associated with significant negative health consequences and other harms. The terms 'speed' (amphetamines) and 'marijuana' (cannabis) were used in the youth advertising in line with youth understanding and use of these terms.

The end line for each television commercial 'You don't know what it'll do to you' – clearly focused attention on the unpredictable consequences of talking illicit drugs, and emphasised that drugs can affect individuals differently. All three commercials promoted the campaign information and campaign website.

c. The National Drugs Campaign was always intended to address young people's attitudes to drug use. Formative research showed that young people would accept information from their parents about drugs, but generally did not believe their parents had all the facts. Knowing this made it necessary to communicate with parents around drug use and effective ways of communicating with young people. By building their confidence and providing factual and credible information about drugs, the campaign enabled parents to discuss drugs with their children.

Phase Two of the campaign aimed to contribute to a reduction in the proportion of young people using drugs by communicating the possible side-effects and demonstrating healthy alternatives to drug use and availability of treatment services. The campaign was designed to reach young people before they engage in using drugs as well as those who are already using or experimenting with them. The campaign also built upon the messages of Phase One by encouraging communication between parents and young people.

While parents were a secondary target audience for the Phase Two campaign, substantial communication activity was still undertaken to continue supporting them in discussing drugs with their children, with advertising and resources made available to them.

The Evaluation of Phase Two shows that this approach built upon the work of Phase One, with parents continuing to talk with their children about drugs.

Question 18:

The DOHA submission notes that under *Tough on Drugs*, $5.1 million has been allocated to the National Psychostimulants Initiative from 2003-04 to 2007-08.

a. What are the key elements of this Initiative?
b. We are now into the third year of this Initiative. What results have been achieved so far?
c. What lessons have been learnt?
d. Will this become part of the National ATS Strategy?

Answer:

a. The key elements of the National Psychostimulants Initiative can be listed under three main themes:
   - identifying good practice models for treatment;
   - providing training and support for GPs and health workers; and
   - providing information for at-risk youth and families.

b. Given time is required to establish and implement a new measure, the National Psychostimulants Initiative is still a relatively new initiative and many of the projects funded under it are still in progress, such as the trial of different treatment models.

   Guidelines to assist police services and general practitioners have been developed to enable them to effectively and safely manage individuals who are experiencing problems relating to the use of ATS. These two publications *'Psychostimulants – Management of Acute Behavioural Disturbances – Guidelines for Police Services'* and *'Management of Patients with Psychostimulant Use Problems – Guidelines for General Practitioners'* are available on the internet at www.nationaldrugstrategy.gov.au

   National guidelines are also being developed for ambulance officers and for accident and emergency workers in hospitals.

   Much of the work under this initiative is still in progress, with many of the results to be realised into the coming year. The *Combating Emerging Trends* budget measure will build upon and enhance the work done under the Psychostimulant Initiative.

c. Through the National Psychostimulants Initiative, further attention has been focussed on the need to closely consider the number and range of services available to psychostimulant users, and what further research and training for health professional may assist.

d. All work done to date will be considered during the development of the National ATS strategy.

Question 19:

The DOHA submission mentions the National Co-morbidity Initiative, which has funding of $9.7 million over 5 years from 2003-04.

a. Please describe the key elements of this Initiative?
b. Which elements are specifically related to AOSDs?
c. What progress has been achieved so far?

Answer:

a. Implementation of the National Comorbidity Initiative concentrates on the following areas of activity:
   - raising awareness of comorbidity among clinicians/health workers and promoting examples of good practice resources/models;
   - providing support to general practitioners and other health workers to improve treatment outcomes;
   - facilitating resources and information for consumers; and
   - improving data systems and collection methods within the mental health and alcohol and other drugs sectors to manage comorbidity more effectively.

   The Australian Government recently committed a further $8 million to 2009-10 to build on this work. These funds are part of the Council of Australian Governments $1.8 billion announced by the Prime Minister on 5 April 2006, which also includes new funding for drug and alcohol treatment services so that people working in these services are better skilled in dealing with people who suffer from both a mental illness and a drug or alcohol addiction.

b. All activities include, but are not limited to, ATS.

c. Whilst activities under the National Comorbidity Initiative are focussed on co-existing mental health and all illicit drugs, the following outlines progress to date on ATS:
   - An information brochure for young people entitled *Feeling good: answering your questions about alcohol, drugs and mental health*, which includes information on amphetamines and ecstasy;
   - An Australian Institute of Health and Welfare report reviewing data collections relating to comorbidity identified six datasets that relate to amphetamine use; and
   - A book of family stories, *in my life*, includes a mother's story about her daughters use of amphetamines.

   With the recent increased commitment to comorbidity by the Australian Government in the 2006 Budget, the Implementation Plan will be reviewed and revised to capitalise on the extended time and funding now available and as part of the development of the National ATS Strategy, consideration will be given to the issue of comorbidity.

Question 20:

The DOHA submission mentions that $340 million has been allocated to the Illicit Drug Diversion Initiative from 1999-00 to 2007–08.

a. Please describe the key elements of this Initiative?
b. Which elements are specifically related to AOSDs?
c. Will these be incorporated into the new National ATS Strategy?
d. What progress has been achieved so far?

Answer:

a. The primary objective of the Illicit Drug Diversion Initiative (IDDI) is to:
   - increase incentives for drug users to identify and treat their illicit drug use early;
   - decrease the social impact of illicit drug use within the community; and
   - prevent a new generation of drug users committing drug-related crime from emerging in Australia.

   The key participants in IDDI:
   - Australian Government provides the funding;
   - State and Territories which manage their IDDI programs;
   - Preferred Providers running the assessment and treatment of the States and Territories IDDI programs;
   - Police Services issuing diversions for those apprehended with small amounts of illicit substances;
   - Courts issuing diversions for those brought before the court for possession of small amounts of illicit drugs; and
   - Users of illicit drugs who are eligible to take part in IDDI programs.

   There are two major groups of programs – those administered by the police services and the other by the courts. Programs can be further categorised as being targeted at adults, youth, the indigenous population and those in rural and remote areas.

   Preferred Providers deliver the services, such as assessment and treatment to ensure that those diverted have the fullest opportunity to address their drug use and expiate their diversion.
   The following is the minimum eligible criteria for a person to be diverted:
   - there must me sufficient admissible evidence of the offence of possession or use of a drug;
   - the person must admit to the offence;
   - the person should have no history of violence; and
   - the person has to give their informed consent to undertake a diversion.

b. Diversion for amphetamines and other synthetic drugs is included as part of the States and Territories diversion programs.

c. In developing the new National ATS Strategy, the Department would envisage that all existing, relevant programs for ATS users would be considered.

d. Since the introduction of the Initiative, there have been approximately 90,000 clients diverted. These clients are diverted to compulsory assessment, and then referred to treatment and/or education services, aimed at keeping clients out of the criminal justice system.

The Diversion program has enabled both 'vertical' integration, allowing each State and Territory Governments the freedom to tailor the way in which their agreed funding has been used, and 'horizontally' integrated, in that it seeks to foster stronger links between the law enforcement and health sectors.

A thorough evaluation of the model is currently underway, with oversight by an evaluation reference group including the Australian, State and Territory Government Health and Law enforcement representatives and the Australian National Council on Drugs. This evaluation will inform the future of the program.

Question 21:

The DOHA submission notes that DOHA's Office of Chemical Safety is a member of the National Working Group (NWG) for the Prevention of the Diversion of Precursor Chemicals. The Office has received funding under the National Drug Strategy to develop a national database on legitimate users of chemicals which could be used in the illicit manufacture of drugs.

a. When did this project commence, and how long is it expected to take?
b. What progress has been achieved?
c. Will pseudoephedrine be included (now the subject of the Pharmacy Guild's Project STOP)?
d. Have other countries developed similar databases?

Answer:

a. A Memorandum of Understanding (MOU) between Attorney General's Department and the Office of Chemical Safety is currently being negotiated. It is anticipated that the project will be completed within 18 months of signing of the MOU.

b. To date, a scoping project on the feasibility of a national database on legitimate users of chemicals, which could be used in the illicit manufacture of drugs has been completed.

c. The database will store information collected by the Office of Chemical Safety about the licit importation of all pseudoephedrine into Australia. The Project STOP database will store information about the sale of pseudoephedrine-based medicines from community pharmacists. These two key databases will complement each other by providing visibility of each end of the pseudoephedrine supply chain in Australia.

d. The proposed database is modelled on the *United Nations'* National Database System. Improvements provided by the proposed database are considered best practice, as demonstrated by regional interest in developing a similar system.

Question 22:

Can you provide an overview of the current programs under the Illicit Drug Diversion Initiative? In responding, can you provide information on a State Basis?

Answer:

NEW SOUTH WALES

Police Diversion - Cannabis Cautioning Scheme
The Cannabis Cautioning Scheme (CCS) provides NSW state wide formal cautioning of adult offenders detected for minor cannabis offences. People with a history of violent, sexual or drug offences cannot be cautioned. CCS uses police intervention to assist offenders to consider the legal and health consequences of their cannabis use and seek treatment and support.

Two cautions can be issued under CCS. Offenders issued with a first caution are encouraged to voluntarily contact the NSW Alcohol and Drug Information Service (ADIS). Offenders issued with a second caution are required to contact ADIS to undertake a mandatory telephone and health education session.

If offenders continue to use cannabis and are caught by the NSW police, they will be charged and will have to attend court.

Court Diversion - Magistrates Early Referral into Treatment
The Magistrates Early Referral into Treatment (MERIT) program is the major component of the NSW Diversion Initiatives. MERIT is available to adult defendants on bail who have an illicit drug problem which contributes to their offending. MERIT is designed for defendants who are eligible for bail and who show potential for treatment and rehabilitation. MERIT aims to reduce drug-related crime by enabling eligible defendants to undertake assessment and treatment. Unlike other drug-crime diversion schemes, it is a pre-plea scheme which means that defendants are not required to plead guilty in order to participate. Offenders may stay on the program for up to 12 months.

Court Diversion - Wellington Option Program
The Wellington Options is trial program which operated only through the Wellington Local Court. The program provides highly flexible and intensive drug treatment, family support and case management services to adult and juvenile defendants with drug and and/or alcohol problems. The program aims to reduce drug and alcohol related offending in the Wellington community.

Court Diversion - Youth Drug and Alcohol Court
The NSW Youth Drug Court deals intensively with a small highly criminal group of young offenders who would otherwise face a custodial sentence. Within a framework of therapeutic jurisprudence, the program delivers a holistic range of health, welfare and criminogenic interventions under close judicial supervision. Sentence is deferred while the young person participates in the program, which can last up to 12 months.

If a suitable program plan cannot be developed for a young person (for example, because the young person suffers from a severe mental illness or intellectual disability) they may not be suitable for program participation. At the end of the program the young person will be sentenced, with the Court taking their participation in the program into account.

Court Diversion - Young Offenders Diversion Drug Schemes
The Young Offenders Diversion Drug Schemes comprises the Juvenile Justice Alcohol and other Drug Counsellors and the Regional Youth Drug Rehabilitation Centres. These interventions increase the diversionary options, both before and after custody.

Juvenile Justice Alcohol and other Drug Counsellors
The Juvenile Justice Alcohol and other Drug Counsellors is a regional program to provide individual counselling, group work, brief interventions, community alcohol and drug education and referral to health and other services. It aims to divert young people away from the criminal justice system and into treatment services by addressing the causes of their drug or alcohol related offending behaviour.

Regional Youth Drug Rehabilitation Centres
The Regional Youth Drug Rehabilitation Centres are based in Dubbo and Coffs Harbour for young people who are either clients of the NSW Department of Juvenile Justice, or at risk of entering the juvenile justice system as a result of their drug and/or alcohol misuse.

Court Diversion – Adolescent Residential Rehabilitations Units
This program provides residential drug rehabilitation in Coffs Harbour and Dubbo for young people who are clients of the NSW Department of Juvenile justice, or at risk of entering the juvenile justice system as a result of their drug and alcohol misuse.

PALM is a medium term residential drug and alcohol service that provides services to Coffs Harbour and Dubbo. It accommodates up to 16 young people aged from 14 to 18 years for a period of 8 to 12 weeks. PALM also incorporates a three months aftercare component aimed at supporting the gradual and positive integration of its participants back into the community.

Court Diversion - Rural Alcohol Diversion Pilot
The Rural Alcohol Diversion (RAD) program is based on the MERIT model for drug-crime diversion but involves adult trial defendants appearing in court on alcohol related offences. RAD is being conducted on a trial basis in Orange and Bathurst Local Courts in the NSW Greater Western Area Health Service. Eligible defendants undertake a comprehensive assessment and placement in alcohol treatment for a minimum of three months as a condition of bail, with the aim that the participants address their alcohol misuse and alcohol related crime.

VICTORIA

Police Diversion - Cannabis

The Cannabis Cautioning Program is a police diversion program that involves the provision of a cautioning notice for simple use/possess cannabis offences to offenders 17 year of age and over. It involves issuing a cautioning notice to offenders who meet the police criteria. An optional education session for offenders may be offered in conjunction with the caution.

Police Diversion – Drug Diversion Program

A person apprehended by the police for use of possession of an illicit drug other than cannabis may be offered a drug diversion caution on the condition that they undertake a clinical drug assessment and attend a least one session of any prescribed drug treatment.

The offender with be provided with a drug assessment appointment within five working days of their arrest. A subsequent treatment appointment will be made within five working days of the initial assessment appointment. Appointment times can be altered if necessary, but a time limit of 28 days from the day of arrest applies for compliance to be completed, this includes attendance at the clinical drug assessment and a treatment session.

The Court Referral and Evaluation for Drug Intervention and Treatment

The Court Referral and Evaluation for Drug Intervention and Treatment program (CREDIT) was developed by a small group of Magistrates at the Melbourne Magistrate's Court who wished to address the high rate of offending on bail among illicit drug using offenders.

CREDIT is a Magistrate's Court program which directs people with a drug problem, on bail for periods up to four months, to assessment support and treatment services. It is open to first-time offenders as well as those with some previous criminal and/or drug history.

There is no maximum number of times a person can be referred to or participate in the CREDIT program and a plea of guilty is not required. It is a diversion option for people who have been charged. The charge may be in relation to a crime that is not necessarily drug related but it is clear the person has a drug problem. It differs from police diversion in that police may **arrest** a person and refer them to drug assessment/education but not charge them.

In courts where CREDIT is not available, Rural Outreach Diversion Workers (RODW) provide a link between the community, police, courts and the drug treatment service system and operate from within a local community-based drug treatment agency.

The Rural Outreach Diversion Workers

The Rural Outreach Diversion Workers (RODW) service was established to provide a rural service suitable to rural needs in areas across Victoria where offenders do not have access to the Victorian CREDIT program.

The Outreach workers provide a link between the community police, courts and the drug treatment service system. The primary target is young offenders below the age of 25 years. However, older offenders can be assessed as being appropriate for an outreach program. The use of Outreach workers in this program is particularly relevant for the targeted rural areas and younger offenders.

There is no maximum number of times a person can be referred to or participate in the RODW program and a plea of guilty is not required. It is a diversion option for people who have been charged. The charge may be in relation to a crime that is not necessarily drug related but it is clear the person has a drug problem. It differs from police diversion in that police may arrest a person and refer them to drug assessment/education but not charge them.

Deferred Sentencing
Deferred sentencing is a sentencing option for Magistrates in determining disposition of an offender with and identified drug problem. Sentencing is deferred for up to six months with specific condition to attend drug treatment. The deferred sentence must be identified as being an appropriate sentencing option for the offence committed.

Drug Treatment Order
Drug Treatment Order (DTO) is a sentencing option for Magistrates in determining disposition of an offender with and identified drug problem. The offender target group is similar to the Deferred sentencing Program. However, all age groups are eligible. Sentencing is deferred for up to six months with specific condition to attend drug treatment.

The deferred sentence must be identified as being an appropriate sentencing option for the offence committed.

Koori Court Diversion
Koori courts have been established to allow for more culturally appropriate sentencing orders. The Koori courts divert offenders away from a custodial sentence, where that is an inappropriate outcome. It also seeks to enhance knowledge in the Magistrate's court in relation to culturally significant factors that may affect the type of sentencing order imposed or the conditions that are imposed on such an order. The Koori court model also provides the Magistrate's court with further and better ways of sentencing and managing non-custodial orders. The primary eligibility criterion for the Koori Court Diversion is that a person eligible for CREDIT or RODW must also be of Aboriginal and/or Torres Strait Islander descent.

Children's Court Clinic Program
The Children's Court Clinic Drug Program provides early intervention drug treatment for alleged young offender, between the ages of 10 and 17 who engaged in problematic drug use, by facilitating contact with the Children's Court Drug Clinician and drug treatment services on referral from the Magistrate.

QUEENSLAND

Police Diversion Program
The Police Diversion Program is provided for under section 211 of the Police Powers and Responsibilities Act 2000 (PPRA 2000). Under the Police Diversion Program, people who are found in possession of 50 grams or less of cannabis and who meet the strict eligibility criteria are offered the opportunity to be diverted from the criminal justice system to attend a one off Drug Diversion Assessment Program (DDAP) rather than being charged for the offence.

The Illicit Drugs Court Diversion Program
The Illicit Drugs Court Diversion Program is aimed at diverting all eligible offenders who appear in any Queensland Magistrates or Children's Court charged with possession of a small amount of an illicit drug for personal use. The Court Diversion Program is being conducted under a legislative framework specified in the Drug Diversion Amendment Act 2002. This Act amends both the Penalties and Sentences Act 1992 and the Juvenile Justice Act 1992.

Magistrates are permitted to sentence eligible and consenting offenders pleading guilty to offences of possession of a small quantity of drugs to a recognisance with a condition that the offender attends a Drug Assessment and Education Session (DAES). Attendance and completion of the assessment and education session means the recognisance ends without a conviction being recorded. If a diverted offender fails to attend the DAES, a warrant is issued and other offender is returned to court to be dealt with again for the original offence.

WESTERN AUSTRALIA

Police Diversion – Cannabis Education Session
Under the Cannabis Education Session (CES) police have the discretion of issuing adults with a cannabis infringement notice (CIN) when they are found in possession of small quantities of cannabis, smoking implements with traces of cannabis, or up to two plants for personal use. For those issued with a CIN, they will have the option of paying a financial penalty within 28 days, attending a CES within 28 days or electing to have the matter heard in court.

In some circumstances, the offender will not have the option of paying a financial penalty and must attend a CES to expiate the offence. In addition, police have the discretion to charge the offender at all times.

The CES involves one individual or group education session that provides information on the adverse health and social consequences of cannabis use, the treatment of cannabis related harm and laws relating to use, possession, and cultivation of cannabis. Each session is approximately one and a half hours in length and is provided by Community Drug Service Teams.

Police Diversion – All Drug Diversion
All drug diversion, sometimes called mandatory assessment or other drug diversion, aims to divert first time offenders charged in possession of small quantities of drugs other than cannabis into treatment. Participants must have no prior convictions involving charges, diversion notices under the Misuse of Drugs Act 1981 (MDA) or for offences involving a crime of violence within the previous three years.

Court Diversion – Pre-sentence Opportunity Program
The Pre-sentence Opportunity Program (POP) is an early intervention court diversion program. The program aims to divert offenders with no or minimal criminal record and a clear drug use problem into treatment. Participants in the program would normally expect to receive a fine or community based order on a plea of guilty. The program provides the opportunity for offenders to engage in treatment only.

As POP is a voluntary program, those persons who arrested charged for possession of illicit drugs, will choose not to participate in POP will not be penalised in any way and will be sentenced as they would have been otherwise.

Referral to the POP is at the magistrate's discretion at all times.

Court Diversion – Supervised Treatment Intervention Regime
The Supervised Treatment Intervention Regime (STIR) is a pre and post sentence option for offenders who have substance use problems, whose offending is directly related to their drug use and who are charged with a relatively moderate offence who would normally expect to receive a Community Based Order or Intensive Supervision Order on a plea of guilty.

It consists of short-term residential or non-residential treatment program for a minimum of three months. Unlike POP, STIR provides ongoing case management of offenders. This requires a strong partnership between the drug treatment services, criminal justice services and the judiciary.

Referral to the program is at the magistrate's discretions at all times.

Court Diversion – Indigenous Diversion Program
The Indigenous Diversion Program (IDP) aims to provide an early intervention court diversion program that specifically targets indigenous persons who have committed relatively minor offences and that have an alcohol and/or other drug problem.

While the principles of IDP are closely aligned to POP, IDP has the additional aims of:

- Increasing the number of indigenous person accessing IDDI programs.
- Increase the availability of culturally secure diversions in regional areas WA.
- Where possible provide culturally secure community development, prevention and early intervention strategies.
- Establish links between indigenous persons, local drug treatment agencies, support services and magistrates.

Court Diversion – Children's Drug Court Drug Court Regime
The Children's Drug Court Drug Court Regime operates through the Perth's Children's Court for young offenders between the ages of 12 to 18 years.

Participants are case managed on an ongoing basis by a court assessment and treatment process officer of the Department of Justice. The participants are required to attend court on a regular basis and are subject to a breach point system.

Court Diversion – Young Peoples Opportunity Program
The Young Peoples Opportunity Program (YPOP) targets young offenders, between the ages of 12 to 18 that have been referred by the police or courts to Juvenile Justice Team. Client participation in YPOP is voluntary. The Team have the option of accessing a specialist drug treatment assessment and referral service for more complex clients.

SOUTH AUSTRALIA

South Australian Police Diversion - Cannabis

The South Australian Police Drug Diversion Initiative – Cannabis targets young people aged 10 to 17 years who are apprehended for a Simple Drug Possession Offence i.e. the possession and/or use of small quantities of cannabis and/or cannabis resin and/or equip to use cannabis.

Determination of whether a person has successfully met the requirements of their diversion remains at the discretion of the person conducting the assessment. The assessor may find it necessary to refer the person to other professional services for treatment.

South Australian Police Diversion – Non-cannabis

The South Australian Police Drug Diversion Initiative – Non-cannabis targets young people 10 to 18 years of age who are apprehended for a Simple Drug Possession Offence i.e. possession and/or use of small quantities of any illicit drug, including equipment for the use of the said drug. This also includes the possession of prescription drugs for persons aged 10 to 17 years of age.

Determination of whether a person has successfully met the requirements of their diversion remains at the discretion of the person conducting the assessment. The assessor may find it necessary to refer the person to other professional services for treatment.

Court Diversion - Court Assessment Referral Scheme

The Court Assessment Referral Scheme (CARDS) enables drug using defendants to obtain priority and immediate access to treatment as part of the court process. Treatment consists of a minimum of 4 sessions of counseling over a 3 month period and participation by a defendant may be part of bail, bond or a simple adjournment.

CARDS targets adult defendants appearing at a Magistrate's Court charged with an offence that is clearly drug related and with a demonstrable drug problem who are eligible and suitable for release on bail and who are willing to engage in treatment and rehabilitation.

TASMANIA

The Tasmanian IDDI establishes a process whereby apprehended drug users may, through an admission of guilt, be diverted from the Criminal Justice System to assessment education and treatment as an alternative to receiving a criminal penalty. At this time all diversion programs in Tasmania are operated by Tasmania Police.

Tasmanian Police Diversion – 1st Cannabis Offence

The police issue a cautioning an offender identified for the first time for possessing or using cannabis.

Tasmanian Police Diversion – 2nd Cannabis Offence

The police issue a cautioning and divert, for assessment and possible treatment an offender identified for a second time for possessing or using cannabis. Failure by the offender to attend the diversion will result in a criminal prosecution.

Tasmanian Police Diversion – All illicit drugs other than cannabis and 3rd Cannabis Offence
The police will divert to a drug assessment and a brief intervention session or treatment an eligible offender identified using or possessing illicit drugs other than cannabis or who have been identified as possessing or using cannabis for a third time.

The person attends the diversion session. Criminal charges for the drug offence will not be pursued and offenders will not be required to attend court if they attend assessment and comply with the recommended education and treatment options.

Failure to attend the diversion will result in a criminal prosecution.

NORTHERN TERRITORY

Police Diversion - Cannabis Expiation Scheme
The Northern Territory Cannabis Expiation Scheme enables police to issue a Cannabis Infringement Notice (CIN), educational and self-referral information to 'first time' illicit drug offenders who are apprehended in possession on a non-trafficable quantity of cannabis. These offenders are given the opportunity to participate in assessment, education and/or treatment to expiate their offence.

Police Diversion – Northern Territory Illicit Drug Pre-Court Diversion Program
The Northern Territory Illicit Drug Pre-court Diversion Program (NTDPCDP) enables police to divert 'first time' illicit drug offenders who are apprehended in possession on a non-trafficable quantity of an illicit drug to be referred to drug education counseling and treatment services as an alternative to the criminal justice system. These offenders are given the opportunity to participate in assessment, education and/or treatment to expiate their offence.

Non compliance in assessment or treatment results in the offender being prosecuted through court system.

Northern Territory Court Referral and Evaluation for Drug Intervention and Treatment
The Northern Territory Court Referral and Evaluation for Drug Intervention and Treatment **(**NTCREDIT) is a Magistrate's Court program which directs people with a drug problem, on bail for periods up to four months, to assessment support and treatment services. It is open to first-time offenders as well as those with some previous criminal and/or drug history.

There is no maximum number of times a person can be referred to or participate in the CREDIT program and a plea of guilty is not required. It is a diversion option for people who have been charged. The charge may be in relation to a crime that is not necessarily drug related but it is clear the person has a drug problem. It differs from police diversion in that police may arrest a person and refer them to drug assessment/education but not charge them.

AUSTRALIAN CAPITAL TERRITORY

Police Early Intervention and Diversion – Cannabis

The Australian Capital Territory Police Early Intervention and Diversion – Cannabis Program enables illicit drug offenders who have been apprehended for personal use and possession offences for cannabis to be referred to drug education counseling and treatment services as an alternative to the criminal justice system.

Police Early Intervention and Diversion - Non-Cannabis

The Australian Capital Territory Police Early Intervention and Diversion - Non-Cannabis Program enables illicit drug offenders who have been apprehended for personal use and possession offences for an illicit drug other than cannabis to be referred to drug education counseling and treatment services as an alternative to the criminal justice system.

Court Alcohol and Drug Assessment Service

The Court Alcohol and Drug Assessment Service (CADAS) is a pre-sentencing treatment option for clients charged with alcohol and other drug (AOD) related offences. The goals are to reduce recidivism during the bail period, and to engage the client in treatment. It is therefore designed as an immediate, short-term intervention, when a client first appears before the Court. The CADAS clinician is located at the Court, and provides an immediate AOD assessment, and recommends an appropriate treatment plan. If the client is released on bail to comply with the treatment plan, the CADAS clinician monitors attendance, and reports all outcomes to the Court. Non-compliance does not necessarily result in a penalty, but is taken into account by the Magistrate at sentencing.

Treatment Referral Plan

The Treatment Referral Program is a post sentencing option, for clients who have either committed a crime to get drugs, or money for drugs, or while under the influence of drugs. It currently applies only to those drugs which appear in Schedule 4 of the Drugs of Dependence Act (1989) i.e. not alcohol.

The magistrate or judge may, as part of the sentence imposed, instruct a client to undergo a treatment order rather than receive a custodial sentence or as an option to reduce their custodial time. The treatment is overseen by a Treatment Assessment Panel, and conducted by an approved treatment agency. The treatment can be for a period of 6 months up to 2 years. Clients who fail to complete their treatment order, may revert to a custodial sentence.

Question 23:

The current name, no. and cost of each program under Illicit Drug Diversion Initiative for the last 12 months or nearest financial year?

Answer:

NEW SOUTH WALES

No.	Name
1	Police Diversion - Cannabis Cautioning Scheme
2	Court Diversion - Magistrates Early Referral into Treatment
3	Court Diversion - Wellington Option Program
4	Court Diversion - Youth Drug and Alcohol Court
5	Court Diversion - Young Offenders Diversion Drug Schemes
6	Juvenile Justice Alcohol and other Drug Counselors
7	Regional Youth Drug Rehabilitation Centres
8	Court Diversion - Adolescent Residential Rehabilitations Units
9	Court Diversion - Rural Alcohol Diversion Pilot

In the financial year 2005/06, the grants from the Commonwealth to the state of New South Wales for Illicit Drug Diversion Programs was $16,982,144.00

VICTORIA

No.	Name
1	Police Diversion - Cannabis
2	Police Diversion - Drug Diversion Program
3	The Court Referral and Evaluation for Drug Intervention and Treatment
4	The Rural Outreach Diversion Workers
5	Deferred Sentencing
6	Drug Treatment Order
7	Koori Court Diversion
8	Children’s Court Clinic Program

In the financial year 2005/06 the grants from the Commonwealth to the state of Victoria for Illicit Drug Diversion Programs was $12,307,766.00

QUEENSLAND

No.	Name
1	Police Diversion Program
2	The Illicit Drugs Court Diversion Program

In the financial year 2005/06 the grants from the Commonwealth to the state of Queensland for Illicit Drug Diversion Programs was $2,700,000.00

WESTERN AUSTRALIA

No.	Name
1	Police Diversion - Cannabis Education Session
2	Police Diversion - All Drug Diversion
3	Court Diversion - Pre-sentence Opportunity Program
4	Court Diversion - Supervised Treatment Intervention Regime
5	Court Diversion - Indigenous Diversion Program
6	Court Diversion - Children's Drug Court Drug Court Regime
7	Court Diversion - Young Peoples Opportunity Program

In the financial year 2005/06 the grants from the Commonwealth to the state of Western Australia for Illicit Drug Diversion Programs was $4,853,447.00

SOUTH AUSTRALIA

No.	Name
1	South Australian Police Diversion - Cannabis
2	South Australian Police Diversion - Non-cannabis
3	Court Diversion - Court Assessment Referral Scheme

In the financial year 2005/06 the grants from the Commonwealth to the state of South Australia for Illicit Drug Diversion Programs was $3,500,000.00

TASMANIA

No.	Name
1	Tasmanian Police Diversion - 1st Cannabis Offence
2	Tasmanian Police Diversion - 2nd Cannabis Offence
3	Tasmanian Police Diversion - All illicit drugs other than cannabis and 3rd Cannabis Offence

In the financial year 2005/06 the grants from the Commonwealth to the state of Tasmania for Illicit Drug Diversion Programs was $927,168.00

NORTHERN TERRITORY

No.	Name
1	Police Diversion - Cannabis Expiation Scheme
2	Police Diversion – Northern Territory Illicit Drug Pre-Court Diversion Program
3	Northern Territory Court Referral and Evaluation for Drug Intervention and Treatment

In the financial year 2005/06 the grants from the Commonwealth to the Northern Territory for Illicit Drug Diversion Programs was $1,200,000.00

AUSTRALIAN CAPITAL TERRITORY

No.	Name
1	Police Early Intervention and Diversion – Cannabis
2	Police Early Intervention and Diversion - Non-Cannabis
3	Court Alcohol and Drug Assessment Service
4	Treatment Referral Plan

In the financial year 2005/06 the grants from the Commonwealth to the Australian Capital Territory for Illicit Drug Diversion Programs was $1,041,513.00

Question 24:

Can you provide a list of current programs or partnerships being undertaken with the AFP or ACC in relation to drug markets?

Answer:
The Department works closely with the Australian Federal Police (AFP) and the Australian Crime Commission (ACC), amongst other organisations, to improve health, social and economic outcomes for Australians by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in our society. This partnership is guided by the *National Drug Strategy 2004-2009*.

At the strategic level, the Department works in partnership with the AFP and ACC through forums including the Ministerial Council on Drug Strategy and the Intergovernmental Committee on Drugs. These bodies provide advice to Ministers on the full range of drug-related matters and act as the forum for decisions in relation to licit and illicit drugs in Australia.

More specifically, the Department is involved in two other specific activities of relevance to the question.

National Drug Law Enforcement Research Fund (NDLERF)
The Department provides funding to facilitate and promote quality practice in licit and illicit drug law enforcement in Australia through: enhancing strategic alliances and linkages between law enforcement personnel, other human service providers, and research agencies. The focus of work supported by NDLERF is innovation; experimentation; and research.

National Working Group on the Prevention of the Diversion of Precursor Chemicals into Illicit Drug Manufacture
This multidisciplinary group provides guidance and advice to ensure a consistent national approach to prevent the diversion of pharmaceutical products to illicit drug manufacture and to promote better coordination and collaboration across jurisdictions and sectors. The work of this group is very focused on ATS manufacture, importation and use.

The Working Group is co-chaired by the Hon Chris Ellison, Minister for Justice and Customs and the Parliamentary Secretary to the Minister for Health, the Hon Christopher Pyne.

Question 25:
In relation to the data you receive, do you assess the quality of that data, and if so, how?

Answer:
The Department acknowledges the importance of validity and reliability in research[17]. Therefore, the Department relies heavily on research conducted by the AIHW and the National Drug Strategy Research Centres at the University of New South Wales, Flinders University and Curtin University of Technology.

The AIHW and the research centres are recognised internationally for their research on drug related harms and the size and nature of the subgroups that use different substances. Methodological rigour and consistency is also a key focus in the design, fieldwork, analysis and reporting of social marketing campaign evaluation research. Major projects are overseen by technical advisory committees and draft reports are circulated for technical comment.

17 While reliability is concerned with the accuracy of the actual measuring instrument or procedure, validity is concerned with the study's success at measuring what the researchers set out to measure.

Additional questions from 19 June 2006 public hearing

Extract from Hansard:
Mr Stuart: "…The survey that followed up on the recognition of the campaigns was sample based. We will take on notice what that sample was and we will provide that in our written response."

Response:
The national youth post-campaign survey was conducted by the *Social Research Centre*. It involved 1,490 telephone interviews with young people aged 13–20 years. Quotas were set, based on region and age. The surveys were post-weighted by age, sex and region to match the national profile derived from the 2001 Australian Bureau of Statistics (ABS) Census of Population and Housing Statistics.

The breakdown of the sample's demographic characteristics is as follows:[18]

Post-campaign	Indigenous youth (n=400) %	General youth (n=1490) %
Respondent sex		
Male	46	48
Female	54	52
Respondent age (years)		
13–14 years	29	27
15–17 years	47	46
18–20 years	24	27
Region		
Metropolitan	24	62
Non-metropolitan (net)	76	38
Regional locations	55	na
Remote locations	21	na
State		
New South Wales/Australian Capital Territory	37	20
Victoria/Tasmania	10	20
Queensland	34	20
Western Australia	10	20
South Australia/Northern Territory	9	20
School or work status (main activity)		
High school	69	71
Post-secondary education	7	11
Part-time or casual work	8	6
Full-time work	9	10
Unemployed	4	1
Other NIWF	3	1

Note: totals do not always sum to 100% due to rounding
Base: all respondents

18 Department of Health and Ageing, *National Drugs Campaign: Evaluation of Phase 2*, p.120

Extract from Hansard:
Mr Stuart: "… If you are asking if there was any research as an input into the formation of the [diversion] program, I would have to take that on notice…"

Response:
In April 1999, the Council of Australian Governments (COAG) agreed to work together to put in place a new nationally consistent approach to drugs in the community involving diversion of drug offenders by police to compulsory assessment.

COAG asked the Ministerial Council on Drug Strategy (MCDS) to develop a nationally consistent approach to diversion. The report drew on the work of a number of expert working groups which were chaired by members of the Intergovernmental Committee on Drugs (IGCD) and included representatives of the IGCD and the Australian National Council on Drugs (ANCD). IGCD provided expertise and policy advice to the expert working groups and the National Drugs Task Force during the development of this initiative.

The outcome of this collaborative approach was an agreement by COAG to invest in a new initiative to combat drugs by combining strong national action against drug traffickers with early intervention strategies in order to prevent a new generation of drug users emerging in Australia. Ministers noted that illicit drug use imposed enormous social cost on individuals, families and societies and through helping drug offenders regain control over their own lives, Australians will have a safer environment to live in. The Illicit Drug Diversion Initiative (IDDI) will result in:

- "people being given early incentives to address their drug use problem, in many cases before incurring a criminal record;
- an increase in the number of illicit drug users diverted into drug education, assessment and treatment; and
- a reduction in the number of people appearing before the courts for use or possession of small quantities of illicit drugs".

IDDI targets illicit drug users who have little or no past contact with the criminal justice system for drug offences and who have been apprehended by police for possession/use of small quantities of illicit drugs. Police divert targeted offenders to compulsory drug education or assessment, from where they will be referred to a suitable drug education or treatment programme. Some offenders may also be diverted by Courts under this initiative. If illicit drug users do not participate in the program, they risk being returned to the criminal justice system which includes the possibility of goal.

The IDDI Framework was developed through a consultative process by IGCD representatives who had extensive knowledge and experience of the States and Territories requirements and complemented and broadened existing initiatives. The development approach ensured national consistency whilst providing individual jurisdictions with enough flexibility to manage particular needs and priorities.

To fully explore the questions raised, it would be appropriate to consult with those representatives from that time. However, the perception was that an initiative such as Diversion and separating these individuals from the criminal justice system would reduce their long term criminal history. The evaluation of IDDI, currently being progressed will assist in providing the evidence on whether that aim has been achieved.

Extract from Hansard:
Mr Kerr: "… I wonder whether you might respond by a short note that basically goes through those elements that are said to be part of a harm minimisation strategy in relation to amphetamines and other synthetic drugs, and the budget over, say, the last three years and forward, so we can have a look at what actually has been done or planned. And, if you know of anything useful at the state level, because this is not just a Commonwealth issue—if there are intelligent harm minimisation things being done in this area by states…"

Response:
Australia is recognised as a world leader in its comprehensive approach to policies and programs designed to prevent and reduce harm associated with both licit and illicit drugs.

Under the *National Drug Strategy 2004-2009*, all governments and the non-government sector are continuing to work together to prevent drug abuse (reducing supply and reducing demand), while also ensuring the necessary support and treatment (reducing harm) for people seeking to break their dependency.

It is anticipated that the National ATS Strategy will parallel the principles of the *National Drug Strategy 2004-2009*. Individual elements within the ATS Strategy will be developed further through stakeholder consultation and on the basis of evidence.

Since 2003-04, $5.1 million has been provided for the National Psychostimulants Initiative, which captures issues associated with amphetamines and other synthetic drugs. The aim of the Initiative was to address problems associated with the increased availability and use of psychostimulants in Australia.

In the 2006-07 Federal Budget, funding of $34.4 million over fours years was allocated to combating emerging trends in illicit drugs.

- $23.7 million for the development of phase three of the National Drugs Campaign
- $10.7 million to strengthen the capacity of drug and alcohol workers to deal more effectively with psychostimulants. Identification of effective treatment options for people using psychostimulants will also be undertaken.

The Australian Government continues to work in partnership with States and Territories to deliver initiatives under the *National Drug Strategy 2004-2009*, through forums such as the Ministerial Council on Drug Strategy and the Intergovernmental Committee on Drugs.

Funding is provided to States and Territories to address a range of drug and alcohol problems, including drug and alcohol services, such as, the Needle and Syringe Program and the Illicit Drug Diversion Initiative.

States and Territories are in the best position to provide comments on other programs pertaining to their jurisdiction.