

ANCD 2007-2010 WORK PLAN

ROLE OF ANCD

The Australian National Council on Drugs (ANCD) is the principal advisory body to the Prime Minister and Government on drug policy and plays a critical role in ensuring the voice of the community is heard in relation to drug related policies and strategies. Membership of the ANCD includes people with a wide range of experience and expertise on various aspects of drug policy, such as treatment, rehabilitation, education, family counselling, law enforcement, research and work at the coalface in community organisations.

ANCD BROAD PRIORITY AREAS

The ANCD recognizes the difficulty in adequately representing all the areas of need in the drug and alcohol arena. As a result, the ANCD has identified 3 broad categories that contain a number of specific priority areas, some of which

The broad categories identified by the ANCD are:

<u>Broad Priority Areas</u>	<u>Specific Priority Areas</u>
A. Population Groups	<ol style="list-style-type: none">1. Young people2. Indigenous.3. Co-morbidity4. Asia-Pacific5. Families
B. Key Sectors	<ol style="list-style-type: none">1. Treatment2. Capacity building3. Public Health4. Informing the Public5. Law Enforcement
C. Substances	<ol style="list-style-type: none">1. Alcohol2. Illicit Drugs3. Emerging trends

ANCD SPECIFIC PRIORITY CATEGORIES

Based on the ANCD Terms of Reference, the ANCD has identified a select number of key issues, or “priority areas”, which will be the focus of the majority of the Council’s efforts over the course of its 2007-10 term. Whilst these areas will be a focus throughout the term, the ANCD recognizes that the changing nature of drug use in our society today demands a flexible approach.

Accordingly, the priority areas listed are not intended to cover all issues of significance. Rather, they represent a set of areas around which the Council believes it both should, and has the capacity to make a positive contribution within the scope of its activities for 2007-2010.

A. POPULATION GROUPS

A1. YOUNG PEOPLE

The ANCD recognizes that young people represent an important group in terms of prevention and early intervention, given the greater capacity to avoid later social, health and economic consequences of drug use. Accordingly, the ANCD aims to strengthen our knowledge on issues affecting young people and to support national efforts to address their issues in an appropriate manner.

The ANCD aims to focus on the following areas within youth:

- a) Needs and responses - influences
- b) Linkages to prevention and intervention
- c) Promoting healthy environments
- d) Developing new ways of engaging with young people

A2. INDIGENOUS HEALTH

Aboriginal and Torres Strait Islander people are more likely to experience disability and reduced quality of life due to ill health and have a lower life expectancy than other Australians. The use of licit drugs such as tobacco and alcohol poses a disproportionate health risk to Indigenous communities as compared to the total Australian population. It remains a priority of the ANCD to support national efforts that address drug related harm and associated issues affecting Indigenous people.

The ANCD aims to focus on the following areas:

- a) Ensuring consultation and Indigenous voices in the decision making process;
- b) Ensuring monitoring and evaluation of interventions, particularly the Northern Territory emergency response;
- c) Encouraging development of innovative and culturally appropriate services for Indigenous people;
- d) Increasing the number of Indigenous people in the AOD workforce;
- e) Gaining ongoing and additional financial support for effective AOD treatment services.

A3. MENTAL HEALTH – CO- EXISTING DISORDERS

The ANCD acknowledges the necessity for research to be carried out in the area of co-morbidity, and the need for services that are equipped to treat those with mental health and substance misuse problems. Additionally there is a need for effective service models to be established so they may be replicated throughout Australia.

The ANCD aims to focus on the following areas:

- a) Unplanned service growth;
- b) NGO involvement;
- c) Development of innovative services;
- d) Effective responses.

A4. INTERNATIONAL (ASIA-PACIFIC)

The ANCD recognizes the need to increase Australia's engagement in our region on drug and alcohol issues. The Asian and Pacific regions present very different but equally important drug and alcohol challenges and opportunities for Australia. The previous regional focus on supply reduction requires continued support, as does the more recent focus on harm reduction strategies to address the HIV emergency. However, a real and sustained commitment on assistance for the regions to address demand reduction is an omission that needs to be rectified.

The ANCD aims to focus on the following areas:

- a) Increasing Australian aid for drug and alcohol issues in the Asian and Pacific regions;
- b) Increasing and enhancing existing linkages and co-operative arrangements with international and regional organizations, particularly those within the Asian and Pacific regions.

A5. FAMILIES

There is a growing recognition on the importance of families in obtaining successful treatment outcomes. In addition, the need to engage with families in early intervention initiatives requires a greater level of attention.

The ANCD aims to focus on the following areas:

- a) Increasing the engagement of families in the treatment process;
- b) Increasing the level and ability of treatment services able to cater for the needs of families;
- c) Increasing the level of support for families to establish and maintain positive parenting practices.

B. KEY SECTORS

B1. TREATMENT – SUSTAINABLE ACCESS

Providing drug and alcohol treatment that is both readily available and accessible across Australia remains a key goal for the ANCD.

The ANCD aims to focus on the following areas:

- a) Ensuring access to viable evidence based and appropriately resourced systems of care;
- b) Ensuring a range of treatment is available;
- c) Promoting greater levels of treatment after care to overcome potential relapse points for clients;
- d) Promoting a greater level of community, business, family and consumer involvement in treatment development and expansion;
- e) Promoting treatment linkages such as addressing the disconnect within AOD treatment and treatment for mental illness or other health problems (hepatitis etc).

B2. CAPACITY BUILDING (WORKFORCE AND NGO'S ETC)

The ANCD acknowledges the value of initiatives that build capacity within the AOD sector and wider community to effectively respond to drug, alcohol and related issues.

The ANCD aims to focus on the following areas:

- a) National Accreditation of treatment programs with appropriate support;
- b) Professionalisation of the workforce;
- c) Focusing on rural and regional workforces;
- d) Increasing the level of support and recognition on the capacity of the NGO sector to deliver effective and cost efficient drug and alcohol services.

B3. PUBLIC HEALTH

The ANCD acknowledges the linkages between many public health initiatives. In addressing drug and alcohol issues there are often other public health considerations, such as hepatitis and HIV that need to be taken into account.

The ANCD aims to focus on the following area:

- a) Increasing co-operation and communication with other key public health advisory bodies to ensure effective and consistent advice to government and the public;

B4. INFORMING THE PUBLIC

The ANCD is acutely aware of the need to inform and educate the wider community on drug, alcohol and related issues. It is also imperative that community views and needs are taken into account when developing advice on addressing drug and alcohol problems. The wider public must be kept engaged in policy and program developments as part of a two way process.

The ANCD aims to focus on the following areas:

- a) Promoting accurate and responsible reporting of drug and alcohol issues within the media;
- b) Increasing the level, accuracy and access of information for the wider community on drug and alcohol issues.

B5. LAW ENFORCEMENT

The ANCD acknowledges the invaluable gains that have been made in Australia's responses to drug and alcohol problems by establishing effective partnerships between law enforcement and health sectors.

The ANCD aims to focus on the following areas:

- a) Increasing the level of communication between health and law enforcement personnel on drug and alcohol issues;
- b) Further strengthening the partnerships, understanding and support for each sector's policies and programs.

C. SUBSTANCES

C1. ALCOHOL

The ANCD acknowledges the significant detrimental health implications of alcohol misuse. The ANCD aims to provide government with evidence-based advice and information on addressing the negative impacts of alcohol.

The ANCD aims to focus on the following areas:

- a) Supporting the implementation of the National Alcohol Strategy;
- b) Increasing the contribution from the alcohol industry for alcohol and related health and welfare services;
- c) Developing appropriate coalitions and collaborations to raise community awareness on the impact of alcohol misuse.

C2. ILLICIT DRUGS

The ANCD acknowledges that the availability and use of illicit drugs can cause significant harm to individuals, families and communities. Ensuring a balanced and wide range of programs are in place to address illicit drug use and the harms it can cause is a priority for the ANCD.

The ANCD aims to focus on the following areas:

- a) Increasing the availability and accessibility of effective illicit drug use treatment;
- b) Monitoring and advising upon innovative and new illicit drug use policies and programs;
- c) Maintaining and enhancing the balanced approach undertaken by Australia to implement supply, demand and harm reduction policies.

C3. EMERGING TRENDS

The ANCD acknowledges that to effectively respond to drug and alcohol and related issues there is a need to accurately determine emerging issues and trends.

The ANCD aims to focus on the following areas:

- a) Monitoring changes in drug use patterns and trends and providing appropriate advice to government on these changes;
- b) Enhancing co-operation with research centres and international partners to be kept informed on drug and alcohol issues that develop;
- c) Enhancing systems that increase our knowledge of emerging issues.

HISTORY AND CONTEXT

The ANCD was established as part of the Australian Federal Government's response to reduce the harm caused by drugs in our community. An important component of the ANCD's work is to ensure that policies, strategies and directions in the drug and alcohol field are consistent with the National Drug Strategy.

The National Drug Strategy recognises the importance of building partnerships. It clearly states that the strategy's effectiveness depends on cooperation between a very broad range of sectors. It is with this in mind that the former Prime Minister established the Australian National Council on Drugs. The Council occupies a unique position by virtue of its role in enhancing the partnership between government and the community. It has pivotal advisory, advocacy and representative functions, with a significant role to provide the Prime Minister, government Ministers and government departments with independent, expert advice on matters related to licit and illicit drugs.

ANCD TERMS OF REFERENCE 2007 - 2010

ANCD TERMS OF REFERENCE 2007-2010

- a. Provide independent advice to the Prime Minister, Australian Government Ministers and members of the Ministerial Council on Drug Strategy (MCDS) on national drug and alcohol strategies, policies, programmes and emerging issues.
- b. Provide independent advice to the Prime Minister and the Australian Government on improving the implementation and effectiveness of efforts to reduce the supply, demand and harm from drugs in Australia and internationally.
- c. Provide independent and strategic advice to the Prime Minister, Australian Government Ministers and members of the MCDS on drug and alcohol issues specifically affecting Indigenous people.
- d. Provide assistance and advice on drug policy and services to Australian Government departments, inquiries and other bodies such as parliamentary parties, as appropriate.
- e. Consult and liaise with relevant sectors and in particular the non-government sector on drug and alcohol related issues.
- f. Inform and educate relevant sectors and the general public's knowledge on drug and alcohol related issues.
- g. Build and maintain partnerships across the range of sectors concerned in dealing with and addressing drug related issues.
- h. Work closely with the MCDS, Inter-governmental Committee on Drugs and other National Drug Strategy partners to develop and implement effective strategies, policies and programmes to reduce the uptake and misuse of illicit and licit drugs.
- i. Maintain effective liaison with other stakeholders, public health advisory bodies and relevant peak non-government organisations, including consumer representatives.
- j. Develop a three year Work Plan for the Council.
- k. Report annually to the Prime Minister and the MCDS on the work of the Council.

PRINCIPLES

The ANCD has outlined the following seven principles to guide its work over the 2007-2010 term:

1. **Evidence**
2. **Collaboration**
3. **A Long-Term Outlook & Commitment**
4. **Innovation**
5. **Equity**
6. **Independence**
7. **Community Leadership**

THE PAST (1997)

In the past, a significant majority of the total government expenditure on illicit drugs was for law enforcement. Estimates from 1992 noted that the total government annual expenditure on illicit drugs was approximately \$620 million. Of this, 84% was for law enforcement, 10% for prevention and research and 6% for treatment (MacKay, 2001).

Estimates of drug use among the population around this time are known from the 1998 National Drug Strategy Household Survey (NDSHS). Overall in 1998, there was a general increase in illicit drug use, compared with previous surveys (see Figure 1). Findings from the 1998 NDSHS included the following:

- Forty-six percent of the Australian population aged 14 years and over had ever used an illicit drug, which was an increase from 39% in 1995;
- Twenty-two percent reported they had used an illicit drug recently (defined as use within the previous 12 months), which was an increase from 17% in 1995;
- Cannabis was the most popular illicit drug (see Table 1), followed by analgesics for non-medical purposes;
- Recent use of meth/amphetamines had almost doubled since 1995 (see Figure 1); and
- Recent use of ecstasy had more than doubled since 1995 (see Figure 1).

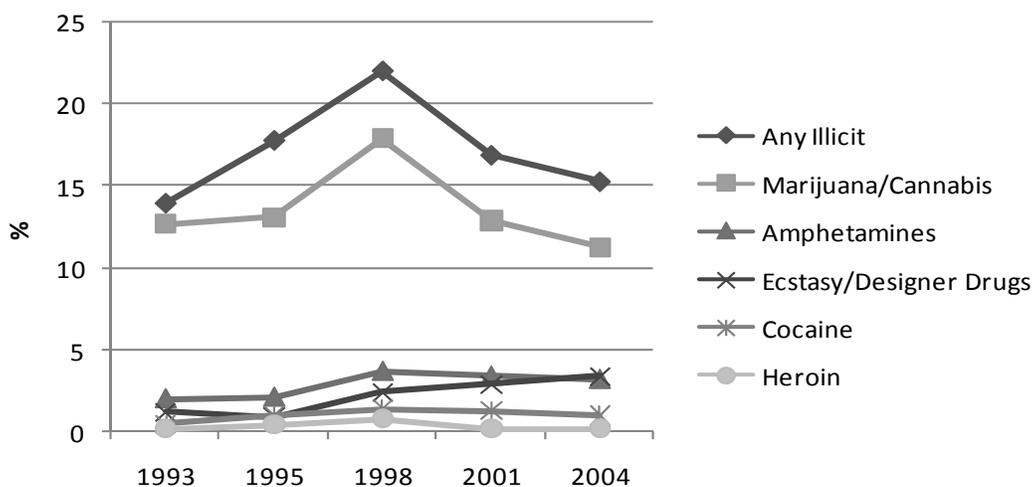


Figure 1 Recent illicit drug use (use in previous year): proportion of the population aged 14 years and over, by selected drug types, Australia, 1993 to 2004
Sources: NDSHS 1993, 1995, 1998, 2001, 2004 (see AIHW, 2007a).

The pattern of increasing illicit drug use was not reflected in licit drug trends at the time. For example, findings from the 1998 NDSHS revealed that:

- The proportion of those 14 years and above who were daily smokers had declined two percentage points to 22% (see Figure 2); and
- Alcohol consumption patterns had remained relatively stable, with, for example, 49% drinking alcohol weekly or more in 1998 (see Figure 2).

As demonstrated by Table 1, 0.7% of those aged 14 years and over had injected an illicit drug in the previous year. Alternative data sources related to injecting drug use found that:

- There were 31 new AIDS diagnoses recorded in 1997 among those with an injecting drug use history (AIHW, 2007a);
- The Needle and Syringe Program (NSP) survey, which is an annual survey targeting those who attend NSPs, found that around 60% of those included in the 1995 survey tested positive to Hepatitis C (AIHW, 2007a); and
- There were 713 accidental deaths due to opioids among those aged 15–64 years in 1997, which was an increase from 557 in the previous year (Degenhardt & Roxburgh, 2007).

Table 1. Summary of drug use: proportion of the population aged 14 years and over, Australia, 1998, 2004

Drug/behaviour	Lifetime use		Recent use ^(a)	
	1998	2004	1998	2004
Cannabis	39.3	33.6	17.9	11.3
Analgesics ^(b)	11.4	5.5	5.2	3.1
Tranquilisers ^(b)	6.2	2.8	3.0	1.0
Steroids ^(b)	0.8	0.3	0.2	–
Barbiturates ^(b)	1.6	1.1	0.2	0.2
Inhalants	3.9	2.5	0.8	0.4
Heroin	2.2	1.4	0.7	0.2
Methadone ^(c)	0.5	0.3	0.2	0.1
Other opiates/opioids ^(b)	na	1.4	na	0.2
Meth/amphetamine ^(b)	8.7	9.1	3.6	3.2
Cocaine	4.3	4.7	1.4	1.0
Hallucinogens	10.0	7.5	3.0	0.7
Ecstasy ^(d)	4.7	7.5	2.4	3.4
GHB	na	0.5	na	0.1
Ketamine	na	1.0	na	0.3
Injected illegal drugs	2.1	1.9	0.7	0.4
<i>Any illicit</i>	46.0	38.1	22.0	15.3

(a) Used in the last 12 months.

(b) For non-medical purposes.

(c) Non-maintenance.

(d) This category included substances known as 'designer drugs' prior to 2004.

na = not asked in 1998.

Sources: NDSHS 1998, 2004 (see AIHW, 1999; 2007).

Estimates of drug use among younger people are available from the Australian Secondary Students' Alcohol and Drugs (ASSAD) survey. This survey includes a nationally representative sample of Australian students aged 12–17 years and is conducted every three years. Results from the 1999 survey found that the most commonly used illicit drugs in the previous year were as follows:

- Cannabis (25%);
- Inhalants (19%); and
- Amphetamines (6%)(White, 2001).

With regard to licit substance use:

- Eighty-nine percent had ever tried alcohol, with 35% having consumed alcohol in the previous week (see AIHW, 2007a); and
- Nineteen percent of the sample had smoked cigarettes in the week before the survey (White & Hayman, 2006c).

The Australian Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS) was established in 2000. This dataset does not include all treatment activities, such as methadone maintenance (see AIHW, 2002 for further details). Of the 393 AOD service providers that contributed to the collection in 2000–01, there were 83,529 client registrations (64% male) (AIHW, 2002). Alcohol was the principal drug of concern for which people sought treatment (34% of clients), followed by heroin (28%) (AIHW, 2002). Data from 1996 showed tobacco was responsible for a greater proportion of the total burden of disease and injury in Australia (10%) than harm from alcohol use (2%) or use of illicit drugs (almost 2%)(Mathers, Vos, & Stevenson, 1999). Consistent with these findings, tobacco was also responsible for the greatest social costs from drug use. Tobacco accounted for 61% of the total \$34.4 billion cost in the 1998–99 financial year, compared with 22% for alcohol and 18% for illicit drugs (Collins & Lapsley, 2002).

PRESENT (2007)

The latest available estimates regarding Australia's total government drug budget revealed that \$3.2 billion was spent on illicit drugs in 2002-03. This is a greater investment than in 1992 and in addition, the proportion allocated to different activities is now more balanced. For example in 2002–03, 42% of the total government expenditure was for law enforcement, followed by 23% for prevention and 17% for treatment (Moore, 2005). Other activities included interdiction (14% of the total expenditure) and lastly, harm reduction (3%) and other activities (1%)(Moore, 2005).

Recent statistics from the 2004 NDSHS demonstrate that almost all illicit drugs have either declined in use or remained stable since 1998 (see Table 1). Findings from the 2004 NDSHS included that:

- The proportion of those aged 14 years and over who have ever used an illicit drug has decreased since 1998 to 46%;
- Fifteen percent have used an illicit drug recently, which is a decrease from 22% in 1998;
- Cannabis remains the most commonly used illicit drug but use has declined (for example, 11% reported recent cannabis use compared with 18% in 1998); and
- Ecstasy has replaced analgesics for non-medical purposes as the second most commonly used recent drug in 2004 (3.4% compared with 3.1% for analgesics).

Consistent with previous surveys, only a small proportion (0.4%) of the population reported injecting a drug in the previous year (see Table 1). Other recent information concerning injecting drug use included:

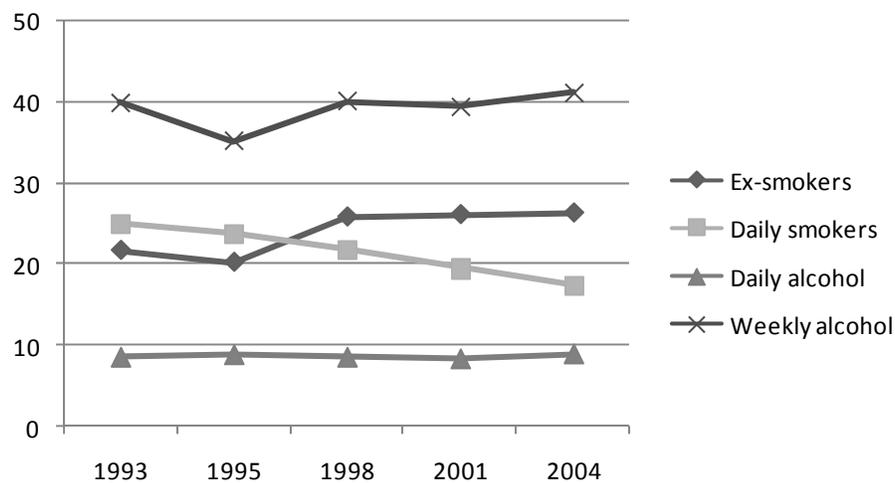
- That the number of new AIDS diagnoses among those with an injecting drug use history has increased from 31 in 1997 to 41 new diagnoses in 2005 (AIHW, 2007a); and
- Of those that took part in the 2005 NSP survey, the proportion that tested positive to Hepatitis C remained around 60% (AIHW, 2007a).

The prevalence of smoking has continued to decline, however the pattern of alcohol consumption has remained relatively unchanged (see Figure 2). Additional results for licit substance use from the 2004 NDSHS included that:

- Seventeen percent of those aged 14 years and over were daily smokers; and
- Ten percent of those aged 14 years and over drank at levels considered to be risky or high risk for long-term harm, with this most common among 20–29 year olds (15%)(AIHW, 2005).

While patterns of alcohol use remain relatively unchanged, the types of alcohol consumed have changed over time, with reports of an increase in wine and spirit consumption and a decrease in consumption of full strength beer (Roche, 2005).

Figure 2 Tobacco and alcohol use: proportion of the population 14 years and over,



Australia, 1993 to 2004

Sources: NDSHS 1993, 1995, 1998, 2001, 2004 (see AIHW, 2007a).

Another ASSAD Survey was conducted in 2005 and results demonstrated:

- A significant decrease in the proportion of those aged 12–17 years who were current smokers (9% compared with 19% in 1999)(White & Hayman, 2006c);
- That a significantly smaller proportion of students aged 12–15 years had ever tried alcohol (82% compared with 87% in 1999);
- No significant change for lifetime use of alcohol among those aged 16–17 years (95% had ever tried alcohol in 2005)(White & Hayman, 2006a); and
- The illicit drugs most commonly used recently were still cannabis (14%), followed by inhalants (13%) and amphetamines (4%), however these estimates have declined since 1999 (White & Hayman, 2006b).

Seizure data from the Australian Crime Commission (ACC) is another useful indicator of the present illicit drug situation. For example, the ACC report for 2005–06 showed that the number of clandestine laboratory detections had stabilised, with 390 detections recorded nationally (ACC, 2007). While methamphetamine use has remained stable, there has been an emergence of high purity crystalline methamphetamine since 1999 (McKetin, 2007). The further emergence of ATS is likely related to a reduction in the supply of heroin that occurred within Australia during 2001 (Moore, 2007). This ‘heroin shortage’ affected all Australian jurisdictions resulting in a reduction of heroin use and positive public health outcomes, such as fewer overdose deaths (Degenhardt, Day, Gilmour, & Hall, 2006). For example, in 2001, there were 386 accidental deaths among those aged 15–64 years, which was a dramatic decrease from the 713 reported in 1997 and the 938 reported in 2000 (Degenhardt & Roxburgh, 2007).

Despite the decrease in heroin availability, opiates account for the greatest proportion of social costs from illicit drug use—amphetamines and cannabis also each account for sizeable proportions (Moore, 2007). Tobacco, however, is still ranked as the health risk associated with the greatest disease burden. In 2003, tobacco use was responsible for 8% of the total burden of disease and injury in Australia, alcohol harm was responsible for 3% and illicit drug use for 2% (Begg et al., 2007).

In 2005–06, 664 agencies contributed to the AODTS-NMDS and 151,362 closed treatment episodes were reported (66% male) (AIHW, 2007b). A closed treatment episode refers to contact between a client and agency that has a defined start and finishing date and no change in principal drug of concern, main treatment type or treatment delivery setting (see AIHW, 2007b for further details). In 2005–06, alcohol remained the principal drug of concern (39% of all closed treatment

episodes), but was then followed by cannabis (25%). Unfortunately, the 2000–01 dataset did not include estimates of closed treatment episodes. However, the 2005–06 figure increased from 120,869 closed treatment episodes reported in 2001–02 (505 AOD treatment agencies contributed to the collection that year) (AIHW, 2003).

At present, drug use remains more prevalent among vulnerable groups, such as young people and Indigenous persons. For example, the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), which was conducted in 2004–05 throughout remote and non-remote regions of Australia, found that more than half (52%) of Indigenous persons aged 15 years and over in the survey reported currently smoking tobacco. In addition, 28% had used an illicit drug in the previous year (AIHW, 2007a). Of additional concern is the drug use among high risk populations with, for example, over half of prisoners reporting a history of injecting drug use (AIHW, 2007a).

THE FUTURE

It is difficult to predict the future of drug and alcohol use in Australia. Information from international organisations is useful for identifying potential trends in the Australian drug market. For example, the United Nations Office on Drugs and Crime (UNODC) has reported on the decrease of heroin production within the Golden Triangle area (which has normally supplied the Australian market), although production in Myanmar has recently increased. Now, Afghanistan accounts for approximately 92% of the global illicit opium production (UNODC, 2007). The UNODC have also highlighted a move towards large scale methamphetamine factories in South East Asia. In these areas, domestic demand is low and as such, production is likely for export purposes (Douglas, 2007).

Domestically, there are various monitoring systems that identify emerging trends in drug use, such as the ACC reports of drug arrests, seizures and detections by Australian law enforcement. The ACC noted that the stability of the ATS market was likely influenced by restrictions placed on pseudoephedrine product sales (ACC, 2007). The ACC stated that this may lead to an increase in attempted ATS (or precursor) importations or perhaps, a move to alternative methods of manufacturing. Although, based on identified operations within the Asian region, the UNODC note that the finished products are likely to enter Australia (Douglas, 2007). While the number of ATS detections has increased since 1997, the weight of the seizures has decreased. The ACC further noted that ecstasy is being produced domestically, whereas the majority of the drug has always been imported. They also stated that the demand for cannabis is unlikely to decrease (in

the short-term) and that there is an emergence of alternative synthetic stimulants in some jurisdictions (ACC, 2007).

Another important data source stems from the Australian Institute of Criminology Drug Use Monitoring in Australia (DUMA) project that annually assesses drug use among those apprehended by police. Recent results from 2006 included the continuance of cannabis as the most popular detected drug (55% among all tested male detainees in 2006) and that the detection of heroin has decreased (Mouzos, Hind, Smith, & Adams, 2007), consistent with other reports.

Other indicators of emerging trends in drugs include the Illicit Drug Reporting System (IDRS) and the Ecstasy and Related Drug Reporting System (EDRS). Both of these systems operate as early warning systems by highlighting drug market trends through the triangulation of information from interviews with injecting drug users (for the IDRS) or regular ecstasy users (for the EDRS), interviews with key experts and examination of indicator data sources. Among the many findings, the data from the 2007 IDRS demonstrated some recovery in the heroin market, although it has not returned to pre-2001 levels. An emergence of a different form of heroin (an alkaline brown heroin) was also noted and was reportedly used by 35% of the 558 IDRS participants that had used heroin in the previous six months. It is unknown whether this is a lasting trend but it may reflect a different heroin source, such as production in the Golden Crescent (Black, 2007).

The above data sources are important for assessing emerging trends in illicit drug use to ensure they are responded to in a timely manner. It is also important to acknowledge the emerging trends in licit drug use, particularly given the greater social costs and burden associated with their use. The increase in alcohol accessibility and shift to consumption of different alcohol types, for example, should be monitored. Further to alcohol use, the interventions currently being implemented among Indigenous communities in the Northern Territory include the banning of alcohol (and kava use). Future evaluations for this, and other strategies, like the national campaign directed towards crystal methamphetamine, are needed to assess their impact on the prevalence of use and associated harms within the community.

There are opportunities to address some issues related to treatment services in the future. These include the potential increase in role for NGOs in service delivery. For example, NGOs may play an important role in needle and syringe programs, methadone and other pharmacotherapies. Other areas that require further attention include the lack of treatment options for people with amphetamine-type stimulant problems and the need to adequately resource the growing reliance on non-government organisations to deliver treatment services. Overall, there is a continued need for

evidence based practice within the Australian alcohol and other drug area. This can be facilitated by the accreditation of treatment services to further improve the professionalisation of the sector.

APPENDICES

- **References and linking documents**
- **AOD Charter**
- **Activities**
- **Committee List (name of committees and short description)**

REFERENCES

Australian Crime Commission. (2007). *Illicit Drug Data Report 2005-06*. Canberra: Commonwealth of Australia.

Australian Institute of Health and Welfare. (1999). *The 1998 National Drug Strategy Household Survey: First results*. AIHW cat. no. PHE 15. Canberra: AIHW.

Australian Institute of Health and Welfare. (2002). *Alcohol and other drug treatment services in Australia 2000–01: first report on the National Minimum Data Set*. Drug Treatment Series no.1. Cat. no. HSE 22. Canberra: AIHW.

Australian Institute of Health and Welfare. (2003). *Alcohol and other drug treatment services in Australia 2001–02: report on the national minimum data set*. AIHW cat. no. HSE 28. Canberra: AIHW.

Australian Institute of Health and Welfare. (2005). *2004 National Drug Strategy Household Survey: First Results*. Drug Statistics Series No. 13. Cat. no. PHE 57. Canberra: AIHW.

Australian Institute of Health and Welfare. (2007a). *Statistics on drug use in Australia 2006*. Drug Statistics Series No. 18. Cat. no. PHE 80. Canberra: AIHW.

Australian Institute of Health and Welfare. (2007b). *Alcohol and other drug treatment services in Australia 2005–06: report on the National Minimum Data Set*. Drug Treatment Series no.7. Cat. no. HSE 53. Canberra: AIHW.

Begg, S., Vos, T., Barker, B., Stevenson, C., Stanley, L., & Lopez, A.D. (2007). The burden of disease and injury in Australia 2003. PHE 82. Canberra: AIHW.

Black, E. (2007, 15 October). *IDRS key findings: what has happened to the heroin market?* Paper presented at the 2007 National Drug Trends Conference, Sydney.

- Collins, D. J., & Lapsley, H. M. (2002). *Counting the Cost: Estimates of the social costs of drug abuse in 1998-99*. Canberra: Commonwealth of Australia.
- Degenhardt, L., Day, C., Gilmour, S., & Hall, W. (2006). The "lessons" of the Australian "heroin shortage". *Substance Abuse Treatment, Prevention, and Policy*, 1, 1-7.
- Degenhardt, L., & Roxburgh, A. (2007). *Accidental drug-induced deaths due to opioids in Australia, 2005*. Sydney: National Drug and Alcohol Research Centre.
- Douglas, J. (2007, 15 October). *Amphetamine-type stimulants in East Asia: the use of monitoring systems to inform strategic responses*. Paper presented at the 2007 National Drug Trends Conference, Sydney.
- MacKay, R. (2001). National Drug Policy: Australia. Prepared for the Senate Special Committee on Illegal Drugs. from [http://www.parl.gc.ca/37/1/parlbus/commbus/senate/Com-e/ille-e/library-e/robin-e.htm#C.%20%20Report%20on%20the%20National%20Drug%20Strategy%20\(1997\)](http://www.parl.gc.ca/37/1/parlbus/commbus/senate/Com-e/ille-e/library-e/robin-e.htm#C.%20%20Report%20on%20the%20National%20Drug%20Strategy%20(1997))
- Mathers, C., Vos, T., & Stevenson, C. (1999). *The burden of disease and injury in Australia*. AHIW cat. no. PHE 17 Canberra: AIHW.
- McKetin, R. (2007). Methamphetamine. In J. Ross (Ed.), *Illicit drug use in Australia: epidemiology, use patterns and associated harm* (2nd ed.). Canberra: Commonwealth of Australia.
- Moore, T. J. (2005). *Monograph No. 01: What is Australia's "drug budget"? The policy mix of illicit drug-related government spending in Australia*. DPMP Monograph Series. Fitzroy: Turning Point Alcohol and Drug Centre.
- Moore, T. J. (2007). *Monograph No. 14: Working estimates of the social costs per gram and per user for cannabis, cocaine, opiates and amphetamines*. Sydney: National Drug and Alcohol Research Centre.
- Mouzos, J., Hind, N., Smith, L., & Adams, K. (2007). *Drug use monitoring in Australia: 2006 annual report on drug use among police detainees*. Research and Public Policy Series No. 75. Canberra: Australian Institute of Criminology.
- Roche, A. (2005, 21-23 February). *Alcohol trends in Australia*. Paper presented at the Thinking drinking: achieving cultural change by 2020, Melbourne.
- United Nations Office on Drug Control and Crime. (2007). *2007 World Drug Report*. Vienna: United Nations.
- White, V. (2001). *Australian secondary students' use of over-the-counter and illicit substances in 1999*. Monograph series no. 46. Canberra: Commonwealth of Australia.
- White, V., & Hayman, J. (2006a). *Australian secondary school students' use of alcohol in 2005*. Monograph series no. 58. Canberra: Commonwealth Department of Health and Aged Care.
- White, V., & Hayman, J. (2006b). *Australian secondary school students' use of over-the-counter and illicit substances in 2005*. National Drug Strategy monograph series no. 60. Canberra: Australian Government Department of Health and Ageing.
- White, V., & Hayman, J. (2006c). *Smoking behaviours of Australian secondary students in 2005*. Monograph series no.59. Canberra: Commonwealth Department of Health and Ageing.

