DRUG POLICY MODELLING PROGRAM

MONOGRAPH 15

PRIORITY AREAS IN ILLICIT DRUG POLICY: PERSPECTIVES OF POLICY MAKERS

Alison Ritter
National Drug and Alcohol Research Centre

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THE DRUG MODELLING POLICY PROGRAM

This monograph forms part of the Drug Policy Modelling Program (DPMP) Monograph Series.

Drugs are a major social problem and are inextricably linked to the major socio-economic issues of our time. Our current drug policies are inadequate and governments are not getting the best returns on their investment. There are a number of reasons why: there is a lack of evidence upon which to base policies; the evidence that does exist is not necessarily analysed and used in policy decision-making; we do not have adequate approaches or models to help policy-makers make good decisions about dealing with drug problems; and drug policy is a highly complicated and politicised arena.

The aim of the Drug Policy Modelling Program (DPMP) is to create valuable new drug policy insights, ideas and interventions that will allow Australia to respond with alacrity and success to illicit drug use. DPMP addresses drug policy using a comprehensive approach, that includes consideration of law enforcement, prevention, treatment and harm reduction. The dynamic interaction between policy options is an essential component in understanding best investment in drug policy.

DPMP conducts rigorous research that provides independent, balanced, non-partisan policy analysis. The areas of work include: developing the evidence-base for policy; developing, implementing and evaluating dynamic policy-relevant models of drug issues; and studying policy-making processes in Australia.

Monographs in the series are:

01. What is Australia's "drug budget"? The policy mix of illicit drug-related government spending in Australia
02. Drug policy interventions: A comprehensive list and a review of classification schemes
03. Estimating the prevalence of problematic heroin use in Melbourne
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05. Drug law enforcement: the evidence
06. A systematic review of harm reduction
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08. A review of approaches to studying illicit drug markets
09. Heroin markets in Australia: Current understandings and future possibilities
10. Data sources on illicit drug use and harm in Australia
11. SimDrug: Exploring the complexity of heroin use in Melbourne
12. Popular culture and the prevention of illicit drug use: A pilot study of popular music and the acceptability of drugs
13. Scoping the potential uses of systems thinking in developing policy on illicit drugs

14. Working estimates of the social costs per gram and per user for cannabis, cocaine, opiates and amphetamines
15. Priority areas in illicit drug policy: Perspectives of policy makers

DPMP strives to generate new policies, new ways of making policy and new policy activity and evaluation. Ultimately our program of work aims to generate effective new illicit drug policy in Australia. I hope this Monograph contributes to Australian drug policy and that you find it informative and useful.

Alison Ritter
Director, DPMP

ACKNOWLEDGEMENTS

I am very grateful to all the policy makers who willingly made time for an interview amidst their busy schedules and shared their perceptions openly.

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INTRODUCTION

When faced with the opportunity to conduct policy-relevant research on illicit drugs, the most obvious question is: What are the current priorities? This project set out to identify the priority areas in illicit drugs from the perspective of government policy makers.

The impetus for the work was the second stage of the Drug Policy Modelling Program (DPMP), a research program aimed at improving the evidence-base for Australian drug policy. The identification of priority areas can inform the DPMP workplan for the next five years. Whilst the project had this overt purpose, the findings are also useful for a number of audiences other than the DPMP research team.

It will be of interest to funding bodies and committees that consider illicit drug policy – to review the extent of concordance between the priorities raised here by bureaucrats and those of their own funding body or committee.

It is also rich fodder for those seeking a relevant research topic – it will hopefully engage and excite a researcher or new student to pick up a drug-related research area.

Finally, it provides a snapshot of the state of play as at 2006 – hopefully in a few years time we will be able to tick off some of the areas, assess progress on relevant research, or review the extent to which priorities have changed over time.

A restricted definition of 'policy maker' was used here – government officials (bureaucrats) who develop and implement policy. This is not to imply that there are not others substantially influential in the "policy community" including practitioners and researchers, members of government advisory bodies, elected officials and other significant policy advice groups (such as the ANCD). Indeed, other exercises in establishing research priorities have frequently encompassed the research community or broader policy community. The choice to focus only on public servants was deliberate: policy making is core business for this group; theirs is a voice often not solely focussed on; and they are an important key stakeholder to the DPMP. It would be interesting to conduct a corollary study of the other members of the policy making community and assess the degree of similarity and difference from the views identified here.

The report focuses on illicit drugs, and excludes alcohol and tobacco. A few respondents noted that the licit drugs had a higher priority overall than the illicit drugs.

Australia has a good policy making track record in illicit drugs, with the use of evidence, solid processes within the structures and a number of important and unique features, such as the cooperation between health and police that make Australia stand out. This report identifies what is not known and problems associated with policy development processes, but should not be taken to be critical of current Australian drug policy.

METHODS

The senior drug policy bureaucrats were identified in health and police for the seven states/territories and the Commonwealth. The most senior bureaucrat was approached and in most instances agreed to participate in the interviews. Other team members were also interviewed based on advice from the jurisdictional seniors themselves.

A total of 39 interviews were completed with representation from every jurisdiction. The list of interviewees is provided at Appendix A.

Interviewees were asked open-ended questions about priority areas for illicit drug policy ("what do you see as the priority areas for policy over the next 5 to 10 years?"). They were also prompted to reflect on some of the more complex policy issues ("what are some of the outstanding puzzles?"). Interviewees were also asked about resources that they use in policy decision-making (the subject of a separate report).

The project was approved by the UNSW Ethics Committee. Interviews were conducted between 12th September and 29th November, 2006.

Extensive notes were taken during the interviews, and then written up as a record of interview. The responses from health bureaucrats were not differentiated from the police responses, rather all comments were pooled. A thematic analysis was then completed, merging like-comments together and the themes extracted. All comments made in the interviews were included. Any interpretation of the comments is the responsibility of the author.

RESULTS

The results have been clustered into three groups:

1. The 'usual suspects' – those priority areas that would not surprise;
2. The 'difficult conundrums' - areas where we have not made much evidentiary headway; and
3. The 'sacred cows' - priority areas that are difficult to raise or deal with in the usual settings.

Due to the unique nature of DPMP, where we have an opportunity to study the more complex policy problems, we have structured the results this way such that DPMP can focus on those 'difficult conundrums' and 'sacred cows' that may not be picked up through the usual research process.

Some readers may disagree with the relative characterisation into these three groups, and indeed, the report could be read as a simple list of priority areas. There is also some overlap between the topics listed under 'usual suspects' and those in the later sections, which tease out the more complex and difficult research issues.

Policy makers identified areas where further research was required. In some instances, this research has already been completed or is underway. Rather than editing these out, all the comments have been retained.

The 'usual suspects'

The top four priority areas were: methamphetamine; prevention; diversion; and cannabis. Many respondents also talked about mental health (comorbidity), data and information systems, drug treatment, return on investment, indigenous and remote communities, and law enforcement. After this, there were many other topics raised as priority areas for illicit drug policy: these have been listed together (under 'other').

Methamphetamine

This was the most commonly identified first priority area, unsurprising in light of recent media attention around crystal methamphetamine ("priority because everyone is talking about it"); the rising prevalence of methamphetamine use ("ATS the new whiskey of 2006"); and the potency and ease of use, leading to significant harms. Positive comments were made in relation to the substantial advances Australia was making in regard to precursor chemicals (use of third party policing to address problems of local production), alert systems, chemical equipment and consistent national and state scheduling for precursor chemicals.

A number of priority areas in relation to methamphetamine were identified. Firstly accurate data and information is required. In light of the extensive media interest and debate, respondents felt that we "need to get it [methamphetamine] back into perspective". There was a perceived need for greater clarity about the true extent of the problem. Some noted that methamphetamine was not a new occurrence and in some states there had been a stable (not rising) trend in methamphetamine use (notwithstanding peaks and troughs).

The priority areas for data and information included:

- Trends in methamphetamine use into the future – will it continue to grow? Or start to subside? Is there a growing cohort of young people using methamphetamine?
- Better understanding of initiation to methamphetamine use
- Better data on the demographics of users, and different types of users: recreational users versus regular injectors of anything injectable – diversity of users needing to be considered in policy responses
- Long-term effects of methamphetamine use
- High risk groups and their particular patterns of use and harms
- Patterns in route of administration – cycling through snorting, injecting and oral administration.

There were numerous mentions of the need for better research into methamphetamine market operations, including the priority areas of:

- Source of manufacture and production, regional patterns of production and importation, ports analysis
- Relationship between market movements of amphetamine-type stimulants and other drugs (for example groups that manufacture methamphetamine are also manufacturing other drugs)
- Changes in market operations, for example outlaw motorcycle gangs taking over security in nightclubs, leading to potential for market access

- Changes in market operations identifiable from changes in precursor chemicals (seizure data and informant information from arrestees)
- Local production of 'ice'.

Methamphetamine use has posed new challenges for policing and law enforcement; managing aggressive and violent intoxicated people, as well as challenges for supply reduction. Research on the dynamic relationship between effective local law enforcement and interdiction was noted.

The priority areas included:

- Dynamic relationship between domestic and international production - impact of greater enforcement of domestic production on importation? Can improvements in border interdiction lead to more clan labs and vice versa?
- Relationship between police seizures (local production) and treatment seeking?
- Place versus person – is there an evidence-base to inform policing about the relative focus on place versus person?
- Remediation of clandestine laboratories – where the work is dangerous and requires specialised skills to avoid occupational health and safety concerns. It has been unclear whether this is a police or other government agency responsibility
- Police custody – managing the intoxicated methamphetamine user
- Emergency services response options – managing violence on the streets (police and public safety).

Interventions in relation to methamphetamine span prevention (prior to commencement); early intervention and then effective treatment and harm reduction for regular or dependent methamphetamine users. Respondents talked of needing to be faster in developing and implementing new interventions, in "preparedness for a new flood of "ice". The need for an interim strategy whilst treatment "gets its act together" was noted. Other concerns included that there were insufficient treatment places, and police had limited options.

At the prevention end of the spectrum, respondents identified priority areas in public perceptions of methamphetamine. The need for a mass media campaign was raised by some and strongly questioned by others (an example of where the absence of evidence of effectiveness can result in polarised views). Some argued for focussed campaigns targeted towards users. A priority for effective interventions that change the social acceptability of methamphetamine use was identified.

Priority intervention areas included:

- Early interventions for methamphetamine
- Effective harm reduction options for methamphetamine users
- Cost-effective treatment options
- Interventions designed for high risk groups (a few respondents noted the possible need for 'non-drug' treatment facilities because methamphetamine users may be "put-off" by existing services and clients)
- Detoxification - Is it easy/hard? What detoxification interventions work?

- Methamphetamine and mental health – how do you intervene early and appropriately? Research into effectiveness of medications for management of drug-induced psychosis. Services coordination between drug treatment and mental health
- The potential role for the primary health care service system with methamphetamine? Respondents noted that GPs don't necessarily intervene well with illicit drug use amongst their patients, yet we continue to rely heavily upon the GP response.

There are a number of state and federal policy processes underway at present in relation to methamphetamine. The Ministerial Council on Drug Strategy (MCDS) has approved the development of a National Amphetamine-Type Stimulants Strategy and it is noted that the development of this Strategy will be modelled on the recently developed National Alcohol and Cannabis Strategies.

Prevention

Prevention was the second most commonly identified priority area. The most significant priority was the lack of a clear conceptual framework for prevention. Respondents spoke of the problem with the very broad definition of prevention. The prevention agenda is "amorphous" with a "lack of shared understanding". The priority area in this context was to undertake conceptual work to clarify and limit the scope of prevention. The implication was that 'prevention' has been defined too broadly, and the consequence is difficulty specifying the potential range of interventions that governments could apply in responding to prevention needs. (Those that did suggest a definition confined prevention to interventions that occur prior to the commencement of drug use).

Secondly, the poor evidence-base and the need for greater research demonstrating efficacy, effectiveness and returns on investment (cost-benefits, cost-effectiveness) was identified as a priority area. "We need a more compelling case for prevention".
Or as another respondent put it, given the significant focus on "prevention, returns on investment would be helpful!!". Studies on returns on investment would have the potential to guide policy makers in relation to "what to do more of, what to do less of, what to stop doing and what to optimise/improve on". Questions included:

- What are the most cost-effective interventions for young people before they commence drug use?
- Does peer-based education work better than other forms of drug education?
- Which models of drug education work the best?
- Research suggests that the community strengthening models have the most evidentiary support - is there an Australian-friendly operational model of this?
- If we can identify the children most likely to develop problems with drugs, can we then use this information to create an intervention?

Mass media campaigns were raised by many respondents, usually disparagingly. We currently lack an evidence-base on the effectiveness of such campaigns: the way in which mass media campaigns are 'evaluated' is from a marketing perspective (recall, retention), but not in relation to impact on behaviour. Given the size of the investment, a priority area is to conduct return on investment analyses of mass media campaigns. This is not without substantial methodological challenges (as noted in the section on measuring success under 'difficult conundrums'). Additional questions about campaigns included: would targeted mass communication be better?

Is there a way of harnessing new technology to direct the campaigns to "at risk" groups? Is social marketing a new way into effective prevention responses?

A final comment on the evidence-base for prevention: one respondent wondered whether the evidence-base was less influential in this policy area: "We do these things because they are good, feel right, not because we have the evidence". The comment highlights that part of the role of government in civil society is to warn the community, and that it is important to exercise this duty of care irrespective of whether the evidence suggests it changes people's behaviour.
The third major priority area in relation to prevention (following conceptual clarity and the evidence-base) was implementation of prevention interventions. "Risk and protective/resilience factors" was mentioned by many respondents, but respondents felt there could be much more work identifying what these mean for active government policy. Respondents noted that the research work was solid (i.e. we know the risk and protective factors). The priority now is to identify the blocks to effective intervention on risk and protective factors ("we know the answers but haven't implemented them").

Finally, respondents raised questions about responsibility for the prevention agenda and prevention interventions. For example: "What service system do we have for prevention/early intervention? The treatment system is not appropriate". One respondent gave the example of an anxious parent who finds a tablet: "which service system should they use; how accessible is it?" This implicitly raises the question about the appropriateness of the alcohol and drug treatment sector in the provision of prevention interventions. A number of respondents made the general point about lack of clarity regarding responsibility for the prevention agenda. Aside from clarifying who is responsible for prevention interventions, there is also the problem of dealing with boundaries in government (drug policy sits within health, not education. See later sections on structures for policy making and 'sacred cows').

One respondent sought return on investment studies comparing the different prevention providers (the A&D sector versus the non A&D sector); and furthermore how return on investment in prevention compares to that achieved with treatment interventions. The connection between the education and health systems was identified as a potential area for further traction in prevention. As succinctly put by one respondent: "their high risk kids are our drug users".

Diversion

There has been significant investment in diversion programs by the Commonwealth government, and investment in evaluation. Many respondents are awaiting the results of the evaluation of the national Illicit Drug Diversion Initiative, although some noted the complexities associated with the evaluation, including differences of opinion about the appropriate methodology, different forms of diversion programs and restrictions on available data. (This highlights the way in which the design and method for an evaluation can influence the nature and type of results, and hence its impact on policy).

Most respondents suggested that the evidence-base was largely absent, rather than negative but more importantly, some respondents queried whether the establishment of an evidence-base would then influence policy. The intuitive appeal of the program was noted – "no-one can be averse to not going before the courts", however the downside to such intuitive appeal is that the program is unlikely to be withdrawn if negative evidence was demonstrated.

The above comments notwithstanding, all respondents wanted a greater evidence-base around the effectiveness and cost-effectiveness of diversion programs. The types of priority research questions that were posed included:

- Does mandated treatment have different treatment outcomes from voluntary treatment? In all circumstances? In some circumstances? Accommodating different gradations of 'compulsory'? Given that all clients are coerced in some way, perhaps the treatment outcome cannot be attributed to diversion per se (need to measure other outcomes from the program).
- Is there an effectiveness difference between first versus repeat offenders?
- Can we demonstrate effectiveness of court diversion programs?
- What is the return on investment for diversion programs? Is it different for different types of programs?
- Does the effectiveness of diversion differ depending upon user (police can easily pick up more users to push through the system, but dealers, dealer-users, do they respond differently? Does the response need to differ?)
- Can the benefits to the program other than overt better outcomes for users (for example enhanced relationships between police and health services) be incorporated into evaluations/considerations of economic evaluations?
- Can the negative effects of diversion and any unintended consequences be built into evaluations and returns on investment studies?
- What is the potential array of treatments within diversion programs? Is there a best practice model for the interventions?
- Are there other models of diversion that should be pursued? For example alternate sentencing that defaults to prison if the person leaves treatment.

Policy makers see the benefits of diversion programs, and appreciate the complexities of evaluation in this area, but are keen to be informed by more complex research that can accommodate different programs, target groups and outcomes, and that includes analysis of returns on investment.

Cannabis

Cannabis has been the focus of recent policy developments, including developments from the Commonwealth (such as the new National Cannabis Strategy) and states (such as the introduction of decriminalisation models). A well-rounded cannabis strategy would include prevention, early intervention, tertiary treatment, law enforcement and harm reduction components, but it does seem hard to keep all these components in mind when thinking about cannabis policy options. As one respondent put it "we need a package of responses".

There seemed to be some ambivalence expressed by respondents about a focus on cannabis. On the one hand, some respondents questioned whether policy should focus on cannabis, in light of the relatively limited harms compared to other illicit drugs: is the investment on cannabis commensurate with the extent of harms caused by the drug? ("why so much focus on cannabis?"). On the other hand, some respondents noted that the mental health issues associated with cannabis use are now "beyond doubt" and "the gateway effect is being acknowledged".

In relation to prevention, priority areas mentioned included effective strategies to decrease the desirability of cannabis among young people, and strategies to decrease cannabis availability. In relation to early intervention, it was suggested that there may be much to learn from the tobacco control programs. Improving the 'reach' of early interventions, using systems and providers outside the traditional alcohol and drug service system was a priority area. A systematic review of the evidence-base for cannabis treatment outcomes was mentioned; along with the need for greater analysis of effective harm reduction measures.

At the national level, the Illicit Drug Diversion Initiative is seen to be an important response to cannabis use – the results in the section above on diversion therefore apply here in relation to cannabis diversion programs.

Models for cannabis legislation were raised by a small number of respondents, notably from those jurisdictions with recent legislative change. This was one area where responses varied: the majority of policy makers did not raise cannabis legislation as a priority area. For those that did, three were passionate; and one felt it did not deserve a priority. It is an interesting time in Australia regarding cannabis legislation. We have a number of states that have longstanding legislation regarding cannabis decriminalisation, and some states that are relatively newly embarking on legislative reform. Respondents who raised it as a priority area posed the following questions:

- What is the best policy for different jurisdictions?
- Is there a generic best practice position?
- How do you deal with community confusion?
- Is legislation required? (dejure vs defacto: police use discretion anyway, possible that same outcomes could be achieved through non-legislative reforms)?
- Are there negative effects of legislative reform?

A greater number of respondents raised issues in relation to the cannabis market. The changing nature of the cannabis industry was noted by a number of respondents ("criminal-organisation dominated supply versus the cottage industry"). Research on the cannabis market is important in assisting policy makers to make sensible, informed decisions about market interventions that will be responsive to future trends. The focus on hydroponics has driven the industry inside which has made detection harder and new harms have emerged (eg damage to rental properties/buildings). What is the impact of hydroponic cannabis and how does this market work (production, price, sales, growers, sellers, buyers)? Another research question was "Has the potency increased?"

Other priority areas in relation to cannabis that were mentioned by respondents included:

- Cannabis intoxication and driving
- Therapeutic use of cannabinoids
- Cannabis and psychosis – ongoing development of the evidence base. The need more dispassionate debate was noted by one.

Data and information

The desire for data and information that is better, more timely and of greater precision should not be of surprise in this list of the 'usual suspects' of policy research priorities. In fact, Australia

has a very good record relative to other countries in collecting and collating data on a regular basis from a varied group of respondents. In addition, data linkage represents some new possibilities for our sector. Policy makers are interested in improvements to Australian data and better tailoring of the data to their needs: "[we] need to connect collection with end-users, the policy makers".

The main point that was made by a number of respondents was the need to invest in data collections that were part of routine operations or practice (rather than specially designed surveys). It was felt that routine data collection systems would be able to better deal with some policy makers' needs in relation to early warning systems and provide advance notice of changing patterns of use. The challenges of using data collection systems that form part of routine practice were noted (it appears easier to fund a one-off survey than to fund a review of existing data collection, introduce new data points, and regularly extract and use the routinely collected data).

Another point linked to the use of routine data collections was the relationship between what is currently routinely collected and its use to inform interventions. A few respondents suggested that there should be better exchange of information and data between sources: "information exchange between areas is problematic". The need for Memoranda of Understanding and partnerships between policy units and research centres was noted as a priority. More controversially, it was suggested by two respondents that better exchange between health and police data at an individual level was a priority. The suggestion was that there is a wealth of information collected already (in clinical settings, in police settings) but that information is not combined to maximise our understanding of the current prevalence, incidence and harms. Taken a step further, if police could access clinical files, and match the information sources, the effectiveness of detection and arrest would rise. These issues are highly sensitive.

The need for methodological advances was noted by some respondents. These included:

- Better sampling, greater distinction between different types of users (user profiles, dealer-users profiles, trafficker profiles, polydrug use profiles)
- Rural and regional patterns versus metropolitan patterns
- Regional variations and state variations.

A number of other priority areas were raised:

- How do we detect new drugs and how do we model their distribution?
- How do new drugs penetrate the market, how are production skills taught/learnt?
- What are the prices and costs of drugs, and the concomitant levels of crime required to support drug use?
- Better research on lags and cycles in drug use would inform more tailored interventions
- Greater understanding of the international drivers behind drug production and supply would also be beneficial
- What are the predictors of an upswing in usage rates?

Advances in the data and information area require sustained (ongoing) funding – although it was only in this priority area that policy makers made specific mention of funding issues.

Mental health

The Commonwealth has identified comorbidity as a priority area, and unsurprisingly it was raised by many respondents as a priority area, with one respondent noting the "significant impact on family and community". The COAG Mental Health initiative may produce some new strategies for improving clinical and social/community outcomes for people with both a drug problem and a mental health disorder. Again we see a desire to focus on GPs – detection, screening, uptake and referral pathways, but this requires solid evaluation.

Respondents wanted good models for dual diagnosis service provision to be identified, including the different options for the organisation of services and the service system. "What is the effectiveness of different approaches to organising and delivering mental health and A&D services?" The cost-effectiveness or returns on investment for different models could also be explored.

There was interest in new models for police to work with mental health and drug treatment (the Memphis Model was mentioned). Options for police to intervene more effectively have increased in priority following the mental health and aggression problems associated with methamphetamine use.

Changes to Ministerial responsibilities (the creation of a new Minister for Mental Health and Substance Abuse in at least two states) were identified as a potential area for analysis of the strengths and weaknesses of this new ministerial model. This is discussed more fully below ('difficult conundrums' – structures for policy making).

Return on investment

Many respondents identified economic evaluation as a priority research area. This included analysis of returns on investment, cost-effectiveness, cost benefit analysis and cost savings analysis. The return on investment research on the Needle Syringe Program was cited as an example of the value of such research in providing an economic evidentiary basis for the intervention. And as said by another, the return on investment approach will enable us to "find out the things that are just not worth doing".

Some respondents suggested that all policy evaluations should include return on investment. The importance of methodological approaches was noted: more advanced cost information; the need for explicit assumptions; the use of published (public) cost data; the need for further foundational research on the aetiological fractions for crime and health events; and the need for analyses at a state and national level (noting that these may produce different results).

There was also sophisticated thinking about the limitations of return on investment – in the case of law enforcement, where reduction or cessation of drug use is not measurable, how do you measure effective outcomes? What can a return on investment approach help with? How can it apply when "the problem continues unabated"?

Comparative analyses were also identified as priority areas: as put succinctly by one "If you put X dollars into dealing with 'ice' versus the same amount of money into cannabis – this is what you get back". Comparisons across drug types were mentioned, as per the above example of crystal methamphetamine versus cannabis, as well as comparisons between interventions within domains, such as between two different prevention interventions. Finally, comparisons across interventions, for example comparing a law enforcement intervention with a prevention intervention were noted.

Another way of thinking about and using economic evaluation in drug policy analysis is to translate policy into the "language of Treasury". One respondent noted that the drugs area does not use "cost containment" language (unlike other areas of public policy). "We don't use this language to examine re-investments".

Treatment

Overall, the treatment arena has probably the strongest evidence-base, with return on investment analyses, good understanding of important elements and substantial outcome research. However, policy makers identified a number of priority areas in the treatment realm.

A key question was: "If we had $100 treatment dollars to spend, where should we spend it?"

There was a request to see more head-to-head trials of different interventions, including cost-benefit analyses. Comparisons noted by respondents included church-based versus therapeutic communities, and specialist versus office-based pharmacotherapy.

Respondents also noted that an Australian evidence-base was highly valuable in the policy making process. Even if we had overseas studies, one Australian study would have substantially more impact than multiple overseas ones.

Head-to-head trials from the clinical research tradition should also be complimented by more policy analysis of the treatment alternatives (broadening out the comparative criteria from merely efficacy and cost-effectiveness). The distinction between efficacy research (trial conditions) and effectiveness research (usual practice) is important in informing policy makers of the likely outcomes associated with 'real world' provision of treatment. Research conducted under clinical trial conditions often involves components that are not subsequently provided in the usual care models. There was a call for more evaluation of treatment models in practice, and return on investment studies on usual care. At present, we do not have a system for ongoing monitoring of treatment outcomes – a priority area for some respondents.

Pharmacotherapies research was also identified. The issue of patient co-payment and funding systems for pharmacotherapies was noted as a priority area by a number of respondents. We lack analyses of different models for funding and patient co-payment: the impact of patient co-payment on retention and outcomes; the ways in which co-payments can be reduced; the funding implications of this; and the various implications for different funding bodies; all offset by cost savings associated with different funding models. Other priority areas in pharmacotherapies included injectable opioids for maintenance treatment; defining mechanisms for optimum length of stay in pharmacotherapy treatment; analysing the benefits and risks associated with high reliance on GPs for pharmacotherapies; and diversion of pharmacotherapies.

Treatment models other than pharmacotherapies (counselling, withdrawal, therapeutic communities, supported accommodation) were not specifically mentioned but other generic issues in relation to drug treatment included:

- Treatment seeking processes – how do people come to treatment? When? Why? How do we engage reluctant treatment seekers? Or, indeed, should we?
- How do we improve access to treatment services?
- Are there other systems within which drug users present that could be tapped? (other than the usual suspects of hospital emergency departments etc.)

- How are "new buzz" treatments (for example naltrexone implants) best managed in the policy process?
- What processes do we need to revise and update clinical guidelines? One respondent mentioned that the stages of change theory is now apparently outmoded
- Currently treatment is "one size fits all". How do we improve treatment matching?
- How many people in treatment continue to use illicit drugs?
- Can treatment models from other countries be of assistance for Australia?

There were also a handful of respondents who raised some challenging questions about deservingness: "At what point do you give up on people?" Should we continue to invest in "frequent flyers"? And queries from policy makers about how treatment personnel select those eligible for treatment – the belief being that implicitly, treatment services do turn people away.

Finally, there is the bigger picture question about the nature of drug treatment itself. If a comprehensive approach (including housing, vocational training and so on) has the best outcomes, what are the implications for the currently specific and confined specialist drug treatment (withdrawal, pharmacotherapies, relapse prevention)? Related to this is the question of whether case workers rather than clinicians are a better investment. These issues are discussed further under 'difficult conundrums'.

Indigenous and remote communities

Drug use within indigenous and remote communities has shifted from a focus on alcohol, to increasing use of cannabis and some amphetamine-type stimulants. Petrol-sniffing continues to be a problem. Respondents responsible for indigenous and remote communities highlighted the importance of contextual factors in policy making: the dispersal of the population, poor integration between agencies in rural areas, difficulties with client privacy, and cultural norms.

Policy makers who identified indigenous issues as a priority area expressed considerable frustrations around the policy making processes. There were two threads to this: the link between social disadvantage and drug use; and difficulties in commonwealth and state relations.

Respondents argued that effective drug policy initiatives needed to be integrally linked to broader social policies. This creates significant challenges for cross-government coordination. The issue of social determinants of health is discussed under 'sacred cows'. Respondents acknowledged that reform was underway in indigenous affairs and the priority area is long-term analysis of the implications of this. As an aside, there was mention of the extent to which drugs are causal versus consequential to indigenous problems. Research could inform this issue.

Respondents noted a disjunction between state and federal policy processes. Federal government initiatives were noted but lacked coordination with the state level initiatives. The criteria associated with new funding initiatives (such as matched funds by the State; short-term one-off funding; not evidence-based interventions) creates substantial barriers for effective uptake and implementation by the states. As stated by one, there are "strings attached". Respondents were frustrated by the high degree of specificity associated with the funding. For example the federal government nominating specialist treatment, but local policy makers preferring to invest in primary health care services.

"At the policy level we are still paying lip service to remote communities". Issues unique to remote communities are also a priority area. Points made by respondents included: hidden drug use, large drug production sites, access to services and the need for more analysis of drug substitution in remote communities.

A quote from one respondent summarises the issues well:

> "[Indigenous and remote communities experience] greatest victimisation and requires the greatest amount of resources, yet it is marginalised, with poor analysis, throwing short-term money at the problem and quick fixes, and uncoordinated at the government level".

Drugs and crime and policing

Better strategies for reducing drug-related crime were identified as a priority area by many of the respondents. Respondents noted that this needed to be considered in the context of displacement: that we need to seek sustainable policing solutions that deal with displacement of the problem to other areas/locations. There was interest in exploring problem-oriented policing and community policing as models within the drugs area, as well as exploring whether strategies such as "broken windows" (arrest users, move on powers, clean up the area) were worth pursuing. A focus on recidivism (reoffending and reapprehension) was noted. Culture change in the police force was mentioned by a number of respondents, but interestingly no-one mentioned culture change in relation to health services.

One respondent drew a useful distinction between "hard end" policing (trafficking, organised crime, interdiction) and "public health end" policing (street-based policing, public amenity etc.). In relation to the former, respondents identified priority areas including: better interventions for interdiction, production and supply disruptions, and links to organised crime. In relation to the latter, priority areas included increasing the options available to police to respond to immediate crises (including intoxicated and violent people); road safety; and public order issues – behavioural street offences and street level drug dealing.

More research on effective interventions for trafficking and supply at all levels of the supply chain was called for. The social impact of crime, notably fear of crime, was noted by one respondent. Better evidence on the relative effectiveness of policing concentrated on person versus concentrated on location was noted. And more sophisticated law enforcement research that provided analysis of the impact of policing over and above simple counting of arrest numbers. Current law enforcement research has tended to be confined to police themselves. A number of policy makers recognised that the general scientific community could contribute substantially to a stronger law enforcement evidence base.

Other

Below is a list of the other priority areas raised during the course of the interviews.

Drugs and driving

Legislation has been passed or is being developed in a number of jurisdictions. A question was raised about the scientific evidence regarding drug testing measurement and relationship to impairment: "we seem to be jumping the gun on the evidence-base". Is it problematic that the policy implication appears to be ahead of the evidence base? Will the policy implementation be any different if it did have the science and analysis of effects? How do we measure success of the Roadside Drug Testing measure: reduction in road trauma; deterrent effect for drivers; unintended consequences? A cost-benefit analysis or return on investment analysis would be useful.

Neurobiological advances

Policy makers are aware of substantial developments in understanding the neurobiological basis of addiction, and the processes of brain development. How can this knowledge be used to develop new policy: what are the policy implications? How can we maximise the knowledge to make a difference in peoples lives? What do biochemical issues mean for models of addiction and recovery? Translation from science language to policy language is required.

Families and young people

Families need support and access to appropriate services. The tertiary treatment system is not appropriate for families if we are endeavouring to maximise the potential for families to intervene early. Are there good models of family-friendly services that sit outside the usual treatment framework? Should we have a separate youth policy? Are children automatically at risk if parents use drugs? A number of policy makers noted the new legislative developments in relation to injecting drug use and child protection issues.

Heroin

Respondents reminded us that heroin is not "off the streets" and that we should remain vigilant and continue improving policy responses in this area. The heroin shortage was also raised by some respondents as an area that requires further analysis: the causes and consequences appear to be still open for debate; and policy lessons have not been clearly drawn out of the experience. Likewise, we still have much to learn about heroin supply routes and the link to international geopolitics. Cross-substitution and associated harms (eg amphetamine, schedule 8's etc) is another priority area, along with ongoing research developments in the treatment arena.

Early intervention

Greater attention to early intervention was identified as a priority area. Respondents noted that tertiary services are not appropriate for the vast majority of people who use drugs: "we need to do early intervention much better". Creating supportive communities would help people move out of drug use earlier. "Families are the way in" according to another. Research questions included: How do we understand the transition between non-problematic and problematic drug use? What are the "tipping points"? What are the interventions and strategies that are effective at this point (transition point)? "What messages will be heard by this group"?

Misuse of pharmaceuticals

The issue of misuse of pharmaceuticals is moving higher up the policy agenda, and data indicate the concern is not misplaced (for example 25% of A&D clients in one state report getting prescription drugs as their major source of opiates). One respondent noted that people misusing pharmaceuticals were not presenting for treatment: anecdotally they appear to be seeking services from other places: homeless, mental health, acute and primary health providers – which raises the potential for interventions in these systems of care. The priority issues identified by respondents included:

- What are the markets and the drivers?
- How widespread is the problem? Are the current surveys tapping into the right sampling frame?
- How does existing policy in law enforcement and health add to/effect illicit use of licits?
- What types of treatment interventions are required? How do we manage these patients?
- Doctor shopping: what is the extent of the activity? How effective are the partnerships with AMA, health insurance funds? Is there capacity for legal action against doctors?
- Where is the national pharmacy database up to?

Criminal Justice System

A number of priority areas in relation to the Criminal Justice System were raised: What are the best interventions in the Criminal Justice System (CJS)? Does treatment within prison provide value for money? What is most effective way of dealing with illicit drugs in prison? What is best practice in relation to prison services (including treatment programs, harm reduction programs and supply reduction programs)? Pathways for treatment across the entire CJS were needed, and better understanding of how to match the treatment with offender needs at each point in the CJS. Outcome research (and longitudinal follow-up) of offenders through the CJS and post-release was identified as a priority area.

Injecting behaviour

Concern was expressed by one respondent that injecting behaviour has not received sufficient research and policy attention. Other respondents called for more research on transitions to injecting: what are the risk factors for becoming an injector? How can we intervene to reduce the likelihood of commencement of injecting? How can we intervene to reduce injecting behaviour once it has commenced?

New technologies

The role of the internet in supply of illicit drugs presents an opportunity to be ahead on this issue: "we need to think now from the policy perspective about supply from this route". Do we have enforcement models for this? Can the lessons from the high tech crime group on international fraud and pornography be applied to drug supply over the internet?

Use of technology was also raised to disseminate information in the prevention, harm reduction and treatment areas: You Tube, SMS, and the web present opportunities for policy makers. The advantages of using web-based interventions were noted by one: a web-based program can enable multiple people (users, families and others) to access information, support and interventions that can be tailored to their particular circumstances, as a result of the way the intervention is programmed.

Other

- Community attitudes – degree to which the community demonises drugs; importance of public perceptions
- Deterrent effect from effective mass media campaigns
- Balancing different needs: needs of the community to feel safe versus needs of drug users
- Chronic disease prevention – can we ride this wave?
- Drug testing in schools and workplace
- Chroming/inhalants: Looking for better solutions (police can't seize the substance because not illegal)
- Regulatory apparatus – regulated hydroponics, glasswares etc. (given success with precursor chemicals)
- Classifications of dangerousness of drugs – scheduling of drugs
- National grid for tablet identification
- Performance and Image Enhancing Drugs
- Information on other jurisdictions' policy responses.

The 'difficult conundrums'

There are seven priority areas classified here as "difficult conundrums". These are areas of research that require substantial intellectual and creative analysis in order to begin to deal with the issues (ie they are difficult). The first is the problem of measuring success, notably when success is defined as the absence of a future occurrence; the second is harm minimisation. The third and fourth are issues around services: service planning and service providers. The structures for policy making were raised as a priority, along with the need for more complex policy analysis/research. Some of these areas overlap with each other and similar issues and themes are drawn out even though the priority areas are discussed separately.

Measuring success

A number of themes were mentioned by respondents about measuring our success. Some reflected on a bigger picture, conceptual angst about the work; others reflected on methodological dilemmas.

On the big picture front, when one takes a step back from the day-to-day, there are questions about the overall success of drug policies. Given that drug use is a reality within society, and that patterns of drug use and harm are constantly changing, evolving but not decreasing, this creates the potential for anxiety about the overall purpose or end-goal of effective drug policy. Respondents asked: What are we trying to achieve? What are realistic goals? Does any of it matter? Are we making a difference with policy? Is there progress? "Is it merely holding the line – keeping it at bay?"

Another big picture issue was raised – we do not have agreed or shared outcomes across the sector or across the community. An example given was in relation to cost-effectiveness of methadone maintenance treatment: different members of the community (researchers, general public, patients, practitioners) may have different views about which benefits should be valued. Given the diversity of views and stakeholders to drug policy, the problem of contrasting notions of acceptable outcomes is unlikely to be resolvable.

Processes that undermine evaluation (eg policy change before evaluation results come out) were noted. Some programs have implicit goals (eg culture change in the police force) that are then not measured in the overt evaluation (because then these would have to be publicly acknowledged). In addition, new policies often do not have clearly identified scope and outcome expectations from the start – which means that you cannot evaluate the programs against the outcomes that were intended.

Finally, many respondents noted that indeed there was much evaluative activity in Australian drug policy and that this was a valuable and important part of the policy making processes, but raised the problem of the utility of an evaluation in the context of a well-established program with funding attached. The example given was the diversion initiative: "research suggests it has made no difference but this policy will continue because it's a good idea". In addition, jurisdictions would be reluctant to say no to a program that was funded by another source (in this example, the Commonwealth). The dilemma of stopping an ongoing policy may also apply to other priority areas, such as roadside drug testing, or cannabis legislation.

All the above indicates a level of sophisticated thinking and appreciation of the complexities in evaluation – which augurs well for our policy making environment.

Measuring success is usually framed as reduction in drug use or reduction in harms associated with drug use. This outcome metric works well for treatment and harm reduction, but less well for law enforcement and prevention.

Unsurprisingly therefore, the two specific areas mentioned that raise challenges for measuring success were prevention and law enforcement. There was agreement that both of these domains are priority areas for evaluation, but are noted for the difficulties associated with outcome evaluation. Policy makers noted that a return on investment approach used reduction or cessation of drug use as outcomes. Given that these are not readily specifiable for prevention and law enforcement (yet?) we might need proxy measures, which may then make comparative analyses (between treatment, prevention and law enforcement) biased. In both instances (prevention and law enforcement) we are seeking to measure the future absence of behaviour (deterred drug use).

In relation to prevention, research questions included:

- How do you measure delayed or deterred drug use?
- What metric(s) could be used?
- How confident would you be of the measurement?
- Can you conduct return on investment for prevention?
- What are the cost savings from one averted drug user?
- What does the benefit of prevention look like (quantifying the investment)?

In relation to law enforcement, respondents noted work by the AIC and NDLERF. As with prevention, the overall question was "how do we measure the deterrent effect of law enforcement?". Additionally, respondents noted that in law enforcement the measures of activity (for example arrests) are driven by multiple variables but do not necessarily relate to effectiveness. For example if one "key player" in the drug market was arrested, this may have major impact, compared to the arrest of 20 minor players, ie the number of arrests is not a good measure of impact.

In law enforcement the problem of displacement highlights the importance of defining the boundaries around the area of study – if it is a local area, it may be evaluated as successful, but if at regional level, less so. This raises the problem of where to set the 'boundary' for the evaluation (potentially it could be as wide as international if we understood displacement at a global level).

Another 'boundary' problem is the timeframe for measurement of outcomes. For treatment it is usually within 12 months of the intervention, for prevention it needs to be many years down the track. Likewise for law enforcement's deterrent effect, a timescale of many years is required.

In conclusion, there is considerable scope for development of methods and explication of some of the difficult issues in measuring success across different intervention types. Conceptual advancement in the methods can then lead to comparative analyses for prevention and law enforcement (along with treatment and harm reduction).

Harm minimisation

Relative to other countries, Australia is applauded for its harm minimisation approach.

> "Law enforcement has done very well with harm reduction".
>
> "Cops at street level have embraced harm reduction".

But there continues to be significant tensions within the harm minimisation approach: policy makers noted that conceptual confusion continues (deliberately placed to avoid debate?) and tension between levels of government exist (reconciling zero tolerance and harm minimisation). There were musings about where the tension came from, with suggestions that it is not between federal and state governments, but rather a media agenda; another suggestion was that states were becoming more restrictive and "draconian" in their approach to drug policy (examples were given) and competition between the states has encouraged this move away from harm minimisation approaches.

At one level the issues around harm minimisation seem more about perception and politics than policy making, however some respondents did suggest that it impacts upon policy making. As posed by one policy maker: "can we have a government-sanctioned program that is about pill-testing"? implying that government support for a harm reduction intervention would be problematic in that jurisdiction at this time.

Furthermore policy makers are vexed by the need for complex messages – for example that drug use is harmful and an offence but there are ways to reduce harms. As noted by one respondent, there are significant differences between tobacco and illicit drug prevention, where tobacco prevention can say "there is no safe levels of consumption" but this seems much more difficult to say about illicit drugs (perhaps because of the evidence-base?).

The priority area is the establishment of a stronger and clearer evidence-base in relation to the influence/impact of overarching frameworks, and clear analysis of the costs and benefits associated with zero tolerance and harm minimisation policies.

Service planning and funding

In the service planning and funding area, the focus by respondents was largely on tertiary treatment services, but the priority areas identified here apply equally to other services within illicit drugs, such as prevention and early intervention services and harm reduction services.

The methods for estimating demand for treatment are surprisingly unsophisticated. "We still don't know how to estimate demand for treatment". Respondents noted that research should be able to provide better guidance about the numbers of different types of treatment services that would be required. There is a significant gap between estimates of the prevalence of illicit drug use and the numbers seeking treatment; it is possible that people are accessing other services or service systems, or that the number of people who cease drug use without formal help is large. Greater analysis of the relationships between demand for treatment and supply of treatment was called for.

Another priority area in the service planning arena was in relation to purchasing services – both funding formulae and benchmarks were noted as lacking, especially in comparison with acute health services. "[There are] agreed benchmarks on all sorts of things in acute care – we have none". In addition, services do not have efficiency and effectiveness performance targets.

The role of the commonwealth vis-à-vis the states in funding services was noted by many respondents (this priority area is linked to the structural issues discussed later). There is currently a perception of "disintegrated treatment funding" with the lack of integration between federal and state funding. Respondents spoke of various frustrations, including that "NGO services that are commonwealth funded don't talk to 'us'"; and implications for clients' continuity of care, for service planning, for review of state government performance and for treatment outcomes.

There are two other contrasting funding dilemmas: NGO versus government treatment services – which is handled here; and specialist versus generalist services – which is handled in the next section on service providers.

Government policy (purchaser-provider split; 'more steering less rowing') has led to the development of a significant non-government treatment service system in Australia. Jurisdictions differ in the extent of NGO service provision (creating the possibility for comparative analyses?) but in the main, the non-government sector has become a major provider of services. This has raised a number of research questions.

Analysis of the government policy approach is much broader than illicit drug policy. If that is put to one side, the research priorities centre on the relative merits of NGO versus government sector service provision. Questions about corporate and clinical governance; the importance or otherwise of professional clinical qualifications in client outcomes; and the potential downstream implications of a continued competitive tendering approach ("race to the bottom") were all raised by respondents. Other questions included:

- Has NGO service provision been evaluated in terms of the outcomes for clients?
- What are the differences (in performance and outcome) between NGO providers and government/state providers? (Do they manage different clients, are they differentially effective, are they differentially cost-effective?)
- How much do clinical qualifications contribute to superior treatment outcomes?
- How is Quality Assurance managed in the NGO sector?
- Who is the best sector? How do you decide?
- What are the criteria for judging the balance between the two systems of care?
- If something goes wrong, what protections are there?

Another difficult area is the ideal of a "seamless service system". Continuity of care from the clients' viewpoint is lacking – they experience a "chopped up" set of services, being passed on at various points. It is probable that a single clinician seeing them through from first presentation via withdrawal, maintenance treatment, residential rehabilitation, relapse prevention counselling and ongoing after care follow-up, may produce better outcomes. Services are not structured in such a way to enable this kind of clinician-continuity. Research into the structure of services, including the different service types and providers was raised as a priority area.

Service providers

The above quest for research on the evidence-base for government versus non-government service provision is mirrored in the need for research to examine the provision of interventions by a specialist versus generalist service system. Given a finite pool of resources, bureaucrats need to decide the best investment mix between specialist dug treatment and generalist welfare support services. This is confounded by the reality (and restriction) of government departmental boundaries – bureaucrats are unlikely to choose to fund services outside their own departmental border. This may account for the continued funding of specialist drug treatment services over more generic interventions (such as housing, employment services). But beneath these practicalities, there is an evidence-based question: What level of specialisation is required to produce good clinical outcomes?

Youth outreach workers were raised as one example of some of the dilemmas between a specialist versus generalist role. Is there a unique youth *drug* outreach worker role that is distinct from a generic youth outreach worker role? Are there differences in clinical outcomes between a youth *drug* outreach worker and a youth outreach worker? Who should fund these? What is the better investment for drug treatment bureaucrats? As stated by one: "where [do you] draw the line between drug-funded versus generic-funded?" One of the implied concerns about generalist services is that they are of a lower quality than specialist services (although there is not an evidence-base to inform this in relation to drug interventions). One respondent thus noted the importance of ensuring that our drug clients are perceived as deserving: "if we assume that all A&D clients are 'deserving', then they should receive the highest quality of care".

The questions posed did not suggest that it should be all one or all the other, but rather analysis of the best investment mix between specialist and generalist services was needed. Again, on the balance issue, respondents asked to what extent has the establishment of a 'specialist' service system been advantageous (expertise/knowledge/skills) versus disadvantageous (lack of systems view, less flexibility)?

A number of other priority areas were raised by respondents in the area of service providers:

- Recruiting, retaining, training and maintaining flexibility of skills to deal with new problems
- Improving clinicians' use of evidence-based practices
- What level of specialisation is required? What competence is required for the interventions? Can the same outcomes be achieved with generalists rather than specialists? Does this map against the distinction between government and non-government service provision?
- Does service accreditation improve service delivery and hence improve clinical outcomes? At what cost?

Structures for policy making

This priority area covered jurisdictional structures around drug policy, the more general problem of federalism in relation to health care in Australia, and the structures for policy decision-making.

The drug policy agenda appears to be driven from the MCDS, IGCD, jurisdictions and bodies such as the ANCD. Structurally, health bureaucracies dominate. The models vary between jurisdictions – for example in South Australia the policy unit is embedded within the government service delivery and research functions, compared with other states where service delivery is entirely outsourced and independent from the policy unit.

Almost every jurisdiction was undergoing some form of restructure at the time the interviews took place. This included changes to the bureaucracy (establishment or dissolution of a cross-government policy unit); and at the political level (changes to Ministers responsible for illicit drugs).

It does appear that there has been a shift away from the placement of the drugs portfolio within Premiers Departments, and a return to models where the health bureaucracy takes responsibility for drug policy.

All jurisdictions have "coordinating committees" which cover all the major portfolios (education, health, police, justice, etc). But there was some suggestion that these bodies are largely communication mechanisms rather than drivers of policy initiatives.

Changes in Ministerial structure were noted by respondents: the merging of Mental Health and Substance Abuse portfolio's raised questions about how to maintain a whole of government perspective, how to ensure equal status between mental health and substance abuse and how to continue a breadth of focus that includes prevention and law enforcement.

The relationship between the commonwealth and the states vis-à-vis drug policy was raised. One respondent suggested that the Commonwealth was in two minds about its role: agenda-setting and big picture policy development versus funding grassroots programs. The capacity for the commonwealth to have a direct influence and in some cases override state-based drug policy was also noted.

All the above raise some interesting research questions:

- Where is illicit drug policy best placed in the political structures?
- What is the preferred relationship between the commonwealth and the states vis-à-vis drug policy?
- Where is illicit drug policy best placed in the bureaucracy (Health, Premiers, AG's or other Departments)?
- And, does it matter? Does structure (political or bureaucratic) have an impact on policy implementation and outcomes in terms of drug use, harms and interventions?

Policy analysis – need for more complexity

All of the priority areas identified here point to the need for more policy analytic research. Respondents also made explicit comment about the need for greater and more complex analytic research.

One pertinent example is the issue of polydrug use. At present, policies look at substances in isolation (eg petrol sniffing), yet polydrug use is the norm and we cannot and should not develop policy for one drug in isolation. The problem is confounded by the fact that frequently funding comes through for a particular drug. Respondents noted the need for better analysis of what polydrug use means for prevention and treatment services; analysis of the ways in which prevention or law enforcement responses targeted at a single drug impacts on other drug types; and overall policy interventions for polydrug users.

Another example of the need for more complex analyses, as noted by one respondent, is asset forfeiture. Asset forfeiture is a police intervention, where police can seize the assets of an offender, post-conviction. The performance measure is usually the money received from the assets, but this is not necessarily the best outcome measure. So for example if a car is worth less than $5,000 the police won't seize it because the cost associated with the seizure is greater than the asset from the police perspective. But this might be precisely the user profile where forfeiture has the biggest impact on behaviour change.

A final example raised by respondents is in the area of cannabis policy. A recent initiative is the $12m Cannabis Centre. Respondents asked: "is this the best thing to spend the money on"? Would a return on investment analysis assist policy makers? Given the existing investment in cannabis diversion programs, how will the two initiatives interact? When should one policy be abandoned?

There was interest in greater analysis of unintended consequences of different policy options and the iatrogenic impact of some policy choices. Unfortunately potential negative consequences of policy options are often raised negatively and interpreted as red herrings or 'nay saying'. Avoiding this reactionary response and conducting systematic objective analysis of potential consequences would be valuable.

The timeliness of such policy analysis was also noted: "I bet the problem goes away before we have the solution"; "the cycle changes before you have the answer".

The 'sacred cows'

During the course of the interviews, policy makers demonstrated their extreme thoughtfulness and intelligence about some of the more taboo and complex topics in drug policy. I was privileged that the policy makers spoke frankly about some of these things. Here I have drawn together the taboo issues that were raised during the interviews. Instead of dividing them up into discrete sections, they are discussed together, and the 'sacred cow' questions posed in italics along the way.

There is much to be proud of in Australia drug policy. In particular, we are internationally recognised for our balanced approach between law enforcement, treatment, harm reduction and prevention. Without taking away from that deserved acknowledgement, what is the evidence base for a balance? Is a balance really the best thing? At what point do you reach a balance between law enforcement, prevention, treatment and harm reduction? How do you know and how do you measure these things? Are there alternate assumptions other than balance that should be explored?

Question: Is the goal of a balance of elements appropriate? What should that balance be?

Following on from questioning the presumption of balance as a good policy approach, research to date has not analysed the implications and outcomes from focussing solely on one intervention type. For example, if we assumed a natural and self-limiting level of drug use, and invested solely in treatment and no law enforcement – what would be the result?

Question: What are the costs and benefits associated with focussing policy on one domain (treatment, law enforcement, prevention)?

There is strong rhetoric about 'whole of government', 'partnerships', 'collaboration and integration'. This acknowledges that drug problems occur and should be responded to across the whole system, that artificial boundaries (between funding systems, between specialisations) stand in the way of potentially advancing outcomes and reducing harms. "Community strengthening" is another catch cry – which alludes to the broader social, welfare and economic issues for which drug use is arguably a symptom.

This whole of government, community strengthening rhetoric raises some significant issues:

- Drug policy is isolated
- Drug policy is not seen to be integrative across agencies, whole of communities.
- Different ideologies from other sectors may create barriers
- There is a lack of understanding of what 'whole of government' means in practice

- Key principles are documented, but not translated into effective practice
- "All this means at present is a single meeting".

Question: How can we implement effective 'whole of government' policies?

Linked to the 'whole of government' rhetoric is recognition of the importance of a social determinants of health framework. Indeed, almost all respondents at some point in the interview mentioned social or structural determinants of health, or the risk and resilience framework, so it is clearly in the minds of policy makers. We have a demonstrably strong evidence-base but significant difficulty with establishing effective policy.

Policy makers noted that social determinants of health need to be considered as part of drug policy, that the interface between drug policy and policies in other areas was crucial, and that implementing good policy requires you to work very broadly – across agencies / government departments, and consider all the policy levers.

However, it seems completely unclear how to move forward on this as a policy initiative. That drug policy is at least to some extent an artefact of social policy was noted and some teasing out of this from the policy perspective would be useful.

One respondent suggested that the problem arises because of the focus on health: as argued by this person, drug problems are perceived to be "fixed" by increasing treatment and other direct health service provision to users. Because health predominates in this way, it reinforces the treatment solution, which reinforces that it is health focussed. Hence it is hard to shift out of this and move to a social determinants focus.

Question: What would real policy using a social determinants of health framework look like? What would we invest in? How can we overcome the funding boundaries?

Structures and power-base were themes identified for these issues. The structures for decision-making do not accommodate 'whole of government' or community strengthening approaches. The funding and power base is largely in health – and as a result, policy making concentrates effort in the health, tertiary end of the spectrum. Arguable this is because drug policy exerts little power over the agencies and structures that could be responsible for broader policies (eg: Treasury).

Question: Is the threat of being dissolved or replaced by new structures and power-bases standing in the way of innovative drug policy?

"Risk and protective/resilience factors" were mentioned by many respondents, but it is not clear what these mean for active government policy. What are the stumbling blocks to effective intervention on risk and protective factors? Is it because they are too broad, too big? Do issues of civil liberties, that are multiple and complex, need to be resolved? Again, is it because initiatives that address risk and protective factors don't involve the usual structures for drug policy (but other parts of government such as Treasury, economic policy, employment services etc)?

Question: How do we get traction on policies arising from the evidence-base regarding risk and protective factors?

Lastly, some respondents commented on the policy making structures in Australia. Again, it is important to recognise the significant strengths within the intergovernmental committee approach that combines both health and police elements. At the same time, it was suggested by two respondents that the consensus approach does not lead to innovations, rather only to that which can be agreed to. It was suggested that major debates are avoided - potentially for strategic reasons – but that this may mean that we have less opportunity for chaos to produce a new unique equilibrium.

Question: Do our policy processes err towards a compromise, and result in lowest common denominator decision-making?

CONCLUDING COMMENTS

This report has documented the priority areas identified by Australian bureaucrats responsible for drug policy across the country. Many priority areas were identified, including specific research questions on individual drugs; the call for new methods and comparative analyses; questions about the structures of services; and policy decision making.

Not all the issues and priority areas raised lend themselves to being resolved through the provision of evidence. Indeed, policy making processes use research evidence as only one part of the overall decision making process. Hence it should be clear that some of the priority areas require ethical and community debate as much as they require evidentiary work.

One potential criticism of the project is that the respondents were all bureaucrats, albeit in positions of influence and authority for policy making across all jurisdictions of Australia. It is unusual to focus solely on this group but it does generate an interesting set of priority areas, with a greater relevance and focus for the bureaucracy. This should not be taken to suggest that there are not other influential players in policy making in Australia (academics, research experts, lobby groups) and of course politicians. One interesting exercise may be to repeat the interviews with these other groups and look for convergence or divergence of views.

APPENDIX A: RESPONDENTS

Silvia Alberti
Manager, Drugs Policy and Services
Department of Human Services, Victoria

Robert Ali
Director, Clinical Policy and Research
Drug & Alcohol Services Council, South Australia

Steve Anstis
Senior Advisor, Prevention
Alcohol, Tobacco & Other Drugs Unit
Queensland Health

Chrys Athanasos
Centre, Research, Data & International Section
Drug Strategy Branch, Department of Health and Ageing
Commonwealth Government

Melanie Bettenay
Consultant
Government of Western Australia

Tony Biggin, Detective Superintendent
Covert Support Division
Victoria Police

Stephen Biggs
Manager, Drug Programs and Support Projects
Tasmania Police

Myra Browne
Manager, Policy, Strategy and Information
Drug and Alcohol Office
Government of Western Australia

David Clements
Executive Officer
Alcohol, Tobacco & Other Drugs Council of Tasmania (ATDC)

Shane Connelly, Commander
Deputy Chief Police Officer, Investigations & Support ACT Policing
Australian Federal Police

Katrina Currie
Co-Manager, Strategy Group
Drug Policy Branch
Department of Human Services, Victoria

Helene Delany
Manager, Alcohol & Drug Policy Unit
ACT Health

Sylvia Engels
Program Manager, Alcohol & Drug Services
Statewide Specialists Services
Department of Health and Human Services, Tasmania

Keith Evans
Executive Director
Drug and Alcohol Services, South Australia

Scott Feeney, Senior Sergeant
Senior Project Officer, Drug & Alcohol Coordination
Operations Support Command
Queensland Police Service

Peter Fielding
Acting Regional Manager
Alcohol & Drug Services (South), Tasmania

Robin Fisher
Manager, Drug Treatment and Health Protection Services
Department of Human Services, Victoria

Frank Hansen, Superintendent
Manager, State Crime Command
Drug & Alcohol Coordination
NSW Police

Virginia Hart
Assistant Secretary
Drug Strategy Branch, Department of Health and Ageing
Commonwealth Government

Amelie Hunter
Victoria Police

Jack Johnston, Deputy Commissioner
Tasmania Police

Gary Kirby
Director, Prevention and Practice Development
Drug and Alcohol Office
Government of Western Australia

Kevin Lambkin
Director, Alcohol, Tobacco & Other Drugs Unit
QLD Health

Peter Mansfield, Inspector
Drug & Alcohol Coordination, Operations Support Command
Queensland Police Service

David McGrath
Director, Mental Health and Drug and Alcohol Programs
NSW Health

Jim Migro, Superintendent
Metropolitan Regional Coordinator
Western Australia Police Service

Terry Murphy
Acting Executive Director, Drug & Alcohol Office
Government of Western Australia

Mark Payne, Assistant Commissioner
Operations
NT Police

Karen Price
Director, Centre, Research, Data & International Section
Drug Strategy Branch, Department of Health and Ageing
Commonwealth Government

Linda Rigby
Assistant Director, Illicit Drugs Section – Emerging Trends and Comorbidity
Drug Strategy Branch, Department of Health and Ageing
Commonwealth Government

Jann Smith
Team Leader, Alcohol & Drug Services (South)
Department of Health and Human Services, Tasmania

Paul Smith
Director, Drugs Policy & Services
Department of Human Services, Victoria

Wendy Steendam, Detective Superintendent
Crime Department, Victoria Police

Ian Thompson
Executive Director, Health Policy
ACT Health

Irene Tomaszewski
Manager, Drugs Policy Group
Department of Human Services, Victoria

Joanne Townsend
Director, Alcohol and Other Drugs Program
Department of Health and Community Services
Northern Territory

Allan Trifonoff
Senior Project Officer, Drug & Alcohol Policy Section
South Australia Police

Mark West
Program Manager, Services Development
Alcohol, Tobacco & Other Drugs Unit
Queensland Health

Bruce Wight
Director, Illicit Drugs – Partnerships & Treatment Section
Drug Strategy Branch, Department of Health and Ageing
Commonwealth Government