



drug policy

the Australian approach

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Executive summary

In the drug policy arena, we often talk about an Australian approach to drug policy. But do we really know what the Australian approach is? The idea that Australia has a national identity is a simplification of the complexity that goes with being Australian. Likewise the suggestion that there is an Australian approach belies the complexity of the way drug policy is made.

Nevertheless, many who have participated in drug policy debates nationally and internationally refer to the pragmatism and balance inherent in the Australian approach. Indeed, our National Drug Strategy (NDS), in each of its permutations over its 15-year life, has identified key philosophies underpinning the Australian approach: balance, harm minimisation, evidence-based practice, integration, social justice, and coordination.

This report aims to document the Australian approach to drug policy making. Particular emphasis will be placed on:

- providing evidence for and examples of Australia's approach;
- identifying the conceptual and philosophical shifts and influences on drug policies and programs; and
- analysing the strengths and possible weaknesses of the approach.

In each jurisdiction data were assembled relating to:

- the historical development of State, Territory and local government drug policy;
- the advisory structures and funding mechanisms;
- outcome indicators according to the existing literature; and
- an audit of the current partnerships.

As part of the jurisdictional consultations, we collected data on policy maker experiences of partnerships in drug strategy; accounts of projects that could serve as examples of successes or failures of the current approach; and data that verified the interpretations of existing outcome indicator data.

Through interviews and focus groups with those in the policy community we generated themes that encapsulated the Australian approach to drug policy making. These themes were expressed to different extents in each jurisdiction. They enabled us to describe the Australian approach in terms derived from the interviews we conducted. This process is closely akin to what is known as inductive analysis. These themes reflect the values of the drug policy community.

Our description of the Australian approach to drug policy and practice is structured around the themes of: *tolerance; the good sense of bureaucracy; independence; frank and fearless advice; checks and balances; and leading the community.*

The Australian approach

During consultations with policy practitioners, it became apparent that the original conceptualisation of partnerships in the Australian approach required greater sophistication. The term ‘partnership’ did not adequately describe the breadth of relationships that constituted the activities of those involved in drug policy making.

Partnerships in Australian drug policy are connections between governments, people, ideas and institutions. Partnerships between the Commonwealth and its States and Territories have been a feature in Australian drug policy history since 1925. In all but a few areas of government, governance of drug policy is shared across different government levels. Health, law enforcement, community services, education, and employment and training all require coordinated action between the Commonwealth and the State and Territory governments. Managing drug problems requires partnerships between all levels of government.

Since 1996 Australia has had a National Public Health Partnership between the Federal Government and its States and Territories. This partnership aims to improve collaboration; develop better coordination and sustainability; strengthen infrastructure; and facilitate two-way connections between key professional, community, consumer, educational and industry interests in the development of national public health priorities and strategies (NPHP 2000).

These connections are similar to the connections found in a community. The policy community provides an overarching example of partnerships.

To be more specific about the types of relationships in the sector, the policy community can be analysed in more detail. The system of financial and advisory structures that supports the policy community is overlaid by a policy framework, a set of words that establishes a common language for members of the community.

The Australian approach is described by three key concepts: the *policy community*; the *system of financial and advisory structures*; and the *policy framework*.

The policy community

Bringing people together and mobilising support is a key feature of the Australian approach. What sustains this approach is the community of policy makers who participate in the national drug policy community.

The national drug policy community is constituted through the policy communities in each jurisdiction. These communities may overlap and cover different States and Territories and, like communities more generally, they have fluid boundaries across different policy arenas. For example, mapping the networks of interest of policy bureaucrats in different States produces an intriguing map of a policy community that extends across the nation over several decades. Often policy professionals working in one jurisdiction have worked in other jurisdictions and have substantial professional networks that provide both stability and an institutional memory. Thus the policy community in one State or Territory can have intimate and long-term links with the policy community in other States and the Commonwealth.

The policy community carries with it the history and the values underpinning the Australian approach. Many of those we interviewed reflected on the values of the community. The values of this community are expressed in the six themes that have structured our description: *independence; a diversity of voices; the good sense of bureaucracy; frank and fearless advice; checks and balances; and leading the community.*

The system underpinning the policy community

Having participated in a relatively stable system overlaid by changing rhetorical frameworks, many interviewees distinguished between the system (of advisory structures and funding arrangements) and the policy framework (the policy rhetoric dominant at any particular time). We believe that this distinction is a useful way of thinking about the Australian approach.

The drug policy framework

The policy community, like any community, shares a common language. Our policy framework establishes the policy community's common language. Without a consensus about the meaning of key terms, the community can lose coherence, purpose and effectiveness.

In contrast to the system underpinning the policy community, the drug policy framework (the rhetorical framework) is subject to greater change. Since the redefinition of harm minimisation in the last National Drug Strategy, our common language has splintered. While the policy community and the system underpinning it have successfully established themselves, the policy framework is not perceived to be so stable.

There have been a number of alternative drug policy frameworks proposed based on different rhetorical positions. One such framework discussed by many during the course of the study is the prevention framework. Given the disquiet over the capacity of harm minimisation to bring people together, a number of groups suggested that discussion should centre on a new framework based on the broad strategy of prevention of harm and drug use.

One characteristic of the Australian approach has been the adoption of a policy framework that can bring people together. Whether the framework is harm reduction, harm minimisation, prevention or another policy framework, it must be able to unite people.

Challenges and achievements

The achievements of the Australian approach are many.

- Population use of licit drugs (alcohol and tobacco) has decreased between 1988 and 1998.
- The overall per capita consumption of alcohol has fallen from an average of 9 litres per person in 1985–86 to 7.6 litres per person in 1997–98. However, in the period 1993–98, more females than males consumed alcohol at hazardous and harmful levels.
- The amount spent on alcohol as a proportion of total household expenditure on goods and services has decreased from 3.4 per cent in 1984 to 2.9 per cent in 1998–99 (AIHW 2000).
- In 1998, 22 per cent of the adult population were regular tobacco smokers, down from 24 per cent in 1995 (AIHW 1999).

- In terms of its per capita cigarette consumption, Australia was ranked 8th in 1986, and 17th in 1996 (AIHW 2000).
- Australian initiatives regarding HIV prevention, extensive treatment and innovative practical research are internationally recognised.
- One in four injecting drug users in the United States is infected with HIV, whereas fewer than three in 100 injecting drug users in Australia are infected with HIV.
- Australia has a treatment system in which each year thousands of individuals receive help in their struggle to deal with their addiction.

The central challenges for the Australian drug policy community are to retain consensus on the value and key character of the Australian approach and to sustain a commitment to its key elements.

Independence

Clearly State and Territory independence is necessary in the National Drug Strategy. But independence is a two-edged sword. A key achievement of the Australian approach has been to balance the independent needs of the States and Territories with the need for a national approach. However, there is a constant tension in the Australian approach and a constant challenge to ensure that uniform national strategies respect individual and independent jurisdictional differences.

A diversity of voices

Maintaining the capacity to tolerate a diversity of voices in the policy community is the most significant challenge for the Australian approach. Partnerships illustrate an essential part of the Australian approach through sustaining a diversity of voices. The challenge for the future will be to sustain that diversity in a changing partnership. Non-government organisations have a role in sustaining the diversity of views in the Australian approach.

The good sense of bureaucracy

There is a central place for bureaucracy in maintaining the system that underpins policy making. The good sense of bureaucracy refers to both the good sense inherent in a bureaucracy replete with committed individuals, and the good sense to have a bureaucracy to enshrine the role of government in the drug policy process. As the demands of the system of policy making have become more complex, so too has the network of advisory structures. The good sense of bureaucracy must be tempered with the need to maintain simplicity in the system. The complex web of national advisory committees at times provides a daunting prospect for the members of the policy community.

The network of advisory structures cannot continue to grow and become more complex and more difficult to manage. As much as the complex system provides stability, it may also become an impediment to innovation. The good sense of bureaucracy needs to be tempered and balanced with the good sense of the broader community.

Frank and fearless advice

The capacity to provide frank and fearless advice varies across the different Australian jurisdictions. Nevertheless, it was a theme that policy practitioners reiterated as being a prime achievement and central value of the Australian approach. Managing the impacts of frank advice for bureaucrats is a constant difficulty. For drug policy advocates, strategising through the provision of advice is a full-time job.

Having the capacity to be frank and fearless in debate is a necessary part of the activities of the policy community, and one that should be fostered.

The community is fundamentally challenged when drug users frankly state their case. Disclosing one's life as a drug user is perhaps an act few would choose in the current social climate. The Australian approach of including drug users in the policy community continues to be an achievement. It will also continue to challenge discriminatory community beliefs about drug use.

Another particularly important source of frank and fearless advice can be found in the activities of the Alcohol and Drug Council of Australia (ADCA). From its 'No Quick Fix' evaluation through to the most recent policy document, the ADCA has focused on accountability by monitoring income and expenditure in each jurisdiction. A constant tension for the ADCA is its proximity to the system of advisory structures in the National Drug Strategy.

Checks and balances

Checks and balances are sustained through a continued dialogue between service providers, the government and the community about the nature and level of funding for services. One characteristic noted in interviews was the perception that the purchaser/provider framework made it more difficult for service providers to maintain the checks and balances in policies and funding agreements. As States and Territories move to more complete purchaser/provider funding bases, there is the potential to lose the capacity to maintain these checks and balances. The notion of partnership has emerged as a way for services, providers, community and government to work together. In the context of the purchaser/provider funding framework, the very notion of 'partnership' has lost its meaning precisely because these models do not necessarily reflect equity in policy practice. It was strongly suggested in interviews that not everyone in a partnership can have an equal voice when the partnership is based on a purchaser/provider distinction. This has a marked impact on the capacity to provide the checks and balances in partnerships.

As the purchaser/provider funding arrangement is common throughout Australia across many areas of service provision (be it primary prevention, secondary prevention, or detox and rehabilitation), this is a significant challenge for all jurisdictions. Partnerships are not simply equitable relationships. The meaning of partnership is perhaps far more complex than it was initially thought to be.

Leading the community

The final challenge for the Australian drug policy community is to lead the community. A number of policy makers who participated in the first National Campaign Against Drug Abuse suggested that a key characteristic of the Australian approach has been that drug policy often runs ahead of public opinion and political support. Perhaps the fact that many Australian drug strategies tap into a key Australian ethic explains why this leadership has been so successful. This key ethic is a belief in humane pragmatism – a practical fairness in our social and professional lives. This attribute is manifest in a commitment to supporting the most vulnerable in our community.

Conclusions

The Australian approach can be summarised by a policy community supported by a system that provides stability, and a policy framework that can bring people together at the policy table.

Those participating in the policy process have articulated several key values in the Australian approach: *independence; a diversity of voices; the good sense of bureaucracy; frank and fearless advice; checks and balances; and leading the community.* The greatest challenge for the Australian approach is to recognise its strengths, and to build upon them to sustain the Australian drug policy community in the future.

1. Introduction

In the drug policy arena, we often talk about an Australian approach to drug policy. But do we really know what the Australian approach is? The idea that Australia has a national identity is a simplification of the complexity that goes with being Australian. Likewise the suggestion that there is an Australian approach belies the complexity of the way drug policy is made.

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When comparing international drug policies for their effectiveness, we often note cultural differences not only in the content of policy strategies but also in how policies are developed and implemented. When examining different policy approaches, we need to take into account both the content of a particular drug policy and the process and systems underpinning it.

Since the turn of the twentieth century, Commonwealth, State and Territory governments have enacted legislation to control a wide range of drugs. The emphasis has shifted over time from laws designed to criminalise drug use to more health-oriented approaches that tend to medicalise it. In different jurisdictions, different approaches have predominated over time: for example, South Australia, the Northern Territory and the Australian Capital Territory decriminalised possession of small quantities of cannabis some time ago, while other States have chosen not to follow this policy path.

This report focuses on the process of the Australian approach to policy making rather than on particular policy outcomes. Is it possible to define the Australian approach? We believe that an examination of how policy has been made can shed light on the nature of the Australian approach.

1.1 The current position

Problems related to drug use are numerous, and quite rightly we tend to focus on our failures as motivation for new innovations. Nonetheless, Australia has much to be proud of in its approach to illicit drug use (Samet 2000):

- The overall per capita consumption of alcohol has fallen from an average of 9 litres per person in 1985–86 to 7.6 litres per person in 1997–98. However, in the period 1993–98, more females than males consumed alcohol at hazardous and harmful levels.
- The use of licit drugs (alcohol and tobacco) has decreased between 1988 and 1998.
- The amount spent on alcohol as a proportion of total household expenditure on goods and services has decreased from 3.4 per cent in 1984 to 2.9 per cent in 1998–99 (AIHW 2000).
- In terms of its per capita cigarette consumption, Australia was ranked 8th in 1986, and 17th in 1996 (AIHW 2000).
- In 1998, 22 per cent of the adult population were regular tobacco smokers, down from 24 per cent in 1995 (AIHW 1999).
- One in four injecting drug users in the United States is infected with HIV, whereas fewer than three in 100 injecting drug users in Australia are infected with HIV.

- Australia has a treatment system in which each year thousands of individuals receive help in their struggle to deal with their addiction.
- Australian initiatives at HIV prevention, extensive treatment and innovative practical research are recognised internationally.

International comparisons of rates of drug use and related harms are difficult and should only be made with caution (EMCDDA 1998). Data are compiled in different ways, and the social context of drug use varies significantly between countries, limiting the strength of the comparisons that can be made. But there are some uniform trends. Drug-related deaths are on the increase in Spain, the United Kingdom, the United States, the Netherlands, Italy and Sweden (Miller 2001). High rates of hepatitis C (HCV) infection have been reported in Australia but also in countries such as Spain, the United Kingdom, the United States, the Netherlands, Italy and Sweden.

There have been transient changes in heroin supply internationally. In 2001, indicators suggested that there were substantial changes to the heroin supply in Australia. There has been widespread speculation about the causes and consequences of this change. Based more on speculation than stable time series analysis, the 'heroin drought' has variously been attributed to failing crops in the Golden Triangle, drought and floods in Afghanistan, the low value of the Australian dollar relative to other currencies, price inflation strategies by suppliers, and increased policing success in reducing supply both locally and overseas.

The notion of a heroin drought implies that previously heroin was supplied at 'normal' levels. The perceived large reduction in heroin availability may be related to the extremely high visibility brought about by more sophisticated data collection in the late 1990s as opposed to any objective understanding of what should be considered usual heroin market functioning.

Table 1: Drugs used the day before IDRS interview, by jurisdiction ('Change' data adapted from Topp et al., 2002)

	Heroin			Methamphetamine			Cocaine		
	2000	2001	Change	2000	2001	Change	2000	2001	Change
NSW	78	62	-21%	3	7	133%	18	48	167%
ACT	54	35	-35%	10	18	80%	1	0	n/a
VIC	78	40	-49%	4	21	425%	0	1	n/a
TAS	4	0	n/a	12	24	100%	1	1	0%
SA	45	21	-53%	21	32	52%	0	2	n/a
WA	40	14	-65%	20	40	100%	0	4	n/a
NT	11	6	-45%	22	25	14%	1	1	0%
QLD	51	21	-59%	22	27	23%	0	3	n/a
Total	49	27	-45%	13	23	77%	3	10	233%

For this reason, we treat the ‘drought’ as an ill-defined transient change in heroin supply. In the period prior to this transient change heroin was readily available, its purity had increased and heroin prices had dropped to very low levels (Victorian Drug Policy Expert Committee 2000). At the time of writing, the non-fatal heroin overdose rates in Melbourne were approaching the pre-‘drought’ levels of 2000.

Nevertheless it is instructive to examine the most recent drug use prevalence statistics derived from the Illicit Drug Reporting System (IDRS). The IDRS obtains a convenience sample of drug users in each State, which allows jurisdictional comparisons of self-reported use prevalence (Topp et al., 2002). The results shown in Table 1 should be interpreted with caution as there is no indication as to how sampling bias may have influenced the findings.

The IDRS reports that there are marked differences between jurisdictions as to the prevalence of illicit drug use reported on the day before interview. Table 1 illustrates the differences in prevalence for seven of the most commonly used drugs over the period 2000–01. Rates of heroin use were highest in New South Wales, Victoria and the Australian Capital Territory. Rates of methamphetamine use were highest in Western Australia, and lowest in New South Wales and the Australian Capital Territory. Rates of benzodiazepine use were higher in Tasmania and Victoria than in other jurisdictions.

There were also differences in the degree of change from 2000 to 2001. The rate of heroin use by the overall sample in 2001 was markedly lower than that in 2000. There were substantial differences in the proportional changes in methamphetamine and heroin use over this period between jurisdictions. What emerge from this picture are vast differences both in the baseline prevalence and rates of change of illegal drug use across different States and Territories.

Cannabis			Benzodiazepines			Methadone		
2000	2001	Change	2000	2001	Change	2000	2001	Change
39	43	10%	17	12	-29%	26	23	-12%
52	61	17%	15	15	0%	22	29	32%
50	56	12%	25	33	32%	13	20	54%
62	76	23%	23	33	43%	35	46	31%
58	52	-10%	19	16	-16%	24	24	0%
54	58	7%	26	14	-46%	9	17	89%
50	45	-10%	5	13	160%	9	13	44%
38	45	18%	9	10	11%	13	16	23%
50	53	6%	18	18	0%	19	23	21%

International comparisons of drug policies usually focus on their outcomes. Drucker (1999) has made significant contributions to understanding the American approach to drug policy. With an emphasis on zero tolerance and supply reduction through law enforcement, the overall adult prevalence of illicit drug consumption in the United States has decreased. However, the public health harms related to drug use have continued to increase. As Drucker notes:

It would appear that drug use is becoming more dangerous. Even as numbers of drug users have gone down, the per-user rates of ER [emergency room] visits and fatalities have been much higher since the mid-80s. If we measure the success of our drug policy in terms of adverse public health outcomes, instead of prevalence of use, it is clear that we are doing worse, not better. (p. 11)

Drucker notes that drug policy is often based on emotion and a naïve wish for a drug-free society. He compares that wish with a vision based on human and pragmatic policies:

It is time that we move beyond this drug fundamentalism and abandon our unhappy history for prohibition for more human and pragmatic policies that protect public health and support our democratic values. (p. 15)

The Australian approach is internationally respected as inclusive, responsive, humane and progressive. Detailed documentation of the Australian approach is, however, currently not available. In an effort to fully appreciate the origins of the current position, the next section of this report will outline the history of drug policy making in Australia.

1.2 Aims of this report

This report aims to document the Australian approach to drug policy making. Particular emphasis will be placed on:

- providing evidence for and examples of Australia's approach;
- identifying the conceptual and philosophical shifts and influences on drug policies and programs; and
- analysing the strengths and possible weaknesses of the approach.

The National Drug Strategic Framework has outlined the key elements of the Australian approach: harm minimisation; partnerships between stakeholders; the need for coordination, integration and balance; evidence-based practice; and social justice. All jurisdictions have sought to implement these elements through their respective approaches to drug policy development.

This report documents the experiences of those who were or currently are involved in the drug policy process. In this way we hope to encapsulate the Australian policy community and to give depth to the overly simplified and frequently overlooked human dimension of the Australian approach to drug policy.

2. History of significant events at the national level

- 1901 Federation
- 1901 Introduction of the *Customs Act*, and the first tariff imposed on opium
- 1905 Prohibition of the use of opium for recreational purposes; opium imported without licence declared an illegal import by the Commonwealth
- Agreement reached at Premiers Conference to prohibit the non-medical use of opium and confine the sale of the drug to chemists
- 1910 Establishment of a royal commission to examine contents and labelling issues for drugs; subsequent requirement for labelling of medicines to declare drugs and contents
- 1911 Australia agreed at Hague Conference to control the manufacture, sale and import of opioids and other drugs
- 1914 Commonwealth prohibited the importation of raw and prepared opium; licensing controls introduced on manufacturing opium
- 1919 Treaty of Versailles; establishment of the League of Nations with the responsibility to oversee international narcotic conventions
- 1925 Geneva Convention increased the number of drugs that are subject to international control
- 1931 Australia became a signatory to the Narcotics Limitation Convention, which introduced controls over the production of illicit drugs, including morphine, opium and Indian hemp
- 1948 Paris Protocol signed in response to the expanding synthetic drugs industry
- 1951 Publication of a United Nations report claiming that Australia has the highest per capita consumption of drugs in the world
- 1961 Single Convention consolidated all existing international drug control conventions to control the supply, manufacture, trafficking and use of illegal drugs
- 1967 Enactment of the *Narcotic Drugs Act* by the Commonwealth
- Establishment of the Alcohol and Drug Council of Australia (ADCA)
- 1970 Amendment to the *Customs Act* to allow the prosecution of persons found in possession of illegal substances
- 1971 Senate Select Committee on Drug Trafficking and Drug Abuse (Marriott Inquiry) argued that drug addiction should be seen as an illness, not a crime
- 1977 Report of the Senate Standing Committee on Social Welfare (Baume Report) recommended that cannabis be distinguished from other illegal drugs
- Commonwealth appointed the Australian Royal Commission of Inquiry into Drugs
- 1980 Australian Commission of Inquiry into Drugs recommended stronger focus on law enforcement
- 1981 Establishment of Royal Commission into Drug Trafficking (Stewart Inquiry)
- 1983 Release of report by Stewart Inquiry
- 1984 Prime Minister Hawke admitted publicly that his daughter had developed a heroin addiction

- 1985 Special Premiers Conference to discuss a national coordinated approach to drug problems
- Ministerial Council on Drug Strategy (MCDS) and the National Drug Strategy Committee (now known as the Intergovernmental Committee on Drugs (IGCD)) established to lead development of drug policy across major portfolios in each jurisdiction – the National Campaign Against Drug Abuse (NCADA)
- Four major portfolios established for NCADA: education/prevention; treatment/rehabilitation; research/information; enforcement/controls
- 1986 Australia signed the Nairobi Convention to improve coordination in reducing drug trafficking
- 1988 United Nations Convention against Illicit Drug Trafficking in Narcotics and Psychotropic Substances
- First evaluation of NCADA (with positive results)
- 1989 Parliamentary Committee established to investigate activities of the National Crime Authority and activities surrounding the control of the supply of drugs
- 1991 Second NCADA evaluation
- 1992 Manly Meeting: decision to assign greater role to law enforcement in the ongoing administration of the National Drug Strategy
- Establishment of National Drug Crime Prevention Fund
- 1993 National Drug Strategy (NDS) launched to run to 1997
- 1997 Evaluation of the NDS undertaken by Single and Rohl
- 1998 National Drug Strategic Framework launched
- National Illicit Drug Strategy, ‘Tough on Drugs’, launched by Prime Minister Howard
- ANCD established by the Prime Minister to act as the peak advisory body to government on drug policy and programs
- Community Partnerships Initiative and NGO Treatment Grants Program established by the Commonwealth
- MCDS agreed to coordinate a national approach to testing and evaluating alternative pharmacotherapies
- 1999 Council of Australian Governments (COAG) agreed to a number of strategies under the ‘Tough on Drugs’ framework
- Prime Minister announced funding to support introduction of diversion programs in each jurisdiction; COAG endorsed a comprehensive set of guidelines for the initiative
- 2000 House of Representatives inquiry into the impact of substance abuse on families
- Department of Health and Aged Care evaluation of the National Drug Strategic Framework
- Department of Finance and Administration inquiry into funding relationships and COAG initiatives

During the late nineteenth century, many State governments had developed mechanisms to generate revenue from the importation of drugs, particularly opium. In 1901, as a result of the demarcation of constitutional powers, the control over customs and excise became a federal responsibility. Anxious to develop a strong revenue base, particularly given that the States were constitutionally entitled to three-quarters of the customs revenue for the first ten years after Federation, the Commonwealth Government introduced the *Customs Act* in 1901. Under the Act, opium was initially regarded as merely another commodity on which to impose a duty; the only restriction placed on the importation of opium was on the size of the packages.

The issue of the use of drugs quickly moved from a primarily economic focus to one of health and control. In 1905 the use of opium for recreational purposes was prohibited, and under the *Customs Act*, opium was declared a prohibited import. Import licences were restricted to medical practitioners, wholesale and manufacturing chemists, and pharmacists.

Perhaps it is at this time that the Commonwealth and State governments first cooperated in developing a united approach to drugs. A simple analysis of the Constitution often assumes that there is a vertical division of governmental responsibility between the Commonwealth on one level and the States (and Territories) on the other. The reality, however, is a complex relationship on legal, financial and administrative levels. Whereas the Commonwealth enacted the legislative framework banning the importation of opium, the law was administered by the States. The Collector of Customs in each State was charged with the responsibility for collecting taxes in relation to the importation of opium.

Yet the Commonwealth was also limited in its constitutional powers to control the import of drugs. It has only very weak constitutional power over issues that involve regulating human behaviour. Thus, while prohibiting importation, the Commonwealth could not control the use of opium by individuals. At the 1905 Premiers Conference, State governments committed themselves to prohibiting the non-medical use of opium. Specifically it was decided to:

- confine the sale to chemists under the *Sales of Poisons Acts*, or to other persons specially licensed; and
- prohibit and penalise opium dens and other places for promiscuous opium smoking.

It has been argued that the decision not to include morphine, cocaine or heroin in the anti-opium legislation introduced by the States and the Commonwealth indicated the racial basis of the decision to prohibit opium use (Lonie 1979). At that time, Australians believed that drug use was limited to a small section of the population, namely the Chinese. As Manderson (1993) observed:

Drugs laws throughout Australia developed, steadily if almost imperceptibly, between the wars not because heroin, cannabis or opium were dangerous social or health problems, but because they were not; not because we as a community cared, but because, by and large, we did not. (p. 5)

By 1908, the use of drugs for medical purposes, and their contents, had become public issues. In 1910 the Commonwealth and State governments jointly appointed a Royal Commission to explore proposals for uniform legislation on drug contents and labelling. The States adopted the Commission's recommendations, restricting the availability of medicines containing

dangerous drugs, placing the responsibility for prescribing such drugs on the medical profession, and thereby limiting the role of pharmacists. Labelling regulations were also changed as a result of the recommendations: medicines now had to carry labels declaring their contents. A concession, however, was made to pharmacists in that drugs supplied by a chemist on prescription, proprietary medicines and specially prepared medicines were exempt from the regulations, provided that the formulae of such medicines were registered with the Central Board of Health.

As a consequence of pressure from the United States, narcotics control became an international issue. The first significant international forum to which Australia was a party, albeit represented by the British Government and not recognised as an independent sovereign state, was the 1911 Hague Conference. Despite the fact that there was no mechanism developed to enforce the resolutions of the Convention adopted by the Conference, this was perhaps the first indication of some attempt at international cooperation in controlling drugs.

Delegates to the Conference agreed to apply controlling legislation to the manufacture, sale, import and export of drugs including morphine, cocaine, medicinal opium and medications containing certain amounts of these drugs as well as heroin. In May 1912 the Australian Prime Minister informed the States that the British Government had ratified the Protocol to the Hague Convention and requested that all dominions apply the Convention.

Commonwealth regulations concerning the import of opiates were tightened after the Convention. In 1914 the Commonwealth prohibited the importation of raw or prepared

opium, and companies importing medicinal opium, morphine, heroin and cocaine were subject to licensing controls. Licence numbers were also limited. However, limited again by the Constitution, the Commonwealth could do little in terms of controlling the manufacture and sale of these drugs within Australia other than ask individual States to examine their legislation in light of the Convention. In 1912 the Commonwealth wrote to the States to request that they consider legislation to cover the additional requirements on the manufacture and sale of opium and other drugs.

During World War I, the Commonwealth expanded its powers under the provisions of the *War Precautions Act*. As a result, for a brief period the Commonwealth restricted the supply of drugs, arguing that this was required to ensure a supply for the war. After the war, control immediately returned to the States.

International efforts of control were strengthened in 1919 following the formation of the League of Nations which was created by the Treaty of Versailles. Under its covenant, the League was given the responsibility to oversee international narcotic conventions which included the 1911 Hague Convention and the earlier 1908 Shanghai Opium Commission which called for 'drastic' control by all governments of the manufacture, sale and distribution of morphine and other opium products. As with the Hague Convention, these resolutions were not binding. Both conventions were primarily focused on controlling and restricting the production of narcotic drugs as a means of reducing the use of such drugs.

The Geneva Convention of 1925 reiterated a principle already embodied in the Hague Convention, namely that the manufacture of drugs be limited to legitimate needs. Additionally, a number of drugs were added to the list of drugs specified for control; they included cocaine, coca and Indian hemp. The system of control was tightened by transforming it into legal obligations. It was not until the Narcotics Limitation Convention of 1931 that the proposed controls on production were introduced. In 1948, a further measure was taken to deal with the issue of the rapid growth of the synthetic drugs industry: the Paris Protocol was designed to bring under control other addiction-producing drugs that were not covered by the 1931 Convention.

The British Government had a significant impact on Australian drug policies. The Colonial Office acted as a mediator in situations where colonial governments disagreed over drug control issues. In 1924 the British Government banned the import of pharmaceuticals produced by the major Swiss manufacturer Hoffmann La Roche in an effort to place pressure on the Swiss Government to ratify the international drug control conventions. Australia followed the lead of the British Government (Lonie 1979).

In 1951 the United Nations published figures relating to heroin consumption, which showed that Australia had the highest per-capita consumption in the world (McAllister, Moore & Makkai 1991, p. 207). Outrage from other countries was directed at the Australian Government and in response it banned the importation of heroin in 1953. Although the States originally opposed the prohibition, by 1953 all had banned the manufacture of heroin in their jurisdictions.

In 1961 the principles of the international drug control conventions were consolidated into the Single Convention of 1961. This convention reaffirmed the principle that drugs were to be used only for medical and scientific purposes, extended its application to raw materials such as opium, poppy straw, coca leaf and cannabis, and established the International Narcotics Control Board to implement these policies. In 1967 the Commonwealth enacted the *Narcotic Drugs Act* which established a licensing system for the manufacture and distribution of drugs covered by the Single Convention in an effort to enable monitoring of the movements of drugs domestically.

Prior to the 1960s Australia was not regarded as having an illicit drug problem and the major motivations for drug control policies were in response to international pressures. But by the time of the 1961 Convention drug consumption patterns in Australia had begun to change and concerns were raised as to the levels of illegal drug use.

Various efforts were made by the Commonwealth during the 1960s to control illicit drug use through the application of the *Customs Act*. In 1967 the penalty for the unlawful importation of narcotics was increased from a maximum of \$2,000 or two years imprisonment to \$4,000 or ten years imprisonment. It also became an offence to be in possession of a narcotic on a ship or plane without reasonable excuse; to import, or attempt to import, narcotics; or to be in possession of unlawfully imported narcotics. In the early 1970s the *Customs Act* was once more amended to allow prosecution of individuals found in possession of illegal substances that were considered to have been imported illegally.

But at this time the success of these measures was beginning to be questioned. In 1971 the Senate Select Committee on Drug Trafficking and Drug Abuse, the Marriott Inquiry, found that 'drug abuse in Australia is mainly a problem within the individual and therefore greater emphasis should be placed on the treatment of an illness rather than punishment for a crime' (p. 3).

In 1977 another Senate Committee, the Standing Committee on Social Welfare, released the Baume report, which reached similar conclusions, recommending that the Commonwealth and the States enact cannabis legislation to recognise the differences between narcotics and cannabis in terms of their respective health effects and their criminal impact on users and the community (Australia. Parliament. Senate Standing Committee on Social Welfare 1977). Decriminalisation of the personal use of cannabis was seen as a possible mechanism in reducing the harmful effects of drug taking.

It was not until this time that significant concerns about the health effects of smoking were raised. The report of the Senate Standing Committee on Social Welfare (1977) identified tobacco use as the most important cause of drug-related mortality in Australia. The first to draw attention to the detrimental effects of smoking had been the Royal College of Physicians in the early 1970s. In 1971 the Action on Smoking and Health lobby group was formed, and a number of medical groups, including the Australian Medical Association, the Anti-Cancer Council and the National Heart Foundation, publicised the links between smoking and health.

It is interesting to note that at the same time as the Senate Committee published its report, in October 1977, the Commonwealth Government appointed a Royal Commission of Inquiry into Drugs. In its terms of reference it was asked to focus on investigations into illegal dealings in narcotic or psychotropic drugs, and to assess the extent to which drugs were illegally used or diverted to illegal uses. With narrower terms of reference than the Senate Committee, the Commission was to inquire specifically into:

[t]he adequacy of existing laws (including the appropriateness of the penalties) and of existing law enforcement (including the arrangements for co-operation between law enforcement agencies) in relation to the prohibition, or control of the importation, exportation, production, possession, supply or use of or trafficking in drugs. (Australia. Royal Commission of Inquiry into Drugs 1980)

At the same time, a Royal Commission of Inquiry into Drugs was established in New South Wales to investigate the supply and possession of drugs of addiction, prohibited drugs and other drugs of dependence, and the identity of persons involved in illegal activities in connection with those drugs.

Both the New South Wales Royal Commission, which reported in 1979, and the Commonwealth Royal Commission, which reported in 1980, recommended tighter law enforcement and improved coordination, extending prohibitionist policies. Referring specifically to the findings of the earlier Senate inquiry regarding cannabis, the Australian Royal Commission of Inquiry into Drugs recommended that the legal prohibition of cannabis be reviewed in ten years if the policies had not proved effective.

These reports prompted the Commonwealth in 1984 to establish the National Crime Authority (NCA), which was given the power to investigate organised crime. At the same time, the Australian Federal Police expanded its activities, and law enforcement agencies and Customs agents were given additional powers. A primary motivation for the establishment of the NCA was to attempt to tackle organised crime that crossed jurisdictional boundaries.

While law enforcement capabilities were strengthened in the late 1970s and early 1980s, it was not until 1984 that the impetus for the development of a concerted health-focused approach to dealing with drugs arrived. The daughter of Prime Minister Bob Hawke had become involved with heroin. Hawke appeared on television and effectively broke down in tears. It was not until his wife appeared to explain the family predicament that it was fully understood. Largely motivated by his daughter's addiction, the Prime Minister announced as part of his re-election strategy that he would deal with the issues of drug addiction and abuse should he be returned to office. Following the election, Prime Minister Hawke announced that he would call a Special Premiers Conference to be held early the next year.

The details of the first National Drug Strategy are outlined in the remainder of this report. Launched in 1985 with broad agreement from the States and Territories, the National Campaign Against Drug Abuse (NCADA) provided significant funding towards a range of efforts, effectively shifting the primary focus away from law enforcement and towards a more multi-faceted approach to managing drug problems.

2.1 Origins of the Australian approach to drug policy making

In 1985, in the early days of Australia's first National Campaign Against Drug Abuse, Earle Hackett (previously a member of the South Australian Royal Commission into the Non-Medical Use of Drugs) reflected on the workshops held in 1985 prior to the first Special Premiers Conference on Drugs:

In the Workshop, our Australian dislike of philosophical or moral analysis was strong. The secular syndicates muttered throughout their first day like gangs of chained felons. Nobody was able to think out a general position until a flintlock was put to the heads of the policy syndicate ... Had we been in clear thinking France there would have been entire structuralist, theist, existentialist, Marxist and anarchist policies offered for us workshopppers to choose from. In the Canberra Workshop, we largely ignored even the proffered belated policy guidelines and straight-away we chose minutiae. Thus we did not have to look at the difficult wood; we preferred to see easy trees.

The outcome, although a monument of small prejudices and compromises, was a lot of trees that probably added up to much the same wood that we would have got had we started the other way round and scratched, patched and adapted an original ideal social policy. Pragmatism, decency and ignorance, well-mixed, usually get as far as the philosopher king on Australia Day. (Hackett 1985, cited in Brown et al. 1986)

The Sackville Royal Commission (South Australia. Royal Commission into the Non-Medical Use of Drugs 1978), which included Earle Hackett, recorded a commitment to reducing the conflict and disruption brought about by a massive policy change:

Social concern in relation to drug use – specifically in the form of official control policies – should be directed only to those activities which clearly place public and private safety at risk ... The official policies expressing that social concern ought to evolve smoothly so that they grow out of, rather than disrupt, existing arrangements for controlling, preventing or mitigating undesired consequences of the use of drugs.

This commitment, a feature of the Australian approach at the time, was accompanied by an explicit recognition that it was not solely the government's responsibility to control drug use:

People acting within their own families and local communities have the opportunity to develop or redevelop values and norms appropriate to the ways in which drugs, including alcohol and tobacco, are used, thereby discouraging any unwarranted behaviour and encouraging responsible decision making. Drug use, after all, was common before governments took a hand in trying to control it. (South Australia. Royal Commission into the Non-Medical Use of Drugs 1978, p. 40)

It is evident that the late 1970s saw an acknowledgement of the role of multiple stakeholders in drug policy, and of the need for a sensible strategy that fitted into an Australian ethos.

In his paper for the 1991 Window of Opportunity Conference, British drug expert Professor Griffith Edwards noted that Australia's planned and effective national response at the time 'has about it a touch of brilliance' when compared to that of 1970, which he remembered as having been fragmented. For Edwards, the merits of Australia's modern national drug strategy lay in its infrastructure and in its capacity for a coordinated response (Edwards 1992).

From its earliest moments as the National Campaign Against Drug Abuse, the Australian approach to drug policy making has been to bring government and interested stakeholders to the policy table, and to devise pragmatic solutions through discussion, debate and compromise. This approach differs markedly from other policy approaches based on political conflict, adversarial negotiation, government imposition or the application of ideological force (AIC 1992).

2.2 National policy frameworks

Several national policy frameworks have – with broad agreement from all jurisdictions – influenced the Australian approach to drug policy making.

National Campaign Against Drug Abuse

In April 1985 a special meeting of the Premiers and the Prime Minister was convened to discuss alternative strategies to dealing with what was increasingly being considered a ‘drug problem’. The result of this meeting was the launch of the National Campaign Against Drug Abuse (NCADA). This campaign marked a distinct shift in policy objectives towards a reduction of the harm associated with drug abuse. In launching the campaign, the Commonwealth Minister for Health, Neal Blewett, stated that its aim was to:

[m]inimise the harmful effects of drugs on Australian society. Its ambition is thus moderate and circumscribed. No utopian claims to eliminate drugs, or drug abuse, or remove entirely the harmful effects of drugs, merely to minimise the effects of the abuse of drugs on a society permeated by drugs.

The NCADA provided the national framework for liaison and cooperation between State and Federal governments. While this cooperation had to a certain extent been developing since the time of Federation, it enshrined the primary objective, namely to reduce the harmful consequences of drug use. While there had been evidence of cooperative activities in the development of drug policies throughout Australia’s modern history, there had not, until this time, been any common goals for such cooperation.

As part of the NCADA, the Commonwealth Government allocated approximately \$37 million per year to the campaign. Almost two-thirds of this money (approximately \$24 million) was distributed as specific purpose payments to State and Territory governments, who were then asked to at least match the Commonwealth payment on a dollar-for-dollar basis. In addition, the Commonwealth provided separate funds for national activities, which it approved independently.

Initially funded for three years, the campaign injected significant funds into prevention efforts and treatment opportunities. In recognition of the need for reliable data, resources were also dedicated for additional research and for data collection. The campaign comprised initiatives in four key areas: education and prevention; treatment and rehabilitation; research and information; and enforcement and controls.

The campaign was multi-faceted in its approach, and placed a major emphasis on reducing the demand for drugs through education, treatment and rehabilitation programs, especially for young people. Large-scale media campaigns increased community awareness of drug issues. Treatment services were also expanded considerably through the campaign. At the launch of the NCADA, methadone treatment was endorsed as an appropriate modality for those who were heroin-dependent. This led to the development of the National Methadone Guidelines, which have formed the basis of common principles and practice throughout Australia.

The acceptance of methadone as an alternative treatment option signalled an important outcome of the Special Premiers Conference. Prior to the campaign, treatment programs focused mainly on the specialist alcohol and drug area, and provided little funding for mainstream health and welfare services. As a consequence of the conference, there was a greater understanding of the need to incorporate public health principles into the response to drug problems. The perceived risks from unsafe drug injecting practices, particularly with the spread of HIV, meant that by the late 1980s methadone programs had become accepted as a central policy instrument to achieve public health outcomes. At the same time, the provision of needles and syringes indicated the significance of the impacts of the NCADA.

Control through law enforcement was also maintained as an essential component of a balanced approach to the goal of minimising harm associated with drugs. Two major law enforcement initiatives were developed as part of the NCADA, with \$2 million provided to the Australian Bureau of Criminal Intelligence for the development of a drugs intelligence network, and \$5.5 million to improve the detection of drugs entering Australia.

National Drug Strategy

In 1992 a recommendation to re-package the NCADA as the National Drug Strategy (NDS) was accepted. The new strategy was released in 1993 and ran until 1997. A comprehensive set of initiatives was laid out in the plan. The plan was built on the four key areas enunciated in the initial NCADA and included working with the media, and developing effective mechanisms for enhancing the partnerships of health, law enforcement and education. The plan identified six specific concepts, which were to underpin the development and implementation of the next wave of Australia's drug policy:

- harm minimisation;
- social justice;
- maintenance of controls over supply;
- an inter-sectoral approach;
- international cooperation; and
- evaluation and accountability.

As part of the plan, law enforcement activities were accorded greater priority. The Ministerial Council on Drug Strategy agreed to increase the proportion of the NDS for law enforcement incrementally over the lifetime of the plan. This resulted in an increase of funding for law enforcement projects from 3 per cent in 1992–93 to 10 per cent in 1994–95.

The plan was ambitious in its approach, and developed a comprehensive set of performance indicators. Emphasis was placed on the need for an evidence-based approach. The Commonwealth Government built an evaluation component into the National Drug Strategy as an essential mechanism to inform future policy-making decisions.

National Drug Strategic Framework

As the result of an evaluation undertaken in 1997, the National Drug Strategy was relaunched, this time as the National Drug Strategic Framework (NDSF). This policy currently forms the basis for Australia's approach to drug problems. As part of the NDSF, the Prime Minister also released a specific strategy focusing on issues surrounding the availability and use of illicit drugs. Announced in two instalments, on 2 November 1997 and on 16 March 1998, the National Illicit Drug Strategy outlined a number of measures that aim to reduce both the demand and supply of illicit drugs.

A key strength of the framework is its effect in encouraging a cooperative and consistent response throughout Australia, while remaining sufficiently flexible to enable appropriate action to be taken at the local level. Running from 1998–99 to 2002–03, the strategy's mission is:

[t]o improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society.

The National Drug Strategic Framework maintains the policy principles of the previous phases of the National Drug Strategy, and outlines a number of priorities based on the recommendations made in the 1997 evaluation. These include improving the evidence base to better inform policy development, and placing an increasing emphasis on extending partnerships between health and law enforcement agencies to take in a broader range of partners, as recommended by Single and Rohl (1997) in their evaluation report.

One of the key elements of the NDSF was the development of the concept of National Drug Action Plans. These plans were to specify priorities for reducing the harm arising from the use of illicit and licit drugs, strategies for taking actions on these priorities, and performance indicators. The plans were to provide a focus for determining resourcing priorities under the NDSF, and to reflect the focus of individual jurisdictions, in response to their own unique issues, while at the same time aiming for a high degree of national consistency. Action plans can be accessed through the National Drug Strategy web site (<http://www.nationaldrugstrategy.gov.au/igcd/index.htm>). The National Drug Strategy Reference Group for Aboriginal and Torres Strait Islander People's Complementary Strategy, which includes all drug use among Indigenous Australians, is due for release in 2002.

2.3 National Illicit Drug Strategy

Prior to the announcement in 1998 of the revamped National Drug Strategic Framework, the National Illicit Drug Strategy (NIDS) was launched as a major component of the forthcoming National Drug Strategy at the end of 1997. With a focus specifically on illicit drugs, the strategy directed funding over four years towards a range of demand reduction and supply reduction activities.

The National Illicit Drug Strategy focused on the interception of illicit drugs at the borders and within Australia while at the same time enhancing prevention and treatment measures, as well as supporting training and skills development and research. Under the title ‘Tough on Drugs’, the National Illicit Drug Strategy aimed primarily to prevent the use of illicit drugs and to encourage abstinence. It also aimed to prevent the entry of illicit drugs into Australia, with \$212 million of the total NIDS funding of \$516 million allocated for supply reduction measures to intercept illicit drugs at the borders and within Australia. It also advocated ‘no illicit drugs in schools’ as a goal for the National School Drug Education Strategy, launched as part of NIDS.

Following on from the Prime Minister’s announcements of 2 November 1997 and 16 March 1998, the Commonwealth Government, in the 1998–99 Budget, committed \$214.6 million over the years 1997–98 to 2001–02 towards the implementation of the National Illicit Drug Strategy.

2.4 Principles underpinning the National Drug Strategy

There are a number of philosophical underpinnings to the current National Drug Strategy.

Harm minimisation

Both nationally and internationally there has been much debate over the meaning of the terms ‘harm minimisation’ and ‘harm reduction’. From as early as 1985, the Australian approach has been to ‘minimise the harmful effects of drugs on Australian society’ and has included a range of terms to describe the intention of reducing drug problems (Blewett 1987). In workshops conducted in 1985 prior to the Special Premiers Conference on Drugs, harm minimisation was specifically mentioned, as it was in the first NCADA and subsequent National Drug Strategies.

Harm minimisation, harm reduction or the general principle of reducing problems related to drug use has been a cornerstone of the Australian approach. Much of this commitment comes from the groundbreaking findings of the 1977 report of the Senate Standing Committee on Social Welfare chaired by Senator Peter Baume, *Drug Problems in Australia – An Intoxicated Society?* In 1986, when reflecting on guiding principles underpinning national drug policy, Baume noted:

Total drug abstinence is not possible, it is even doubtful that it is desirable. Any national policy which has as its goal the abolition of drug use is doomed to failure even before it has begun ... If drug abstinence is not an option, then the national task is to determine the conditions under which drugs are used, and to

devise realistic policies relating to their supply, to the extent of the demand for them, and towards reducing their adverse effects. (cited in Brown et al. 1986)

The practicality articulated by Peter Baume is often cited as a cornerstone of the Australian approach and one that differentiates it from other approaches. Complications have emerged in recent times, as the terms encapsulating this approach – most importantly, the term ‘harm minimisation’ – have become contested.

The Australian Institute of Criminology (AIC), in a comparative review of drug policy, noted the ubiquity of the term such that ‘the concept is used by different parties to justify quite contradictory strategies’ (AIC 1992). The recent confusion over the meaning of the two terms has its roots in the synonymous use of harm minimisation and harm reduction in strategies developed early in the National Campaign Against Drug Abuse. For example, in late 1988 a working panel on intravenous drug use and HIV endorsed the idea of ‘harm reduction’, whereas the NCADA documents at the time usually referred to ‘harm minimisation’ (AIC 1992).

Single and Rohl (1997) documented a progression of thinking about the term in their influential review of the National Drug Strategy. They also noted that there were significant difficulties with a lack of consensus over the meaning of the term ‘harm reduction’. In more recent publications debate has continued over the original, revised, catholic empirical and pragmatic definitions of harm minimisation. Regardless of the contest over semantics, a key feature of the Australian approach has been a commitment to keep harm minimisation as a philosophical cornerstone of the National Drug Strategy.

The concept of harm reduction has taken different paths for illicit drugs, and for tobacco and nicotine. Berridge (1999) outlined different histories for the term, specifically in the ways in which those concepts have been modified and adopted by different parts of the policy community.

More detail is needed on how the policy community in Australia has managed and is currently working with the range of terms reflecting the original intent of reducing problems related to drug use.

Evidence base

Drug policy internationally has rarely been based solely on rational evidence (Berridge 1999). Australian drug policy is no different. Many policy practitioners have bemoaned the lack of a strong evidence base for drug policy. Calls for a better evidence base for policy still abound (Crosbie 2000).

Berridge and Thom (1996) noted that a range of factors need to be acknowledged in the development of drug policy innovations. The introduction of methadone, needle and syringe programs, alcohol regulation and tobacco policy are all related as much to political circumstance and historical contingency as to empirical evidence.

A key aspect of the Australian approach has perhaps been not so much the exclusive use of an evidence base, but rather the constant quest for it. This commitment to continuing to examine evidence can be seen through the long list of major parliamentary inquiries and royal commissions into drug use and outcome-based drug policy evaluations (Appendix E and Table 2).

Social justice

The current commitment to social justice has its roots in earlier drug policy discussions. Without explicitly mentioning social justice, the workshops conducted in 1985 prior to the Special Premiers Conference on Drugs noted a commitment to ensure access and equity for disadvantaged groups. While the evaluation of the first NCADA recognised the importance of vigilance for the needs of special groups, the 1993–97 NDS policy framework was more explicit in its commitment to social justice:

Recognition of inequities in the health status of Australians has focused attention on injustices and the situation of special needs groups. Accordingly, particular attention will be paid to areas of inequality (including the socio-economically disadvantaged, remote communities and homeless people). Priority population groups (Aboriginal Australians and Torres Strait Islanders, prisoners, women, people of non-English-speaking background, young people and injecting drug users) will be targeted in prevention and treatment activities.

The key elements to social justice in the current NDS are essentially based around access and equity. Precisely how this principle has been put into practice is, however, unclear, other than through the usual government commitments to access and equity.

A coordinated, integrated approach

Following recommendations from Single and Rohl (1997), the current NDS advocates coordination and integration across a number of activity arenas and across a number of government and non-government areas. In the 1970s drug policy was weighted towards alcohol issues, and the 1977 Baume report noted that the coordination of the State–Federal strategy needed attention. Neal Blewett, in his opening comments to the workshops in 1985, made similar if not more strident comments about the state of the advisory structures around alcohol and drug strategy (see citation later in this section).

The first NCADA simplified the advisory structures to ensure rapid communication. But the network of advisory committees has become increasingly complex and extensive, and coordination and integration are tightly woven into the funding, and advisory and policy development structures of the NDS.

The 1998 advent of the Australian National Council on Drugs (ANCD) perhaps exemplifies the Australian approach to coordination across the different areas of drug policy. The ANCD, made up of experts in law enforcement, drug treatment and research, and representatives from the non-government sector, was rapidly integrated into the Commonwealth drug policy advisory structures. By virtue of its role in enhancing the partnership between government and the community, council members occupy a unique position. Central to this position is the provision of independent expert advice to government ministers on matters related to licit and illicit drugs.

While the type and level of coordination may have changed over time, the need to coordinate has been a key feature of the Australian approach. But precisely how coordination is experienced by those in the policy-making process is not well documented. With all the imperatives that underpin the autonomy of different policy stakeholders, it must be assumed that compromise and debate produce difficulties for some.

Berridge (2000) noted that policy makers and bureaucrats are perhaps the least studied population in drug research. Indeed, not only are they the least studied, their experiences of being part of a complex coordinated network of advisory committees are rarely if ever documented.

A balanced approach

The commitment to a balanced approach has been a key characteristic of the Australian approach since the 1977 report of the Senate Standing Committee on Social Welfare, which suggested:

Efforts to reduce the supply of and demand for drugs are complementary and interdependent, and Commonwealth programs should be based on a balance between the two.

In the most recent National Drug Strategy, balance is sought between supply reduction, demand reduction and harm reduction, and between prevention, training and research. In previous strategies, balance was sought between law enforcement (exemplified through the US approach to drug policy) and health (the UK approach to drug policy). The Australian approach is characterised as being balanced somewhere between the two (AIC 1992).

Balance is also sought between emphases on strategies targeted at licit and illicit substances, between funding for government and non-government sectors, and between different philosophies underpinning drug policy. For example, the change to the NDS priorities brought about in the last NDS was thought to reflect an adjustment to the balance between abstinence-based approaches with non-abstinence-based approaches.

The balance between emphases on licit and illicit substance use in the NDS is uncharacteristic in the international drug policy arena. From an international perspective the Australian approach demonstrates a strong commitment to maintaining the balance between reducing the impact of both licit and illicit drugs through a national drug strategy.

Partnerships

A much-discussed feature of Australian political life is the partnership between the Commonwealth and its States and Territories. In all but a few areas of government, governance is shared across different levels of government. Health, law enforcement, community services, education, employment and training all require coordinated action between Commonwealth, State and Territory governments. Managing drug problems requires partnerships between all levels of government.

Because of Australia's constitutional arrangements, partnerships in drug policy are nothing new. For example, in 1925 the Prime Minister communicated with the State Premiers concerning alternative means of combating opium addiction. The Commonwealth proposed the regulated supply of opium and the licensing of opium addicts in an effort to stop smuggling and to wean addicts off opium (Lonie 1979, p. 78). Mixed responses were received from the States and Territories, who considered that the problem was not sufficiently large to warrant such a policy. The policy was not adopted.

At the time of the 1985 Special Premiers Conference on Drugs, Neal Blewett noted the complexity associated with coordination across different levels and sectors of government:

To have any prospect of success a national drug strategy needs to be both co-ordinated and multi-faceted. At present the decision path chart on drugs co-ordination looks somewhat like a complex version of one of those plans for a transistor radio. Unfortunately the sound emitted is far less coherent than

that which emerges from a transistor radio. Therefore we have both to simplify and shorten the decision-making paths in any national drug strategy. (cited in Brown et al. 1986, p. 35)

Indeed, the lines of reporting for Commonwealth and State committees that arose from the 1985 Special Premiers Conference on Drugs were limited to the Ministerial Council on Drug Strategy (MCDS), the Standing Committee of Officials of the MCDS and the National Drug Education Program (NDEP). Most clearly, however, it was stated that the responsibility for drug policy was shared:

The Commonwealth Government and the States share responsibility for controlling the movement and use of drugs in Australia. (National Campaign Against Drug Abuse 1986, p. 31)

In 1995, Blewett, when reflecting on the State–Federal partnerships in Australia ten years after the first NCADA, noted the difficulty of sustaining a national approach in the face of diverse state interests:

We were striving always to have a national drug campaign – this meant compromises with the States. It often meant slowing down and in a couple of cases we had to re-write programs to respond to State difficulties with these programs. There were quite a lot of compromises made in order to keep the States together with the National Campaign. (cited in Allsop 1995)

The partnership approach, as defined for the Strategy, is a close working relationship between the Commonwealth, State and Territory governments, local governments, affected communities (including drug users and those affected by drug-related harm), business and industry, professional workers and institutions.

The first National Drug Strategy focused on partnerships between law enforcement and health. Its first evaluation recommended that partnerships with other sectors of government, community-based organisations and industry bodies be enhanced.

The focus of partnerships is evident in the title of the second phase of the National Drug Strategy. 'Building Partnerships' highlights the need for a cooperative effort between all levels of government, community-based organisations, researchers, health professionals, educators, law-enforcement authorities, drug users and the wider community. In 'partnership' these groups work together to reduce the adverse social, health and economic impacts of drug use and misuse.

In a comparative analysis of illicit drug strategies, prepared for the Ministerial Council on Drug Strategy by the Australian Institute of Criminology in 1992, it was argued that NCADA was not the integrated strategy it was devised as. This review stated:

While proponents of the campaign can point to the many areas of consultation, joint working parties etc., the reality is that there has never been a satisfactory attempt to argue through conceptually the central underpinnings of the NCADA, to relate the NCADA to programs outside its funding boundaries, and to secure agreement from the major stakeholders about the essential nature of the campaign.

The AIC report claimed that one of the major problems in developing partnerships was that law enforcement agencies, which were critical stakeholders in the drug control field, were not persuaded of the new directions embraced by the national campaign. Law enforcement was virtually excluded from the campaign in terms of policy debate or new funding, but it continued to operate as a separate area of drug strategy with considerable government and popular support. Thus, major drug law enforcement and other supply reduction measures were conducted largely outside the drug policy-making forum.

By comparison, the Alcohol and Drug Council of Australia (ADCA) argued:

The NDS has extended the concept of health beyond traditional health professionals to include police, education authorities, court and correctional workers, and a broad range of community and welfare workers (social workers, psychologists, youth workers, teachers, etc.). It has put into practice the ideals of collaboration, co-ordination and strengthening of health capacity. Few other countries in the world have been able to match the NDS in terms of cross-sector and cross-jurisdiction collaboration and co-ordination.

In more recent times, partnerships have expanded to take on a substantial role in public health through the National Public Health Partnership (NPHP). In late 1996 the Council of Australian Governments (COAG) agreed to long-term system-wide partnerships in relation to health standards, research and services. The partnerships aimed to improve collaboration at a national level, to better coordinate public health strategies, and to strengthen public health infrastructure (NPHP 2000).

An example of innovative partnership formation has been the establishment of the National Drug Strategy Local Government Subcommittee, a partnership between the Intergovernmental Committee on Drugs (IGCD), the Council of Capital City Lord Mayors and the Australian Local Government Association. The subcommittee provides advice to the IGCD on priorities and strategies to address drug issues relevant to local government authorities; it provides a local government perspective to the development of national drug action plans; it identifies emerging issues related to the harmful use of drugs within local government authorities; it ensures the development and application of strategies that are responsive to the issues experienced across the full range of local government authorities; and it monitors local government participation initiatives under the National Drug Strategy action plans.

Partnerships are a key component of the Australian approach and have been for some time. Precisely how these partnerships have been sustained in the policy process is not clear. Published commentary by policy practitioners suggests that partnerships are often difficult and mean different things to different people at different points in policy history, but that they are a necessary element of the Australian approach.

2.5 Governance arrangements for the National Drug Strategy

The Commonwealth Government has developed a complex system of advisory structures, which collectively are able to provide advice and input from the perspectives of key stakeholders.

Ministerial Council on Drug Strategy

The Commonwealth's drug strategy is essentially driven by the Ministerial Council on Drug Strategy (MCDS). Established in 1985, following the Special Premiers Conference at which the NCADA was formulated, the MCDS comprises Commonwealth, State and Territory ministers with responsibility for health and law enforcement portfolios. The purpose of the Council is to collectively determine national policies and programs to reduce the harm caused by drugs.

The Council's collaborative approach has been designed to achieve national consistency in policy principles, program development and service delivery. Its purpose is to ensure that Australia has a nationally coordinated and integrated approach to reducing the harm arising from the use of drugs.

Intergovernmental Committee on Drugs

The major advisory group to the MCDS is the Intergovernmental Committee on Drugs (IGCD). At the time of the NCADA, this group was known as the National Drug Strategy Committee (NDSC). All health and police ministers, the Australian Customs Service, the Ministerial Council on Aboriginal and Torres Strait Islander Affairs (MCATSIA) and the Department of Education, Training and Youth Affairs are represented on the IGCD.

The IGCD is also responsible for coordinating the development, implementation and evaluation of National Drug Action Plans and the activities of the advisory committees that have been established to provide expert advice to the MCDS on a range of issues.

Australian National Council on Drugs

The Australian National Council on Drugs (ANCD) was established by the Prime Minister in March 1998 with the launch of the 'Tough on Drugs' strategy to ensure the voice of the non-government sector is heard and influences policy and practice. The ANCD provides independent, strategic advice to the Prime Minister and to Commonwealth, State and Territory health, law enforcement and education ministers on priorities for policy development, emerging licit and illicit drug issues, and on how these may be addressed.

National Expert Advisory Committees

National Expert Advisory Committees have a set of clearly defined tasks to provide advice to the MCDS on specific issues. They have been established as priorities for action have been identified. There are currently six such committees:

- National Expert Advisory Committee on Tobacco (NEACT);
- National Expert Advisory Committee on Alcohol (NEACA);
- National Expert Advisory Committee on Illicit Drugs (NEACID);
- National Advisory Committee on School Drug Education (NACSDE);
- National Drug Research Strategy Committee (NDRSC); and
- Monitoring and Evaluation Coordination Committee (MECC).

Three subcommittees provide advice on specific issues within the Commonwealth's drug policies:

- National Drug Strategy Reference Group for Aboriginal and Torres Strait Islander Peoples;
- APAC Subcommittee on Intentional Misuse of Pharmaceuticals; and
- Methadone and Other Treatment Subcommittee.

The complexities of governance, funding and service provision

For those unfamiliar with the administrative arrangements between the Federal Government and the States and Territories, the following section uses some recent examples to illustrate the balance of State and Territory and Federal Government interests and funding in the delivery of services.

Given the constitutional division of powers, the Commonwealth Government does not have any direct responsibility for the coordination or roll-out of drug services to individuals. This function has historically been the domain of State governments. As a result, the delivery structures that have developed in each jurisdiction are unique. In fact, the Commonwealth Government's ability to direct funding into treatment services was reduced with the introduction of the Public Health Funding Agreements, which meant that funds given to the States for health initiatives could not be tied to specific projects. This is not to say that the Commonwealth Government has no role to play in funding service provision.

Historically, the Commonwealth has played a role in the funding, direction and implementation of services through the provision of additional funding for pilot or best practice programs. With the development of the National Illicit Drug Strategy (NIDS), the Commonwealth has developed an increasingly important role in service provision. The National Illicit Drug Strategy provided a total of \$4.8 million (over three years) to the Community Partnerships Initiative, tagged as one of the demand reduction measures. The initiative funds new and innovative, best practice projects that complement existing programs and services funded through State

government drug treatment services. Projects eligible for a grant under the initiative are required to focus on providing primary prevention activities.

In May 1998, the Commonwealth called for demonstration projects through a community grants scheme. Applicants were requested to comply with a number of principles in designing their projects, and to address a range of key criteria. Of the 168 applications received, 24 programs were funded, receiving a total of \$1.9 million over three years. They included community development programs, training schemes, peer education initiatives for young people and parents, and programs for information dissemination and the production of resources. Another 63 projects were funded in a second round at a total cost of \$3.98 million.

At the same time, through NIDS, the Commonwealth Government introduced the Non-Government Organisation Treatment Grants Program. This program provided funding for the establishment, expansion, upgrading and operation of non-government treatment services. Following a national grant process, 133 projects were granted a total of \$57 million in funding. The program aimed to strengthen the capacity of non-government organisations to achieve improved service outcomes and to increase the number of treatment places.

In November 1999, the Prime Minister announced funding of more than \$111 million over four years to support the implementation of diversion programs in all States and Territories. As part of the 'Tough on Drugs' National Illicit Drug Strategy, the initiative was adopted as an early intervention project, which, it is hoped, will give people who are apprehended for illicit drug use the chance to avoid the criminal justice system, opting

instead for treatment for drug use. The commitment from the States is to implement pre-court diversion programs, which will be complemented by additional funding from the Commonwealth to support the treatment of diverted offenders.

When these funds were announced, an implementation framework was released. Based on 19 broad principles, it states that ‘the approach should operate within a broad national framework, which allows jurisdictional flexibility within available resources’. However, the room for jurisdictional flexibility and independence appears limited in the documentation. Rather, the approach is articulated in astonishing detail, including details of the roll-out of the initiative, as well as the process for each of the three stages of diversion: apprehension by police; compulsory assessment; and drug education or treatment services.

While it is couched in terms of providing additional funds to encourage innovative and best practice projects from community organisations, the scheme can reduce the ability of State governments to plan and coordinate overall service delivery. Through funding of services in specialist programs, the Commonwealth in the late 1990s has provided funds directly to services and has thereby influenced State priorities.

In practice, the rolling-out of the diversion program services has resulted in quite a diverse and flexible range of diversion strategies. A feature of the Australian approach is an inherent tension between the respective needs of the Federal Government, and those of the States and Territories. In this case it would seem that the tension has produced a flexibility in service implementation in the face of constrained funding guidelines. This perhaps exemplifies the governance tensions in the Australian approach.

An important initiative in the national coordination of services has been the development of a coordinated approach to understanding the characteristics and potential role of new pharmacotherapies for opioid dependence. The Federal Government, through the Department of Health and Aged Care, funded a three-year national evaluation project. The National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD) commenced in July 1998 and is coordinated by the National Drug and Alcohol Research Centre and the National Centre for Epidemiology and Population Health. Independent researchers collaborate with NEPOD in South Australia, Victoria, New South Wales, the Australian Capital Territory, Queensland and Western Australia.

The pharmacotherapies under evaluation are buprenorphine, levo- α -acetylmethadol (LAAM), slow release oral morphine, and naltrexone; and new treatment options are being explored for maintenance, withdrawal and relapse prevention.

Far from being inactive in the delivery of services, the Commonwealth has had a distinct role in the coordination, funding and prioritisation of service delivery. These examples illustrate the tensions inherent in the Australian approach, manifest in the governance and funding of services through the NDS.

3. Policy practice – a new framework

Considering the importance of partnerships, coordination and integration to Australian drug policy, it is perhaps helpful to try to bring together these activities into an understandable framework for policy practice.

The policy community

Berridge (2000) suggested that drug policy making in the United Kingdom developed from a characteristic pattern of relationships between government and special interest groups. Policy making that is based on bringing different groups together is in sharp contrast to other methods of policy making in other domains of government and in other jurisdictions. Jordan and Richardson (1983) have called policy making that involves this particular style of interaction between government and special interest groups a 'policy community'.

A key feature of the policy community approach is the deliberate avoidance of electoral politics and public conflict by attempting to maintain consensus and accommodation through an extensive network of consultative machinery. This is achieved by government departments recognising 'relevant' interest groups and mobilising the community on agreed policies. In policy terms, the style of this type of policy community approach is characterised by sectorialisation, consultation, institutionalisation and administrative exchange (Jordan & Richardson 1987). The term 'policy community' will underpin our description of the Australian approach.

The Australian policy community involves government in a policy arena encompassing a range of interest groups. At different times, different parts of the policy community gain ascendancy, only to be repositioned at another point in time. Importantly, by

envisioning the Australian approach as reflecting the life and activity of a policy community, we arrive at a deeper appreciation of the Australian approach to drug policy making.

Describing a policy community requires an examination of how that community functions. Like any community, a policy community has a history, a cultural basis for decision making, values, power relationships and characteristic forms of communication.

In the remainder of this section we will outline how the policy community functions through a description of the policy-making process.

Documentation of the policy process

Given the importance of partnerships in the policy process, it is surprising that relatively little research has been done to document the Australian drug policy process. There is little research also to describe the experiences of those who act as partners in the process and participate in the policy community. Berridge (2000) has noted that the real hidden population in drug research is the population of drug policy makers.

The Alcohol and Drugs Council of Australia in *Drugs, Money and Governments* measured key informant (n=150) perception of inclusiveness in the drug policy process through two questions in their government performance survey (Crosbie et al. 1995). This is one of the few indicators of the activity of the drug policy community in Australia.

Several insights can be gleaned from this material. First, the level of perceived inclusiveness varied significantly from jurisdiction to jurisdiction. Second, of the ten questionnaire items, the two items relating to inclusiveness rated most poorly, suggesting that the dissatisfaction with not being included was stronger than the dissatisfaction with other more outcome-oriented measures of policy performance. The only exception to this pattern was Queensland where the perception of inclusion in the policy process was perceived quite reasonably (Crosbie et al. 1998, p. 18).

Interpreting these findings is, however, difficult. Dissatisfaction with being left out of the policy process could indicate either an actual level of inclusiveness or a pre-existing expectation about appropriate levels of inclusiveness in policy making. In Queensland, for example, the perception of being reasonably included may derive from the fact that policy practitioners in Queensland were usually being excluded. The extreme dissatisfaction of practitioners in Victoria may have been due to high expectations of inclusive policy-making processes, perhaps related to historical precedents in the policy-making process in that State.

Whether or not these interpretations are sufficient, there remains a lot to be learnt about the attitudes and opinions of drug policy practitioners about the policy process.

Quinn (1992) outlined the political processes that generated the successful 'Living with Alcohol' program in the Northern Territory. The often-competing interests of government ministers, the media, the cultural environment and the alcohol industry were all part of the heady mix, which finally resulted in a very successful policy. Importantly, documentation of the process

provides some insight into what pushed this policy. In the case of 'Living with Alcohol', Quinn suggests that a spate of deaths, a report into Aboriginal deaths in custody, the formation of some local alcohol action committees and a push by the Northern Territory Parliament to liberalise liquor licensing produced sufficient government interest to facilitate the committee process, which finally recommended significant policy development. The policy process involved a range of stakeholders, a select committee consultation process and substantial negotiation between the various parties.

While commentary on the state of the policy process at any point in time is readily available, documentation of how the policy process has changed over time is less accessible. The policy process does change over time. Broome (2000), in a reflective piece on the impacts of drugs on political and social life, perceived a recent change to the policy process based on populist politics:

What is indisputable is that there has been an increasing tendency in recent years to react to public opinion rather than to attempt to lead it. Policies produced this way are not going to meet the needs of the community and will often see options reduced. (Broome 2000, p. 122)

Precisely how populist politics have infused the policy process in different ways at different times is difficult to ascertain. Populist politics are not new. Certainly, there have been different emphases given to the Australian approach at different times. The emphasis on alcohol and tobacco in the first NCADA was supplemented in the 1993–97 strategy with greater emphasis on illicit drugs. In the 1997–98 to 2002–03 policy, an even greater emphasis was placed on law enforcement responses and engaging

the non-government sector. Precisely *how* these shifts in policy came about – the real indication of the Australian approach – is, however, rarely documented.

There are significant gaps in our understanding of how policy makers and policy practitioners experience policy making. We know little about what policy makers themselves think about the Australian approach.

Outcome-focused policy documentation

While the Australian drug strategy itself has always paid attention to the structures of policy making, much of the evaluative endeavour is committed to commissions of inquiry (Appendix E) or the evaluation of outcomes (Table 2). Most of the recent drug policy research has not fully recognised the Australian approach to drug policy making because the focus of the research has been on outcomes.

An assessment of policy outcomes is critical for an understanding of the effectiveness of a strategy, and ultimately of government expenditure. But outcomes rarely provide insights into the workings of policy making itself.

Table 2 details a list of recent evaluations and research studies that have focused on the outcomes of policy practice, rather than on the process of policy practice.

The most celebrated example of how drug policy has been evaluated in terms of its outcomes has been ADCA's *Drugs, Money and Governments*. Indeed Crosbie, a key architect of this ADCA initiative, recently emphasised the need for accountability in drug policy through reliable outcome measures:

In recent years, the move towards policy analysis based upon outcomes has led to a diverse range of potential measures against which policy effectiveness might be judged and instruments or performance indicators by which it could be measured. (Crosbie 2000, p. 145)

These evaluations have been highly influential in determining policy direction, but with such an emphasis on policy outcomes, it is easy to lose sight of how policy positions were adopted in the first place.

Outcomes are like snapshots. The sequence of policy outcome reports listed in Table 2 acts like a photo album showing a history of outcomes for the Australian drug policy community. Snapshots can tell us important things about the appearance of a community, but often they cannot tell us about the more in-depth cultural bases of its activities.

This is the focus for the current report. This report will not attempt to conduct an outcome evaluation of the Australian approach, as a number of extensive reviews of policy outcomes are currently available. The submissions to the House of Representatives Standing Committee on Family and Community Affairs inquiry into 'Substance Abuse in Australian Communities' from the Commonwealth Department of Health and Aged Care and from the Commonwealth Attorney-General's Department are excellent reviews of the most recent outcome data.

This report describes the Australian approach from an analysis of historical material and interviews with policy practitioners. Description carries with it interpretation, analysis and the reporting of facts. All of these will make up our description of the Australian approach to policy making.

Table 2: Outcome-focused evaluation and policy documents

1987	<i>NCADA: assumptions, arguments and aspirations</i> : Monograph no. 1
1989	<i>National Campaign Against Drug Abuse 1985–1988: evaluation and future directions</i> : Monograph no. 12
1991	<i>Estimating the Economic Costs of Drug Abuse in Australia</i> : Monograph no. 15 (Collins & Lapsley)
1991	<i>Responses to Drug Problems in Australia</i> : Monograph no. 15 (Henry-Edwards & Pols)
1992	<i>Comparative Analysis of Illicit Drug Strategy</i> : Monograph no. 18 (NCADA)
1992	<i>No Quick Fix: An evaluation of the National Campaign Against Drug Abuse by the second task force on evaluation</i>
1993	<i>Awareness and Effectiveness of the National Campaign Against Drug Abuse and the Drug Offensive</i> (Makkai)
1993	<i>National Campaign Against Drug Abuse National Household Survey Report</i> (AGB McNair)
1993	<i>Drugs, Anti-social Behaviour and Policy Choices in Australian Society</i> (Makkai)
1997	<i>The National Drug Strategy: mapping the future. An evaluation of the National Drug Strategy 1993–1997</i> (Single and Rohl)
1999	<i>The Burden of Disease and Injury in Australia</i> (Mathers, Vos and Stevenson)

4. The States and Territories

The following section provides some background information for each State and Territory. When read in conjunction with the Australian overview, it should become clear that the Australian approach has brought together disparate elements of drug policy making from a vast range of social and political environments.

4.1 Australian Capital Territory

History of significant events in drug policy

- 1988 *Australian Capital Territory (Self-Government) Act* (Cth)
- 1989 *Drugs of Dependence Act*
Appointment of a select committee to report on HIV, illegal drugs and prostitution
- 1991 Select committee proposes expiation scheme for cannabis and heroin trial
- 1992 Simple Cannabis Offence Notice (SCON) expiation scheme for cannabis offences introduced
NCEPH began study to determine feasibility of a heroin trial
- 1995 ACT Drug Strategy released
Heroin Pilot Task Force established by ACT Government
- 1996 Shift to a purchaser/provider model for delivery of community services including alcohol and drug services
Heroin Pilot Task Force recommends that a trial proceed
Commonwealth Government declined to authorise importation of heroin to support the trial

- 1998 Discussions begin around trialling a 'supervised injecting place' (SIP)
- 1999 ACT drug policy 'From Harm to Hope' released
Supervised Injecting Place Bill supported in principle by the Legislative Assembly
Service providers ADDINC appointed to run the SIP
Intention to initiate a community-based methadone program announced
- 2000 SIP trial postponed by ACT Government for 18 months

The Australian Capital Territory, though small in size, has an impressive record as the driver of innovation in Australian drug policy. The intimate relationships between policy makers, service providers and the community have resulted in a policy community with a keen regard for the diversity of voices. The keen regard has opened up possibilities for new and innovative drug policies that garner significant community support. The innovative drive is, however, located in a political environment where drug policy occupies a significant profile in both local and national politics by virtue of the ACT housing the seat of the Federal Government and the City of Canberra. The ACT approach has been to debate, refine and incrementally build consensus around agreed policies. As evidenced in the feasibility study and the SIP trial, politics are never far away from ACT drug policy, with both initiatives being subject to party-led political intervention. Drug policy making in the Australian Capital Territory should serve as a reminder that the drug policy community is inherently a political community and that rational argument, debate and consensus are all but tools in a heated public and politically charged environment.

4.2 New South Wales

History of significant events in drug policy

- 1979 Methadone maintenance pilot program commenced
- 1983 Formation of AIDS Drug Information Collective involving drug users, police and service providers
- 1986 Needle and syringe program (NSP) started as a pilot program
- 1987 NSP became official government policy
- 1992 NSW Drug Strategy released
- 1992 Review of NSW drug detoxification services
- 1995 Inquiry into police corruption launched
 - Death of Anna Wood in a nightclub related to ecstasy use
- 1997 Woods Royal Commission report
 - Inquiry into deaths relating to methadone initiated
- 1998 New methadone policy – reducing take-away doses
- 1999 Public outrage over a photograph of a young boy injecting in an alley, which appeared on the front page of a tabloid newspaper
 - Wayside Chapel opened up the T-Room
 - Drug summit initiated by Premier Carr
- 2000 Office of Drug Policy established
- 2001 Injecting room trial commenced

New South Wales has a history of public inquiries and royal commissions into drug use. It also has a history of strong political investment in the formation of drug policy. The New South Wales approach to the policy process combines a commitment to public accountability and a commitment to the political process. The political imperatives that drive drug policy are strong. The influence of politics tends to be more evident in New South Wales than in other jurisdictions, both because of accountability mechanisms and because the national media tend to follow events in Sydney more closely than in other capital cities. Debates about methadone, tolerance rooms and needle and syringe programs are reported nationally, as are debates about police corruption.

The New South Wales approach involves sophisticated political strategy and wide-ranging public debate. Sometimes the debate and the strategy are fierce, and have resulted in rapid policy responses to media coverage. For the State that experiences the largest impact of drug harms through having the highest population of drug users, the problems in New South Wales are large and require large multi-faceted and politically strategic responses. By virtue of the fact that New South Wales has the largest population of drug users and the highest proportion of drug mortality and morbidity in Australia, it stands apart from the rest of Australia. Through sheer political weight and population density, New South Wales often drives national drug policy.

4.3 Northern Territory

History of significant events in drug policy

- 1977 Cannabis laws reformed to reduce fines associated with cannabis
- 1981 Methadone program restricted to reduction therapy
- 1990 March against the Grog in Alice Springs
- 1991 Bipartisan committee formed to examine alcohol abuse
- Living with Alcohol program established
- 1992 Shift to provision of alcohol and drug services through the community sector
- 1994 AUSDOC service established for prescription of morphine by prominent doctor. AUSDOC criticised as mainly servicing drug-dependent persons
- 1995 Wine Cask Levy introduced to contribute funding towards activities aimed at reducing public nuisance and drunkenness
- Introduction of the 0.05 legal alcohol limit for drivers
- Medical community in Darwin hosted a methadone conference
- 1996 Cannabis expiation scheme introduced with amendment to *Misuse of Drugs Act*
- Alcohol and Drugs Service recommends expansion of methadone maintenance to persons infected with HIV; recommendation rejected by the NT Government
- Coronial inquiry initiated into methadone overdose deaths
- 1997 High Court decision to restrict collection of taxes by States and Territories
- Agreement reached with Commonwealth for funding from alcohol sales
- Commonwealth continued to support the Living with Alcohol program
- S8 Working Group and S8 Forum established to consider pharmaceutical issues and doctor shopping
- 1998 Voluntary contract and notification system established through the S8 committee to monitor prescription of morphine products and curb doctor shopping
- Kava management scheme introduced to regulate the consumption of kava
- 1999 Health Insurance Commission initiated an inquiry into high levels of prescription morphine in the Territory
- 2000 Diversion program established to divert juveniles away from the justice system (does not include drug offences, but supports drug treatment for participants)
- Proposal by the National Liberal Party to extend mandatory sentencing to drug trafficking offences

The Northern Territory approach is characterised by a fierce independence and its status as Australia's last frontier. This independence is borne out of the Northern Territory's remoteness and its small population. There are long memories in the Northern Territory which carry through the political process and the process of drug policy making. Underneath the slow pace of life, there is a rapid stream of intense political activity. Bureaucrats are acutely aware of the links between departmental activity and political life. Some of the toughest drug policies have been instituted in the Northern Territory on different sides of the policy fence.

The Northern Territory was the first jurisdiction to seriously institute a hypothecated alcohol tax as part of an effort to reduce consumption, but has onerous methadone policies. The Northern Territory has had some of the most sophisticated examples of service providers finding innovative ways of working within the laws. As coercive as the different drug policies have been, the service providers in the Northern Territory find a way to maintain a measure of freedom. The Northern Territory approach to drug policy making captures this character. Sometimes harsh and unforgiving, the Northern Territory approach is best described as strong-willed.

4.4 Queensland

History of significant events in drug policy

- 1968 First methadone programs introduced
- 1971 Health Committee on Drugs of Dependence and the State Drug Education Program established
- 1978 Alcohol and Drug Dependence Services within the Department of Health, known as Biala, established as a separate treatment agency
- 1979 Reorganisation of Alcohol and Drug Education under Monte Benjamin
- 1980 Hoteliers become involved in regulating consumption through promoting responsible serving practices
- 1982 Comprehensive methadone standards and policy guidelines provided
- 1986 Possession of needles and syringes decriminalised and availability program commenced
- 1987 Commission of Inquiry into Possible Illegal Activities and Associated Police Misconduct (Fitzgerald Inquiry) report released
 - New offence established for inappropriate disposal of needles and syringes
- 1989 Criminal Justice Commission established as a result of the Fitzgerald Inquiry
- 1991 Reorganisation of Queensland Health and move to purchaser/provider funding relationship
- 1993 Queensland Drug Strategy released
 - Safety Action Project launched on the Gold Coast

- 1994 Criminal Justice Commission recommends decriminalisation of cannabis
Recommendation not adopted
- 1995 Drug Strategy re-released
- 1998 Brisbane Lord Mayor's Illicit Drug Task Force convened
- 1999 Queensland Drug Summit; focus on youth issues
- 1999 Queensland Drug Strategy 'No Quick Fix' launched
- 2000 Queensland Government announced intention to establish a drug court

Queensland has a 27-year history of continuous conservative government followed by a rapid change of governments during the 1990s. As a consequence, drug policy is heavily politicised in Queensland. The Goss Labor government introduced unit costing and a purchaser/provider funding framework and the non-government sector is still developing sustainable mechanisms to keep a unified voice at the policy table. The high amphetamine use levels and the emerging Brisbane street drug market are counterposed to the issues for rural and regional Queensland.

On a more encouraging front, Queensland has been at the forefront of 'place planning' and community policing strategies. The difficulty for Queensland may be that, while drug policy planning at a local level seems to be exemplary, the system underpinning the policy community is not as stable. In the absence of continuity of government leadership, the community sector has developed in disparate directions. There is a continuing challenge to find a balance between local strategies and a State-wide direction.

4.5 South Australia

History of significant events in drug policy

- 1974 Methadone prescribing commenced by psychiatric services practitioners
- 1976 Drug and Alcohol Services Council established

Royal Commission established to examine the non-medical use of drugs
- 1979 Royal Commission report *The Social Control of Drug Use* released
- 1984 Drug Aid and Assessment Panels established
- 1986 Cannabis expiation notice (CEN) scheme introduced for minor cannabis offences
- 1991 Select Committee established to report on drugs of dependence
- 1993 Aboriginal Drug and Alcohol Council established
- 1995 Select Committee report with recommendation to streamline the CEN scheme
- 1996 *Expiation of Offences Act*

Heroin overdose prevention strategy established
- 1997 *Liquor Licensing Act* placed responsibility for service practices on hoteliers; establishment of liquor licensing committee

Tobacco legislation introduced prohibiting smoking in public places

- 1998 South Australian Drug Strategy
'A Time to Act' released
- Select Committee on a Heroin Rehabilitation Trial formed
- 1999 Select Committee report released
- Premier announced the intention to establish a drug court
- 2000 Number of cannabis plants attracting a fine reduced from ten to three
- South Australia's Drug Court commenced
- Illicit Drug Working Party established by the Health Department to develop a comprehensive approach to illicit drug issues

The South Australian approach is characterised by stability and incremental change. The policy community has a corporate and institutional memory that few jurisdictions can match. The stability of the Drug and Alcohol Services Council (DASC) combined with durable policy processes enables the balance of voices in the community to sustain innovations, albeit in an incremental fashion. Once an innovation is established, the South Australian approach is to shape the initiative in response to changing political, social and policy needs. The relationships within the policy community are borne out of a history of financial, advisory and policy interdependence. This stability in relationships has enabled the policy community in South Australia to develop controlled drug policy debate in a manner not seen in other Australian jurisdictions.

4.6 Tasmania

History of significant events in drug policy

- 1964 Pilot production for opiate alkaloid poppies began on the north-west coast of Tasmania
- 1968 *Alcohol and Drug Dependency Act*
- 1972 Decision by Commonwealth and State governments to restrict poppy growing to Tasmania
- 1992 Methadone services introduced
- 1995 Tasmanian Government moved to expand the methadone program into the private sector
- 1996 Tasmania's Drug Strategy developed
- Alcohol and Drug Foundation of Tasmania, peak body for NGOs disbanded
- Interdepartmental Committee on Drugs and Alcohol established
- 1997 Minister announced a review of alcohol and drug services
- 2000 Visit from the International Narcotics Control Board to inspect poppy industry
- Therapeutic use of cannabis investigated by Community Development Committee
- Diversion program introduced in Tasmania

Tasmania is a small policy community subject to many external forces. Recent changes to the patterns of drug use have impacted heavily on the usual processes for making policy. Continued high levels of unemployment, high levels of diverted prescription pharmaceuticals and the growing demand for illegal opioids suggest that the quiet intimate community that characterised Tasmania is changing. The recent diversion initiative has perhaps brought the elements of the policy community together. External pressures in the form of international narcotics control and Commonwealth concern over the opioid industry will continue to place a unique burden on the policy community in Tasmania.

4.7 Victoria

History of significant events in drug policy

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| <p>1959 Establishment of Alcoholism Foundation of Victoria (later renamed Australian Drug Foundation)</p> <p>1960s Autumn School on Alcohol and Other Drugs coordinated by St Vincent's Hospital</p> <p>1978 Working party appointed to examine alcohol and drug issues, with a focus on interdepartmental administrative and governance arrangements</p> <p>1980 Report released by working party</p> <p>1985 Victoria's Drug Strategy released</p> <p>Commencement of Victorian Methadone Program</p> <p>1989 Commencement of Victorian Needle and Syringe Program</p> | <p>1991 Redevelopment of specialist treatment services begins under Liberal government</p> <p>Government withdraws from direct service provision</p> <p>1993 Regionalisation of Drug Treatment Services as part of the redevelopment of services</p> <p>1995 Turning Point Alcohol and Drug Centre established</p> <p>Premier's Drug Advisory Council (PDAC) established to examine drug use, with a focus on illicit drugs (chaired by Professor Penington)</p> <p>1996 Premier's Drug Advisory Council (PDAC) report</p> <p>Police launched the Cannabis Cautioning Scheme to divert minor offences away from the criminal justice system</p> <p>1997 Government's response to the PDAC inquiry, 'Turning the Tide', announced: \$100 million over three years for a range of projects</p> <p>1998 Cannabis Cautioning Program extended to deal with other illicit drugs</p> <p>1999 Incoming Labor government makes a commitment to examine feasibility of establishing five supervised injecting facilities</p> <p>Drug Policy Expert Committee (DPEC) appointed</p> <p>2000 Following the DPEC report, the option for a trial of supervised injecting facilities debated in Parliament and rejected</p> |
|--|--|

DPEC released final report in December, focusing on the need to develop a more cohesive social infrastructure as part of the approach to dealing with drugs

Introduced a range of changes to tobacco control legislation to prohibit smoking in dining areas and increase penalties for sales to minors

Commonwealth and State governments sign the Illicit Drugs Diversion agreement

The Victorian approach has historically been characterised by its independent thinking in both government and non-government sectors. Victoria has a strong research base, a highly developed treatment system and an influential policy community. In many ways Victoria seems self-contained in its policy community and is often absorbed in its own policy issues. Often the site of significant debate and policy contest, Victoria is almost a think tank for the national policy community. Less publicly volatile than other jurisdictions, the Victorian approach has been characterised by leadership from the level of the community. In the past ten years, significant changes have been willed upon the drug treatment services sector through the reduction of direct government service provision. When drug policy reviews do occur in Victoria, they are usually tightly controlled through expert committees. These policy reviews, which occur approximately every five years, are matched by a relative quiescence between times of intense policy activity. When policy reform occurs, the government brings experts together with the range of interest groups, and develops consensus positions through the committee process and private negotiations. The collaborative policy community approach has been dominant in Victoria.

4.8 Western Australia

History of significant events in drug policy

- 1972 Williams Honorary Royal Commission established
- 1973 Methadone treatment becomes available through private practitioners
- 1974 Alcohol and Drug Authority (ADA) established
- 1978 Prescription of methadone assumed by the ADA
- 1981 *Misuse of Drugs Act* introduced to increase penalties for drug-related offences
- 1988 Court diversion service introduced
- 1994 Amendments to *Poisons Act* to establish needle and syringe exchange programs
- 1995 Move to purchaser/provider framework, with Health Department assuming policy advice, and ADA responsible for treatment
 - Premier's Task Force on Drug Abuse established in Premier's Department
- 1996 Implementation of recommendation of Premier's Task Force on Drug Abuse
 - Alcohol accords established to encourage responsible drinking and responsible service practices
- 1997 WA Drug Strategy, 'Together Against Drugs', released
 - WA Drug Abuse Strategy Office formed
 - Next Step Specialist Alcohol and Drug Services established

- 1997 Alcohol and Drug Policy Branch (ADPB) established in Mental Health Branch
- Local Drug Action Groups (LDAG) established
- Select Committee interim report released, focusing on law enforcement powers
- ADA established a community methadone program
- Prescribed naltrexone used to assist in the detoxification of heroin dependents
- Western Australia's heroin overdose prevention strategy initiated
- 1998 Select Committee final report released
- Community Service Drug Teams established
- Host responsibility project launched to encourage responsible service practices
- Trial of cautioning and education system for simple cannabis offences launched
- 'Gurd' drug education program launched by WA Police
- 1999 Introduction of smoking restrictions in public places
- Government announced intention to establish a drug court
- New legislation banning smoking in public places including restaurants passed
- LDAG Inc. established
- Second action plan, 'Together Against Drugs Strategy 1999–2001', launched
- 2000 WA drug courts established
- 2001 WA Drug Summit

Western Australia's approach to drug policy making has undoubtedly been influenced by its isolation from the rest of the country. This isolation has spawned a sense of individualism and independence. While continuing to work within the framework of the national drug strategy, Western Australia has adopted an alternative policy framework upon which to base its own drug policy activities, and has developed its own unique advisory structure, which now many other States and Territories consider 'cutting edge'.

The Western Australian approach demonstrates the potential for linking the community to a structured system of advisory and funding arrangements. Through policy review and restructure, it has drawn upon its culture of separateness and formed its own solutions, while maintaining coherence with the national strategy.

5. An overview of the Australian approach

During consultations with policy practitioners, it became apparent that the original conceptualisation of partnerships in the Australian approach required greater sophistication. The term ‘partnership’ did not adequately describe the breadth of relationships that constituted the activities of those involved in drug policy making. It also did not explain the relationships between different arenas in the sector. Some partnerships were financial, some political and some were simply about who worked in the office next door.

Partnerships in Australian drug policy are connections between people, ideas and institutions. These connections are similar to those found in a community. The policy community provides an overarching example of partnerships.

Trying to be more specific about the types of relationships in the sector, we began to see that the policy community was supported by a system of financial and advisory structures. Overlaid across the system and community was a policy framework: a set of words that established a common language for members of the community.

The Australian approach will be described in terms of it being a policy community, supported by a policy system that shares a common language, a policy framework.

5.1 Policy communities

The drug policy community is a community that participates directly in shaping the decisions that are made in managing drug use. There are a number of ways to conceptualise drug policy making. These include the ‘stumbling through’ model, the ‘policy cycle’ model, the ‘input/output’ model, and numerous others. We have chosen the policy community model in order to understand the Australian approach to drug policy making. Our decision was informed by the data collected in our consultations and historical examples of Australian drug policy, rather than by a review of the advantages and disadvantages of other models.

We argue that, from the late 1970s to 2000, drug policy in Australia has operated chiefly through a policy community approach. While the emphasis of policy activities has changed considerably over time – from the drug summit workshops held in 1985 to the State-based policy developments in 2000 – there is a consistent pattern to policy making.

The central mechanism for policy process across jurisdictions has been for government to bring interested parties together in public and private consultations to develop policy approaches that have broad-based support and mobilise the community into action with the least amount of political conflict and public unrest.

One example that perhaps exemplifies the policy community approach is the Australian response to HIV. As numerous interviewees noted, the policy response was typically Australian and involved bringing people together and developing multi-faceted strategies that mobilised significant sections of the community.

The mixture of bringing people together and mobilising support is a key feature of the Australian approach. An excellent example of this kind of approach operating at a local level is that described by Keenan et al. (2000). What sustains this approach more broadly is the community of policy makers who participate in the national drug policy community.

What is characteristic of the national drug policy community are the policy communities from each jurisdiction. These communities overlap and cover different States and Territories, and like communities more generally they have fluid boundaries between different policy arenas. Often policy professionals working in one jurisdiction have worked in other jurisdictions and have substantial professional networks that provide stability and an institutional memory. Thus, the policy community in one State or Territory can have intimate and long-term links with the policy community in other States and with the policy community at the Commonwealth level.

The policy community carries with it the history and values underpinning the Australian approach. Many of those we interviewed reflected on the values of the community. The values of that policy community are expressed in the six themes that have structured our description: *independence, a diversity of voices, the good sense of bureaucracy, frank and fearless advice, checks and balances, and leading the community*. This section of the report will examine these themes – the core values of the Australian policy community – in more detail.

5.2 The system underpinning the policy community

Having participated in a relatively stable system overlaid by changing rhetorical frameworks, many interviewees distinguished between the system (of advisory structures and funding arrangements) and the policy framework (the policy rhetoric dominant at any particular time). We believe that this distinction is a useful way of thinking about the Australian approach.

The values inherent in the system can be seen in the themes articulated in this report: *independence, a diversity of voices, the good sense of bureaucracy, frank and fearless advice, checks and balances, and leading the community*. The final theme articulates a central and overarching value that dominates the Australian approach, *humane pragmatism*.

Contradictions to these values occasionally appear throughout the history of each jurisdiction. As in any other community, there can be no single mechanism that dominates a policy community. At times, more ideological ways of developing policy may gain ascendancy at the expense of more negotiated and accommodating approaches.

Some key examples of these exceptions may be found in the drug policy process in the Northern Territory. The no-methadone policy established in 1997 and the actions of the Health Insurance Commission to restrict morphine prescribing in 1998 are perhaps examples of more centrally determined policy approaches. They do not accord with the consensus-building model of policy making we have outlined so far.

Many of the interviewees in a number of jurisdictions suggested: 'we are different here'. What makes the policy community approach an appealing way of understanding Australian drug policy is that it assumes that there is inherent variability in the system. While there are differences between States and Territories in how drug policy is made, they are embedded in a system that tolerates these differences. In fact, the system is designed to allow them to flourish. That is why the key value of *independence* captures an important aspect of the Australian approach.

In other jurisdictions, there are also examples of policy making that do not fit neatly within the policy community approach. In Victoria, for example, the move to a purchaser/provider funding framework in 1995 took place with very little consultation with the non-government sector. These changes were consistent with a number of government policy changes across many sectors under the Kennett Liberal government. At the time, the reduction of direct government service provision was being implemented across the whole of government. In fact, it was suggested to us that the only reason the purchaser/provider framework was not introduced earlier was because of industrial complications in moving the drug sector workforce into new industrial awards. The policy model in this illustration is based within an industrial relations model of policy development rather than within an accommodation/consultative policy development model.

The system of financial and advisory structures, however, provides a level of stability to an otherwise highly contested field. Multiple committees with disseminated decision making ensure that it will take an enormous policy rupture to change the system. The system provides a level of

stability through its capacity to manage difference and diversity. The system structurally adjusts to change. One such change was the addition of the Australian National Council on Drugs.

The system has not always been stable. A number of people noted in the late 1980s and early 1990s that meetings of senior health and law enforcement representatives were sometimes quite uncomfortable. At the time, the drug policy community met infrequently. Informal preliminary meetings before the annual Ministerial Council meetings were fundamental to the development of policy at a national level. Prior to the second evaluation of the NCADA, the law enforcement representatives decided to enhance the standing of law enforcement. One of these meetings is referred to by its location: the Manly meeting.

At the 1990 Manly meeting, some important developments for law enforcement grew out of an informal meeting of State health, education, corrections and law enforcement representatives. At this meeting, it was decided to recommend that 10 per cent of the health expenditure in each State be allocated for law enforcement drug policy work. The provision of more funding encouraged senior police officers to attend the senior officers meetings. In the late 1980s Frank Hansen, the New South Wales Police drug and alcohol policy coordinator, attended the national senior officers group at the rank of sergeant. By 1992, New South Wales and Victoria were both sending assistant commissioners to these meetings.

The increasingly sophisticated role of police in the advisory structures has contributed to the stability of the system. The system provides a level of stability through its capacity to manage difference and diversity. It also structurally adjusts itself to accommodate change.

The system has been designed to facilitate communication and coordination across levels of government and different parts of the sector. Like any community, however, there are arenas of activity that by definition remain distinct from each other. In the drug policy community the system of advisory and funding mechanisms serves both to bring people together and to maintain those distinct arenas.

For the system that underpins the Australian approach to continue to be healthy, it has to be recognised that the drug policy community, like any such community, needs to maintain the distinctions (not divisions) between different policy arenas. The arena of activity that defines the NGO sector is precisely that it is non-government. The NGO sector has different mechanisms of accountability from those of government and has specific constituencies that may differ substantially from those of government.

However, the role of government in Australia has changed, as it has in most industrialised nations over the last 15 years. The role of the non-government sector has also changed. The system that sustains the drug policy community needs to recognise the changing attributes of different policy arenas.

However, reducing the distinctions between different policy arenas runs the risk of losing the delicate balance required in the drug policy system. The danger of dissolving policy arena distinctions goes to the heart of our liberal democratic system (Parkin 2000). This system acknowledges two political traditions, the liberal and the democratic. The liberal tradition places great significance on

the rule of law, the importance of a strong private market sector, a general acceptance of individual rights and the right for free association of individuals. The democratic tradition, on the other hand, asserts the rights of individuals to collectively engage in political activity, legitimises a state sector overseen by representative political institutions which underpins the provision of public services by government to its citizens. There is an ongoing tension between these two traditions in the liberal democratic system. This tension is most readily noted in the changing role of the public and private sectors in delivering services. Oscillations in drug policy invariably result from shifting commitments to either the liberal or democratic traditions.

Drug policy in law enforcement encompasses some of the most onerous legal sanctions, and some of the most liberal evidentiary provisions in law. For example, police access to premises is usually granted only by specific legal authority or through imminent risk. It is possible in some jurisdictions to conduct a search *without a warrant* where there is evidence of the commission of a drug offence. The specific provisions of drug law go to the heart of the sovereign rights of every individual. The rule of drug law is preciously protected by the democratic process so as to enable socially just and publicly sustainable social policy. It is critical that drug law reform through drug policy is responsive to democratic process.

Drug services often involve significant intervention into the lives of citizens. The provision of public health interventions (such as prescribed heroin trials and the provision of supervised injecting facilities) challenge many international drug control sanctions. It would be doubtful whether such interventions would be possible if the policy arena was moved out of the role of the state and into the role of the free market, or into the hands of theologically based institutions. Maintaining democratic control of the drug policy arena is critical to the capacity of drug policy to respond to the public good.

In the current globalised context, where health service provision is becoming centralised down to a smaller number of larger health service providers, there is a danger that moving governance of drug policy into the private sector would result in a less regionally independent and ultimately a less democratic process over the control of service provision. If the drug policy arena was to move further out of the public sector (consistent with a liberal tradition), drug services may be treated like a health marketplace, and market forces may well then direct policy change. With the lives of young people at stake, this is indeed a perilous danger and a reminder of the value of retaining drug policy within the protection of the democratic tradition.

The system is currently stable. However, we must recognise that creating further change to the system by reducing distinctions between policy arenas carries with it significant dangers.

5.3 The drug policy framework

The policy community, like any community, shares a common language. The policy framework establishes the policy community's common language. Without agreement over definitional terms, the community can lose coherence, purpose and effectiveness.

In contrast to the system underpinning the policy community, the drug policy framework (the rhetorical framework) is more unstable – as suggested, for example, by Timothy Rohl, co-author of the most recent evaluation of the NDS:

In spite of the many local successes and considerable international acclaim, the NDS is extremely fragile, and is held together more by good will than by good policy or effective leadership. (Single & Rohl 2000, p. 130)

There was particular discontent across all jurisdictions with the current status of harm minimisation as a key term to encompass supply reduction, demand reduction and harm reduction in the NDS. As Single and Rohl anticipated, the policy rhetoric, based firmly in the term 'harm minimisation', has lost a lot of meaning. Those interviewed for this study were primarily concerned that harm minimisation can no longer provide strategic direction for drug policy. Without agreement over the meaning of key terms, the framework can no longer hold people together as it once did.

Harm minimisation has not failed. In fact, harm minimisation (or harm reduction as it was originally defined) has achieved extraordinary success and is the envy of the international community. The Australian drug policy community, however, recognises

that, through the continued debate and redefinition of harm reduction/minimisation, a consensual meaning of the rhetoric has slowly disappeared.

Representatives of the police are mainly concerned about the inability to be clear as to what constitutes harm minimisation. These concerns have been raised by police commissioners in a recent policy discussion document (Australasian Centre for Policing Research 2000).

A number of State police coordinators and members of the Intergovernmental Committee on Drugs reflected on the complexities of harm minimisation and noted the difficulty of selling harm minimisation to police 'on the ground'. The Australian approach to harm minimisation, however, is widely acknowledged at the international level, and contrasted to 'zero tolerance' policy frameworks, such as those applied in the United States and Sweden.

Many practitioners recognise that, despite the debate over the extent of the commitment to harm minimisation, an important component of the Australian approach is the commitment of members of the policy community to sit together at the policy table. For many, the function of the policy framework is to bring people together in a consensual way to deal with drug issues.

There have been a number of alternative drug policy frameworks proposed based on different rhetorical positions. One such framework discussed by many during the course of the study is the prevention framework. Given the disquiet over the capacity of harm minimisation to bring people together, a number of groups suggested that discussion should centre on a new framework based on the broad strategy of prevention of harm and drug use. A recent discussion

paper by the Police Commissioners Subcommittee on Drugs suggested that prevention should complement the harm minimisation framework.

Rather than a review of the prevention material, we encourage further debate around prevention in light of the feelings toward the changing meanings of harm minimisation. If harm minimisation cannot bring people together at the policy table anymore, then we believe the time may be ripe for considering a new consensus-building policy framework. One characteristic of the Australian approach has been the adoption of a policy framework that can bring people together. Whether the framework is harm reduction, harm minimisation, prevention or any other policy framework, it must be able to bring people together.

One particular concern with prevention expressed in consultations has been that, in order for the term to be inclusive and to bring people to the policy table, it must be cast in terms greater than simply prevention of illicit drug use. Prevention from its earliest use in 1985 has focused on the prevention of problems and harms as well as prevention of illicit drug use. Maintaining this broad definition of prevention will be a key element to a prevention framework.

When prevention is cast only in terms of prevention of use, some members of the policy community could be excluded. Drug user groups, who are so central to the Australian approach, may suffer if prevention of drug use is a central priority.

Since the redefinition of harm minimisation in the last NDS, the common language has splintered. While the policy community and the system underpinning it have successfully established themselves, the policy framework, the common language, has suffered.

6. Challenges and achievements

The many achievements of the Australian approach are listed in the body of this report through the review of the activities of the States and Territories. The central challenge for the Australian approach to drug policy is to sustain a commitment to the key elements of the approach. The challenges are discussed in this final section.

6.1 The burden of disease in Australia

There are many challenges for Australian drug policy. An examination of the health outcome indicators from the Australian Institute of Health and Welfare (1999) illustrates the magnitude of the challenge.

- Almost 10 per cent of the total burden of disease in Australia in 1996 was attributable to tobacco smoking.
- The net harm associated with alcohol use is estimated at 2.2 per cent of the total burden of disease.
- Illicit drug use is associated with around 1,000 deaths per year in Australia; however, these deaths are typically among young persons. Illicit drug use is estimated to have accounted for almost 2 per cent of the total burden of disease in Australia in 1996.
- The proportion of people using any illicit drug rose from 17.8 per cent in 1995 to 22.0 per cent in 1998 (AIHW 1999).
- Half the burden associated with mental health comes from heroin dependence and harmful use.

- The proportion of total deaths accounted for by illicit drugs is around half the proportion of years of life lost, reflecting the fact that the consumption of illicit drugs is most widespread among young people.

The challenges presented in this report are primarily about how to do drug policy rather than what outcomes to produce. This report has focused on the process of policy making: how to form partnerships; how to achieve balance; how to find social justice; how to conduct evidence-based practice; and how to maintain a coordinated approach.

We have focused on the policy community, its system of advisory and funding structures and the policy framework as three cornerstones to understand the Australian approach. The final section examines the challenges not just in terms of outcomes, but in terms of the six themes we have used to describe the values that underpin the Australian approach to drug policy making.

6.2 Independence

While State and Territory independence is necessary in the national drug strategy, this independence is a two-edged sword. Maintaining independence, while at the same time ensuring equity and access to services, is essential. The Northern Territory, for example, has reserved the right to manage opiates differently from other jurisdictions. There is, however, the possibility of more damage to the community through the spread of HIV and the hepatitis C virus if a uniform strategy to manage illegal opiates is not put in place. Likewise the Northern Territory has significant alcohol and tobacco control problems. The success of the 'Living with Alcohol' campaign needs to be sustained through a reinvigorated Northern Territory alcohol strategy.

The impetus for specific endeavours rests with the individual States and Territories rather than with the Commonwealth. A number of participants noted the balance of interests in State–Federal relationships. Without allowing the States and Territories the appropriate level of independence, the Commonwealth will never gain the cooperation necessary to implement national policy.

There was a perception in a number of the jurisdictions that drug policy in Australia is driven by concerns in New South Wales. Although New South Wales has the highest density of drug users and the greatest proportion of drug-related harm, many interviewees from States and Territories with a vastly different balance of drug-related problems were quick to note that New South Wales is an exception with regard to the overall patterns of drug consumption.

Western Australia, the Northern Territory, Queensland and South Australia all have low population densities, small injecting drug user populations and large rural sectors. The problems for these jurisdictions are vastly different from those experienced by New South Wales. A policy challenge emerges: how can the needs of the most affected jurisdictions be balanced with those of jurisdictions that have quite different issues? How can the need for a uniform approach be balanced with independent jurisdictional concerns?

A key achievement of the Australian approach has been to balance the independent needs of the States and Territories with the need for a national approach. But there is a constant and necessary tension in the Australian approach and a constant challenge to ensure that the balance between uniform national strategies respects individual and independent jurisdictional differences.

6.3 A diversity of voices

Maintaining the capacity to tolerate a diversity of voices in the policy community is the most significant challenge for the Australian approach. The Alcohol and Drug Council of Australia, in particular, embodies the principles that maintain a diversity of voices.

Maintaining the balance in the diversity of voices can be a valuable and time-consuming task. In focus group discussions, service providers described how partnerships between services holding different philosophies can work well. The Australian National Council on Drugs itself is a microcosm of the diversity of voices in the drug policy community.

Partnerships illustrate an essential part of the Australian approach – sustaining a diversity of voices. However, the challenge for the future will be to sustain that diversity in a changing meaning of partnership.

6.4 The good sense of bureaucracy

There is a central place for bureaucracy in maintaining the system of policy making and in being a source of change. The good sense of bureaucracy refers to both the good sense inherent in a bureaucracy replete with committed individuals, and the good sense to have a bureaucracy to enshrine the role of government in the drug policy process. The challenge is to maintain the good sense of bureaucracy in an environment where governments worldwide have reduced their size and functions.

The warning of the loss of institutional memory that was sounded by Single and Rohl (1997) should again be heeded. Maintaining confidence in the policy community and the system in which it is embedded is essential. Many reflected on the need and the importance of the role of the bureaucracy in supporting the policy community and the system underpinning the Australian approach.

The Intergovernmental Committee on Drugs represents the peak organisation through which the good sense of bureaucracy is achieved. Maintaining confidence in the IGCD as the central policy-making structure is essential for the future.

The good sense of bureaucracy, however, needs to be tempered with the need to maintain simplicity in the system. The complex web of national advisory committees at times provides a daunting prospect for the members of the policy community.

The network of advisory structures cannot continue to grow and become more complex and more difficult to manage. As much as the complex system provides stability, it may also become an impediment to innovation. The good sense of bureaucracy needs to be tempered and balanced with the good sense of the broader community.

6.5 Frank and fearless advice

The capacity to provide frank and fearless advice varies across the different Australian jurisdictions. Nevertheless, it was a theme that policy practitioners reiterated as being a prime achievement and central value of the Australian approach. Managing the impacts of frank advice for bureaucrats is a constant difficulty. For drug policy advocates, strategising through the provision of advice is a full-time job.

Having the capacity to be frank and fearless in debate is a necessary part of the activities of the policy community, and one that should be fostered. Annie Madden, coordinator of the Australian Injecting and Illicit Drug User Group, the Australian Intravenous League (AIVL), has noted that the inclusion of drug users in future debates over the Australian drug policy framework will be a major challenge. Her comments at the New South Wales Drug Summit in 1999 had a significant impact on the summit:

As a drug user for 13 years I can tell you that it is stigma and discrimination that has most prevented me and other drug users from making healthy choices. What I mean by this is that it is fear of discrimination, stigma and judgement that stops us going to the local needle exchange program, for fear of recognition. It stops us getting support and assistance from our families and friends because we do not want them to hate us or, worse still, for them to suffer hatred because of our behaviour. It stops us from seeking medical assistance for all sorts of health problems because we fear being labelled as drug seekers. Discrimination is killing

us. Drug users are not the enemy. We are real people suffering a great deal of unnecessary pain, illness and death. Drug users are part of the community: we are your children, your sisters and brothers, parents and grandparents, taxpayers, employers, employees; and, most importantly, we are your friends. (Drug Summit 1999, extract of proceedings, 18 May 1999)

The response of the tabloid press to these comments was vehement. The intensity of the attacks themselves caused a response from more compassionate members of the policy community. Disclosing one's life as a drug user is perhaps an act few would choose in the current social climate. The community is fundamentally challenged when drug users frankly state their case. The Australian approach of including drug users in the policy community continues to be an achievement. It will also continue to challenge discriminatory community beliefs about drug use.

Another particularly important source of frank and fearless advice can be found in the activities of the Alcohol and Drug Council of Australia (ADCA). The frank and fearless advice of this national body has highlighted a perceived secrecy and lack of accountability in the national drug strategy. From its 'No Quick Fix' evaluation through to its most recent policy document, the ADCA has focused on accountability by monitoring income and expenditure in each jurisdiction. A constant tension for the ADCA is its proximity to the system of advisory structures in the national drug strategy.

One of the most innovative strategies to maintain discussion of key drug policy has been the introduction of the ADCA's list server Update. Although at times Update has been the site for more personality-based discussions, it has contributed significantly to the national policy community and illustrates how new technology can contribute to frank and fearless debate.

6.6 Checks and balances

One of the key mechanisms of checks and balances is through continued dialogue between service providers and government. With more States and Territories, such as Western Australia and the Northern Territory, adopting more complete purchaser/provider funding bases, there is the potential to lose the capacity to maintain checks and balances within partnership-based funding mechanisms. Partnership has lost meaning precisely because the funding mechanisms in purchaser/provider models do not necessarily reflect equity in policy practice.

A number of interviewees commented on the difficulty inherent in partnerships formed primarily through a purchaser/provider funding mechanism. Several interviewees noted difficulties in the capacity of service providers to communicate changing needs, when the partnership could be jeopardised if the provider wanted to change the terms of funding.

The degree to which jurisdictions have opted for a purchaser/provider funding model has varied. Comparatively, Victoria's system represents perhaps the most comprehensive move to purchaser/provider arrangements. In Western Australia, by contrast, there is a balance between the purchasing and the direct government provision of services. The location of each jurisdiction on the continuum of funding model options also shapes the type of accountability mechanisms and partnership relationships between the government and non-government sector.

Many service providers suggested that when a service is in a purchaser/provider relationship, it is often more difficult to provide advice to a government that facilitates checks and balances. The government as purchaser (sometimes through unit costing) is often tied to contractual arrangements that reduce flexibility in the provision of services. When there are rapid population changes, it is often difficult to adjust service provision accordingly. The checks and balances required for such a rapidly changing system may not always be best suited to a purchaser/provider model.

While service providers in the Australian Capital Territory believed that the needs of the purchaser/provider arrangement were adequately balanced with those for flexibility, this has not always been the case. Service providers in the ACT noted that, as a result of the purchaser/provider relationship, they had experienced difficulties in the process of checks and balances when negotiating and renegotiating funding levels for service provision.

As the purchaser/provider funding arrangement is common throughout Australia across many areas of service provision (be it primary prevention, secondary prevention, or detox and rehabilitation), this is a significant challenge for all jurisdictions. Partnerships are not simply equitable relationships. The meaning of partnership is perhaps far more complex than was initially thought.

Maintaining checks and balances in a policy community that experiences 'partnerships' in very different ways is indeed a challenge for everyone.

6.7 Leading the community through humane pragmatism

The final challenge for the Australian drug policy community is to lead the community. A number of policy makers who participated in the first National Campaign Against Drug Abuse suggested in interviews that a key characteristic of the Australian approach has been that drug policy often runs ahead of public opinion and political support. It is perhaps the fact that many Australian drug strategies tap into a key Australian ethic that this leadership has been successful in the community. The ethic that we explore in this final section is the key element of the Australian approach. This key element is a belief in humane pragmatism, and practical fairness in our social and professional lives.

There was an implicit pragmatism in the early days of the NCADA. This was based on the expectation that the bigger issues related to human life and human suffering must take precedence over commitment to ideological or personal predilections.

A number of key policy makers noted that the policy community has a key responsibility that originates from this deep-seated Australian commitment to help those in need and be pragmatic and fair. For some, it was a commitment borne from a *noblesse oblige* – a responsibility of the privileged to assist those who struggle.

For others, the application of the medical profession's privilege and position for the social good was characteristic of participation in the HIV response at the beginning of the NCADA. We believe that there is a core commitment to assist drug users and the community in a humane and pragmatic fashion. Continuing to pursue this ethic through the drug strategy is perhaps the most important achievement and challenge.

The paternalism inherent in this commitment assumes a fundamental role for government in the lives of its citizens. Interviewees who were advocates for a tighter regulation of the alcohol industry articulated this tension as a tension for liberal democracies generally. The Australian approach is one that balances the right for individual freedom with the need to care for the community. We believe that the non-government sector has a key role to play at this level. Many non-government organisations are defined by the care they provide for the community. The Australian National Council on Drugs provides a key role in communicating the imperative of this sector through the humanity of its ethical commitment.

7. Concluding remarks

The aims of the study were to document the Australian approach to drug policy making, in particular to provide evidence for and examples of Australia's approach, and to identify philosophical shifts and influences on drug policies and programs. The Australian approach can be summarised by a policy community committed to an ethic of humane pragmatism, supported by a system that provides stability and a policy framework that brings people to the policy table.

7.1 National significance

Throughout this report we have noted the tensions in the Australian approach. Tension, in this sense, is not a burden. This tension is a productive and powerful force that infuses the three key elements of the Australian approach: the policy system, the policy community and the policy framework. The drug policy process in Australia should be seen as an exemplar of the liberal democratic tradition: the lobbying, argument and political contestation over drug policy reflect a healthy and vibrant democratic arena. What is surprising perhaps is that the health of the Australian approach has been sustained for so long.

The National Drug Strategy is one of only a few Australian national policy initiatives to have achieved bipartisan support across Federal, State and Territory boundaries over this period. It is difficult to estimate the significance of this achievement.

Over the past 15 years of the National Drug Strategy, Australia has fundamentally restructured its fiscal economy, the funding structures for the delivery of health services, the banking and finance sectors, federal education funding and the governance structures for competition through the National Competition Policy and the Council of Australian Governments. These are not insignificant changes, and to have been able to sustain such a strong commitment to National Drug Strategy over this period is indeed admirable.

There have been philosophical shifts over this period. The balance between health, law enforcement and social control mechanisms has changed over time. Nowhere has this been more evident than in the tensions around the very term that encapsulates the policy framework – harm minimisation. Just as a healthy body can be measured according to the pressure in its veins, the health of the drug policy system should be measured by how it is able to sustain the tensions between its various elements. The tension in the Australian approach illustrates healthy debate and productive discussion about innovation for change.

An underlying feature of the shifting emphases has been the willingness to innovate. Rosemary Mammino's historical work on drug education in Queensland is instructive in this matter (Mammino 1993). Innovation is the introduction of new ideas, methods and approaches into something previously established. Historical work provides the basis upon which to innovate.

Alcohol and drug education in Queensland underwent substantial change from 1970 to 1990. Information-based approaches were replaced by effect-based approaches, then subsequently supplanted by educative approaches about settings, and then replaced by more integrated school-based approaches and specialised community-based education services (Mammino 1993).

Similarly, the Queensland Temperance League transformed itself from simply promoting drug-free lifestyles to having a greater role in community service provision through its public face, Drug Arm. In this instance, a theologically based temperance organisation was able to innovate in parallel with State government policy. These philosophical shifts are substantial. However, with a commitment to innovation, they are sustainable and contribute to our rich history of quality service provision. The preparedness to look forward and undertake philosophical challenges is a key attribute of the Australian approach. The significance of this commitment to innovation is a mature national drug strategy that has adapted to a changing social, economic and political landscape.

7.2 International significance

There are important international considerations flowing from the Australian approach. In an environment where support for an American-style War on Drugs has wavered, the Australian approach is noted internationally as an approach that has matured over the past 15 years. For such a young nation, our maturity and balance on the drug policy world stage are rightfully respected.

There are, however, some significant challenges at an international level. There is increasing disparity in the globalised environment (Oxfam 2002). Income from the illegal drug trade has been, and will continue to be, a substantial income avenue in impoverished and conflict-torn nations. Australia may well be one of the world's immature drug consumer marketplaces and could be a target for substantial commodity profit making.

The effects of globalisation are not always benign. International trade can generate destructive forces. In circumstances of compromised state sovereignty, the same technologies and infrastructures that facilitate legitimate economic transfers can be used to launder money and trade in arms. In its latest report on the impacts of globalisation, Oxfam (2002, p. 46) noted:

Illegal drugs-trafficking is an industry that generates some \$500 bn per annum, helping to sustain a civil war in Colombia (Bloom and Murshed 2001) ... As in the case of capital markets, the world has yet to develop institutions and systems of co-operation capable of responding to the problems created by globalisation.

In an international environment where barriers to capital and trade movement are being reduced, there are significant challenges ahead for Australia to sustain its own identifiable approach. As much as strategic global coalitions may levy against vulnerability in national security, care should be taken to ensure that participation in global coalitions does not preclude the capacity to sustain the sovereignty of our Australian approach.

There are, however, some important positive international considerations. Tobacco has been a blight on the world's health landscape for several decades. The doubtful future for Big Tobacco brought about through successful litigation in both North America and Australia signals a bright future in terms of regulating legal tobacco consumption. However, illegal tobacco production continues to be a significant challenge at a national and international level.

7.3 Participation in the policy community

A key finding from this study was the articulation of the functioning characteristics of the policy community. This style of policy making features a behind-closed-doors approach to discussion of policy issues. A significant challenge for the policy community is to ensure participation of the broader community in the policy community debates. Because many aspects of drug policy are conducted within the policy community, there may well be a widening gulf between the broader community and the policy community on some issues, especially issues relating to technical knowledge and evidence base.

The evaluation of the Victorian Government's *Turning the Tide* Drug Strategy highlighted the need to integrate drug strategy with broader social policy planning (Victoria. Department of Premier and Cabinet 2000, p. 25). Various State governments have examined social policy development frameworks (such as Howe et al. 2001) which suggest the *process* of community building is as important as the *outcomes*. Capacity building, linked approaches, local democracy, flexibility and sustainability were identified as cornerstones to social policy development.

This shift in focus to community strengthening in social policy has emerged from an extended period of contract-based managerialism and programmatic social policy planning. The shift should be seen as an epistemological change in the conceptualisation of the role of government in social health and a change in the relationships between health, power and participation in social and political life.

As Howe et al. (2001) suggest:

For government, community building represents a significant move away from a sectoral or programmatic approach to policy planning. The focus shifts to people and places rather than programs, and careful attention needs to be given to the *structures, processes* and *culture* of this new approach. It is clear from international best practice that government must lead the process, with full collaboration of key Ministers in cross-portfolio initiatives. Furthermore, effective coordination across departments and spheres of government is essential.

Participation and partnership in decision making are essential features of building capacity in local communities. While the policy approach is a cornerstone of the Australian approach, there are some dangers. A danger inherent in the policy community approach to policy making is to fail to connect with local communities at a local level, particularly through failing to be transparent in debates and controversies over the evidence base for interventions. The connection of evidence base to priority setting would enable the broader community to participate in the policy community policy to a greater extent. In this light, the necessity for representative bodies in the functioning of community in policy is never more evident. To ensure participation in the policy community, truly representative bodies are needed to advise on policy development at the local, State and Territory, and national levels.

This report provides an overview of the findings and interprets the history, development and status of the Australian approach. It should be noted that any history is interpretative. Indeed, if other members of the policy arena had undertaken this study, different histories may well have been written. The selectivity and emphases accorded to historical work are authorial responsibilities not borne lightly. Additionally, when disagreements occur about the salience, accuracy and utility of a history, the authors bear the responsibility for both insight and error.

Those participating in the policy process articulated several key values in the Australian approach: *a diversity of voices, the good sense of bureaucracy, frank and fearless advice, checks and balances, and leading the community with humane pragmatism.* The greatest challenge for the Australian approach is to recognise our strengths, recognise our key ethic of humane pragmatism, and build upon those strengths to sustain our policy community for the future.

We often fail to acknowledge our achievements in drug policy. Perhaps it is time now to acknowledge our achievements and be proud of our approach.

Appendix A: Methods used in this study

Study design

The study was conducted in three stages, combining historical and archival research with empirical qualitative research. In *Stage 1* we collected material concerning the historical and philosophical bases for the Australian approach. *Stage 2* of the research involved interviewing and data collection in each jurisdiction. *Stage 3* involved the analysis and synthesis of the data collected.

Different data sources were used to inform different elements of the study. Figure A1 describes the relationship between different data sources and the components of the study.

In each jurisdiction data were assembled relating to:

- the historical development of State, Territory and local government drug policy;
- the advisory structures and funding mechanisms;
- outcome indicators according to the existing literature; and
- an audit of the current partnerships.

Quantitative outcomes and population data were collected from key sources such as the key national drug research centres, the Australian Institute of Health and Welfare, and Commonwealth, State and Territory agencies. These details were often collected prior to the jurisdictional consultations in order to contextualise the key informant experiences of partnerships in drug strategy; to provide accounts of projects as examples of successes or failures in the current approach;

and to verify the interpretations of existing outcome indicator data. Table A1 provides details of the consultations. Further population data were sought during the writing of the report to further illustrate the progress of the Australian approach. This study did not collect, nor does it report on, novel quantitative data.

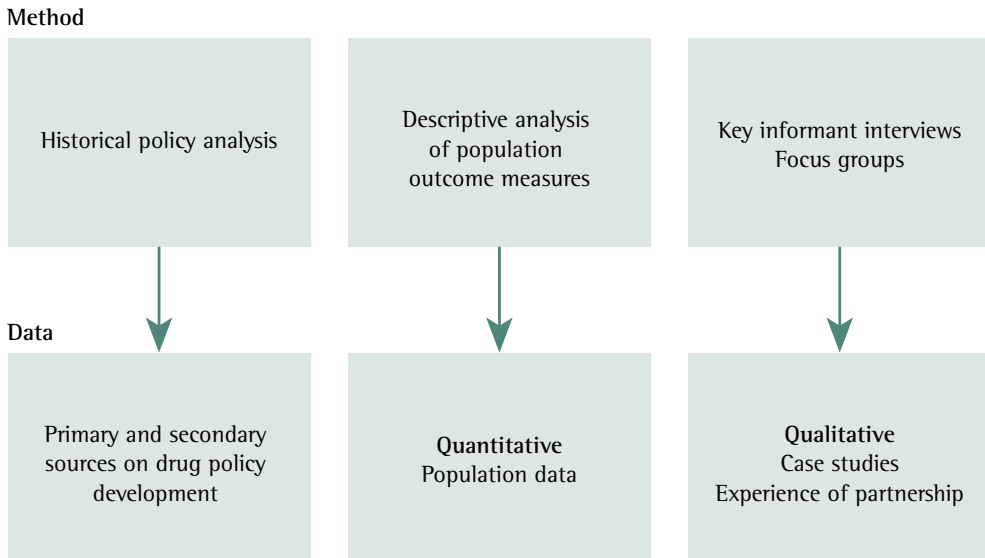
Data analysis

In *Stage 3*, data collected in the previous stages were analysed by jurisdiction. The Commonwealth was treated as a jurisdiction in its own right. Historical information was analysed with a particular emphasis on the configurations of governance through health and law enforcement partnerships over the past 25 years.

Data on advisory structures and funding mechanisms were examined to establish the balance of health and law enforcement strategies in the administrative development of drug strategy over the past 25 years.

Rather than concentrating on the extent to which, across all jurisdictions, the National Drug Strategy was acting through its essential elements, the analysis focused on how the themes articulated in the consultations with policy practitioners that approximated the Australian approach were manifest in the strategies in each jurisdiction.

Figure A1: Methods and data for the project



In-depth interviews

Ministers responsible for drug policy in each jurisdiction were contacted and asked to nominate suitable people to be interviewed as part of the study. We spent between one and five days in each jurisdiction conducting site visits, in-depth interviews and focus groups with policy advisers, bureaucrats, researchers and service providers. A complete list of those consulted for this study is provided in Appendix B.

We ensured that in each jurisdiction we talked with the non-government sector either through direct contact with service providers or through umbrella organisations. At least three people were contacted in each jurisdiction who could advise on the historical progression of drug strategy in that State or Territory.

Focus group discussions

Focus group discussions were conducted with service providers in all States and Territories. Group sizes ranged from four to 13. One focus group in Queensland was conducted using a teleconference embedded in small group discussion. This enabled rural service providers to join the focus group.

Confidentiality / anonymity

The study was approved by the University of Melbourne's Human Research Ethics Committee. Given the sensitive nature of the subject matter, we offered interviewees a spectrum of options regarding the degree of confidentiality and anonymity to be provided in the study.

Table A1: Characteristics of those consulted

	ACT	NT	VIC	NSW	SA	QLD	WA	TAS	CTH
Policy bureaucrats	2	5	1	3	2	3	3	8	11
Researchers	1	2	1	4	1	0	5		
NGO service providers	4	7	7	5	13	19	11	8	
Police	1	1	1	2	3	2	2	2	
State Totals	9	15	11	14	19	24	21	18	11
								Total	142

We advised interviewees that any data they provided could be fully attributable to them in our published text, effectively placing everything they said ‘on the record’. At the other extreme we also advised interviewees that they could request us not to record their consultation, not to publish any details they provided, or not even record the fact that they had contributed to the study. Thus, interviewees were given the option at the start of the consultation (during the informed consent process) to choose the level of confidentiality and anonymity they were comfortable with. The informed consent procedure took from 15 minutes to 1.5 hours illustrating the care and attention interviewees took when considering how they would participate in the study.

Most interviews and focus groups were digitally recorded to enable rapid data coding and analysis. Whereas a few people chose not to be recorded, only one interviewee actually declined to be interviewed at the time of our jurisdictional visits.

Thematic analysis

Through the interviews and focus groups with people in the policy community, we generated themes that encapsulated the Australian approach to drug policy making. These themes were expressed to different extents in each jurisdiction, but they enabled us to describe the Australian approach in terms derived from the interviews we conducted. This process is closely akin to what is known as inductive analysis.

Evidence and experience

Policy analysis that combines historical documentation, the qualitative experiences of the policy makers and quantitative outcome or population data can provide rich accounts of policy making. This study draws on multiple academic traditions including interpretative social science, policy research and qualitative evaluation. It should not be confused with more positivist studies that attempt to demonstrate causal relations between policy practice and health outcomes. As a consequence, care should be taken when looking for correlations between the experiences and beliefs of policy makers and the outcomes from policy practice. This research uses materials from different paradigms and care should be taken when comparing qualitative and quantitative data.

A key component of this report was to document the experiences of those who have in the past been involved or are currently involved in the drug policy process. In our efforts to encapsulate the Australian policy community and to give depth to the overly simplified and oft-overlooked human dimension to the Australian approach to drug policy, we have selected only some of those voices. We make no apologies for our empirical method. Rigour in this type of research arrives from a demonstration of a close understanding of the core issues at stake in representation. In a spirit of innovation, this description of the Australian approach comes from an interweaving set of stories from a diversity of voices. Some parts of this

story are welcome and some may produce disquiet. The task was, however, to bring to light a previously undocumented belief that there is an Australian approach to drug policy. Like most stories, we have created heroes and villains as part of our description. One core commitment in this task remained throughout: to derive the story from those who participate in it, the policy practitioners.

A central aim of this report is to obtain evidence for an Australian approach and to identify conceptual and philosophical shifts in policy and programs. A core source of evidence for conceptual shifts is contained in the testimonies of those who take part in the policy community. We have drawn heavily on this source of evidence. Our description of the Australian approach to drug policy and practice is structured around the themes of: *a diversity of voices, the good sense of bureaucracy, independence, frank and fearless advice, checks and balances, and leading the community.*

Appendix B:

Individuals consulted

B Aldred
L Barden
G Barnden
A Barnes
B Barnett
J Barrett
F Barry
J Batteley
J Baxter
S Biggs
T Bignell
D Billing
R Bingham
A Biven
D Brogan
A Burgess
K Burns
J Byrne
D Calvert
M Capitaine
S Carruthers
R Carvolth
S Chapman
P Christie
G Clarke
V Conway
A Cooney
A Cropley
I Crundell
P d'Abbs
G Davey
A Davis
A Dawson
A Deanus
P Ditchburn
K Dolan
B Dorgelo
P Duance
S Evans
V Fabre
F Farmer
M Farmer
C Fitzwarryne
B Flaherty
S Fox
M Geddes
K Gee
S Gordon
D Gray
J Gray
J Guest
M Guy
E Hales
M Hamilton
R Hamilton
F Hansen
J Hart
D Hawks
C Hayward
M Healy
B Heaton
V Henderson
D Hill
L Hipper
B Hume
A Hunter
W Hunter
P Jackson
J Johnston
D Jory
R Judd
C Kantilla
P Kay
K Kemp
J Laris
K Larkins
T Lenthall
G Lough
W Loxley
P Lucas
L Lumsden
I Martin
P Martin
L Matthews
C McDonald
D McDonald
R McDonald
P McDowall
L McLauchlan
M McPherson
D Meadows
G Meyeroff
J Migro
T Miller
S Mitchell
K Morgan
E Murphy
T Murphy
R Nicholas
C Ober
S Park
G Perry
L Pierce
L Piggott
F Poeder
J Rasmussen
A Reddy
D Rigby
S Roberts
J Rundle
V Rundle
B Saunders
L Skinner
W Smith
A Soares
A Speed
G Strathearn
B Stronach
M Tansky
N Toloni
J Townsend
S Trajdos
T Trimmingham
H Vandenberg
S Vaughan
G Wardlaw
B Watters
I Webster
L Wells
J West
G Williams
S Wilson
A Wilson-Hill
A Wodak
R Woods

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Appendix D: Abbreviations and acronyms

ADCA	Alcohol and Drug Council of Australia	NCEPH	National Centre for Epidemiology and Population Health
ADF	Australian Drug Foundation	NDEP	National Drug Education Program
AIC	Australian Institute of Criminology	NDRSC	National Drug Research Strategy Committee
AIHW	Australian Institute of Health and Welfare	NDS	National Drug Strategy
AIVL	The Australian Intravenous League	NDSF	National Drug Strategic Framework
ANCD	Australian National Council on Drugs	NEACA	National Expert Advisory Committee on Alcohol
APAC	Australian Pharmaceutical Advisory Committee	NEACID	National Expert Advisory Committee on Illicit Drugs
COAG	Council of Australian Governments	NEACT	National Expert Advisory Committee on Tobacco
DASC	Drug and Alcohol Services Council	NEPOD	National Evaluation of Pharmacotherapies for Opioid Dependence
EMCDDA	European Monitoring Centre for Drugs and Drug Abuse	NGO	non-government organisation
HCV	hepatitis C virus	NIDS	National Illicit Drug Strategy
HIV	human immunodeficiency virus	NPHP	National Public Health Partnership
IDRS	Illicit Drug Reporting System	NSP	needle and syringe program
IGCD	Intergovernmental Committee on Drugs	SCON	Simple Cannabis Offence Notice
LAAM	levo-alpha-acetylmethadol	SIP	supervised injecting place
MCATSIA	Ministerial Council on Aboriginal and Torres Strait Islander Affairs		
MCDS	Ministerial Council on Drug Strategy		
MECC	Monitoring and Evaluation Coordination Committee		
NACSDE	National Advisory Committee on School Drug Education		
NCADA	National Campaign Against Drug Abuse		

Appendix E: Major inquiries into drug use

Year	Jurisdiction	Body	Major focus
1966	SA	SA Commission on the Licensing Act	liquor licensing
1969	WA	Committee of enquiry appointed to enquire into ... the laws of the state	liquor licensing
1971	Commonwealth	Senate Select Committee on Drug Trafficking and Drug Abuse	illicit drugs
1973	NT	Board of Enquiry Appointed to Enquire Concerning the Liquor Laws of the NT	liquor licensing
	WA	Honorary Royal Commission Appointed to Inquire into and Report upon the Treatment of Alcohol and Drug Dependents in Western Australia	illicit drugs/ alcohol
1977	Commonwealth	Senate Standing Committee on Health and Welfare Report: <i>Drug Problems in Society – An Intoxicated Society?</i>	alcohol/ tobacco
1978	NSW	New South Wales Joint Parliamentary Committee on Drugs	illicit drugs
1979	SA	South Australian Royal Commission into the Non-Medical Use of Drugs	drug use
	NSW	New South Wales Royal Commission into Drug Trafficking	illicit drug trafficking
	NT	Northern Territory Liquor Commission Report	liquor licensing
1980	Commonwealth	House of Representatives Standing Committee on Road Safety	alcohol/ illicit drugs
	NSW	Further Report of New South Wales Royal Commission into Drug Trafficking	drug trafficking
	Commonwealth	Australian Royal Commission of Inquiry into Drugs	illicit drugs
1981	NSW	New South Wales Committee of Inquiry into the Legal Provision of Heroin	opioid treatment
	Commonwealth	Senate Standing Committee on Social Welfare	pharmaceuticals
1982	Commonwealth, NSW, QLD & Vic	Royal Commission into Drug Trafficking	drug trafficking
	Commonwealth	Royal Commission into the Activities of the Federated Ship Painters and Dockers Union	drug trafficking

Year	Jurisdiction	Body	Major Focus
1982	Commonwealth	Australian Broadcasting Tribunal	alcohol advertising
1983	SA	Committee of Inquiry into Mental Health Services in South Australia	alcohol and other drug services
1984	WA	Western Australian Select Committee Inquiry	illicit drugs
	WA	Honorary Royal Commission Appointed to Inquire into and Report on Liquor Laws in Western Australia	alcohol
	SA	Legislative Council Select Committee Enquiring into Random Breath Testing and Related Matters	alcohol
	SA	Liquor licensing review	liquor licensing
1985	NSW	Committee of Review into Drug and Alcohol Services in New South Wales	drug treatment
	NSW	Report of the Non-Government and Alcohol Services System	drug treatment
	Commonwealth	Senate Select Committee on Volatile Substances	volatile solvents
1989	Commonwealth	Report of the Joint Parliamentary Committee on the National Crime Authority (NCA) – <i>Drugs, Crime and Society</i>	police corruption and trafficking
1990	QLD	Commission of Inquiry into Possible Illegal Activities and Associated Police Misconduct	police corruption and illicit drugs
1991	ACT	ACT Select Committee on HIV, Illegal Drugs and Prostitution – Second Interim Report: <i>Feasibility Study on the Controlled Availability of Opioids</i>	illicit drugs – opioids
	ACT	ACT Select Committee on HIV, Illegal Drugs and Prostitution – Third Interim Report: <i>Marijuana and Other Illegal Drugs</i>	illicit drugs – cannabis
1994	QLD	Criminal Justice Committee Report on Cannabis and the Law in Queensland	illicit drugs – cannabis

Year	Jurisdiction	Body	Major Focus
1994	Commonwealth	Report of the Task Force on Cannabis, National Drug Strategy	illicit drugs – cannabis
1995	SA	SA Legislative Council Report of the Select Committee on the Control and Illegal Use of Drugs of Dependence	illicit drugs – cannabis
	WA	Report of the Task Force on Drug Abuse in Western Australia – <i>Protecting the Community</i>	illicit drugs
	NSW	Royal Commission into the New South Wales Police Service – Interim Report	police corruption – illicit drugs
1996	ACT	Report of the ACT Heroin Pilot Task Force	illicit drugs – opioids
	VIC	Report of the Premier's Drug Advisory Council in Victoria	illicit drugs
1997	WA	Select Committee into the Misuse of Drugs Act	illicit drugs
	NSW	Royal Commission into Police Corruption	
1998	SA	Select Committee on a Heroin Rehabilitation Trial	opiates
1999	NSW	NSW Drug Summit	licit and illicit drugs
2000	VIC	Drug Policy Expert Committee	illicit drugs, injecting facilities
	Commonwealth	House of Representatives Standing Committee on Family and Community Affairs, Substance Abuse in Australian Communities Inquiry	substance abuse