The Australian Illicit Drug Policy Roundtable

January 2009

BRIEFING NOTE

The Australian Illicit Drug Policy Roundtable
being held on 28th January, 2009

Briefing Note

This briefing note, written by the Drug Policy Modelling Program team, has been prepared for delegates to the January 2009 Illicit Drug Policy Roundtable.

Its purpose is to provide delegates with some contextual information and to provoke innovative thinking about possible government responses.

The roundtable is an opportunity for fresh ideas. To that end this report highlights some of the key contextual events/activities that may be influential in shaping future illicit drug policy. In addition, the report summarises Australian trends in drug use and harms. Throughout the report, we pose questions for consideration. These questions do not form the agenda for the roundtable but provide the opportunity to reflect on some important aspects of illicit drug policy in Australia.

I hope the briefing note will assist you in preparing for the Roundtable.

Alison Ritter
Director, DPMP
16th December 2008

Table of contents

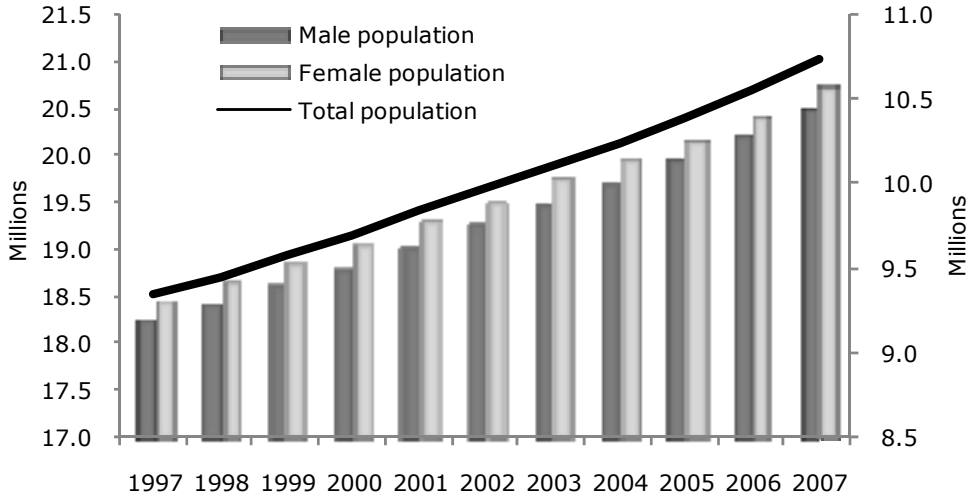
1. Context

In this section we provide relevant contextual information including key population and social trends in Australia and a brief synopses of activities and events that have taken place since the Rudd Labour government took office, such as the 2020 Summit and the Preventative Health Taskforce. These inform and shape illicit drug policy. Section 2 then describes aspects of current Australian illicit drug policy.

1.1 Australian social trends

The Australian population has increased by nearly 2.4 million over the last 10 years, and is currently 21.017 million. It is projected to be 23.8 million by 2021.[1] Australian women are having fewer children and are tending to have them at older ages.

Figure 1: Population growth, 1997-2007



Source: Australian Bureau of Statistics. Cat. No. 4102.0 Australian Social Trends

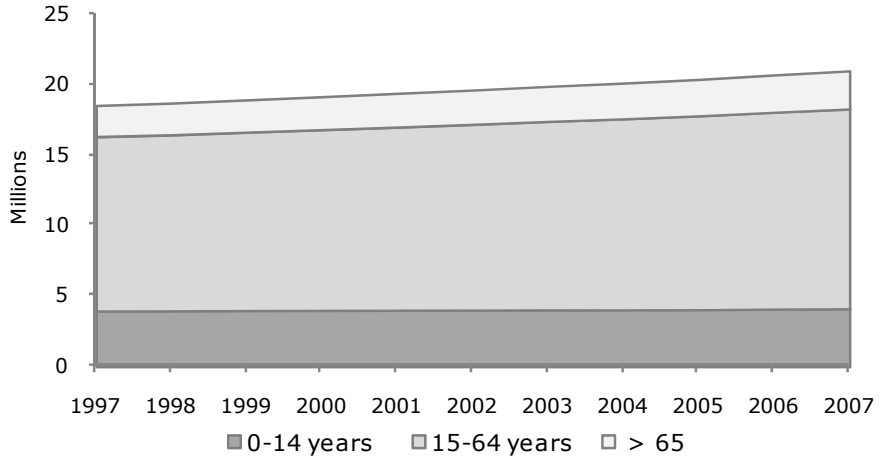
The population is also ageing with the median age in 2007 being 36.8 years.[1] The median age in 1997 was 34 years and it is projected to be 40.7 years by 2021. The ageing Australian population has two potential implications for illicit drug use and policy – the smaller cohort of younger people over time may contribute to reduced incidence of drug use in the community; and the ageing population may result in different patterns of drug use and associated health needs.

Over the last 10 years male life expectancy has increased to 79, while female life expectancy has risen to 83 years. [2] For Indigenous Australians life expectancy is lower for both men (59 years) and women (65).[3] Indigenous Australians face many disadvantages - shorter life span, higher rates of chronic disease, lower education and employment opportunities and over-representation in the criminal justice system. While the results must be interpreted with caution, there is some evidence

[1] Australian Bureau of Statistics. Cat. No. 4102.0, Australian Social Trends.
[2] Australian Bureau of Statistics. Cat. No. 4102.0, Australian Social Trends.
[3] Steering Committee for the Review of Government Service Provision (SCRGSP). (2007). O*vercoming Indigenous disadvantage: Key indicators 2007*. Canberra: Productivity Commission.

that Indigenous Australians have higher rates of illicit drug use than non-Indigenous Australians.[4]

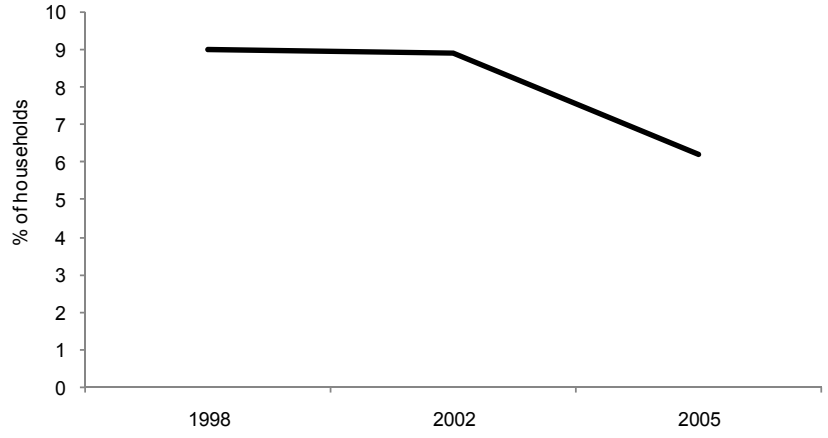
Figure 2: Population age, 1997-2007



Source: Australian Bureau of Statistics. Cat. No. 4102.0, Australian Social Trends

The percentage of Australians experiencing selected personal crimes (assault, robbery and sexual assault) showed an increase between 1998 and 2005 from 4.8% to 5.3%. For the same time period the rate of selected household crimes (break-ins, attempted break-ins and motor vehicle theft) fell (see Figure 3).[5]

Figure 3: Selected household crime, 1998-2005



Source: Australian Bureau of Statistics. Cat 1383055001. Measures of Australia's Progress: Summary Indicators, 2008.

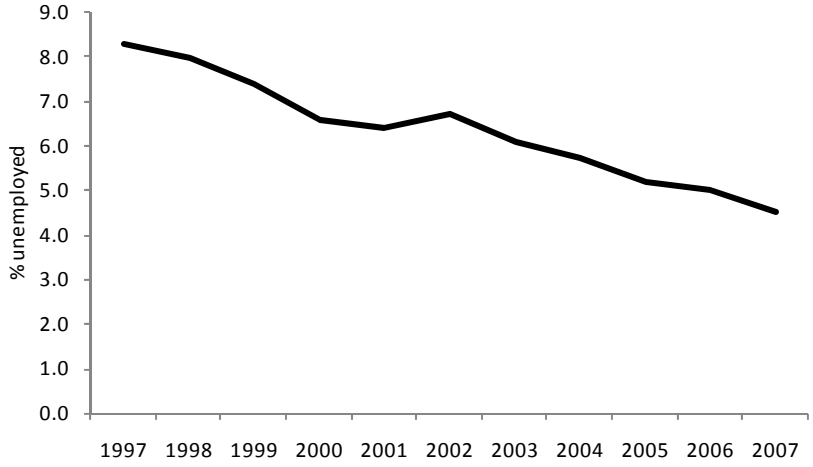
[4] Putt, J. and Delahunty, B. (2006) Illicit drug use in rural and remote Indigenous communities. Trends and Issues in Crime and Criminal Justice, Bulletin No. 322, AIC.

[5] Australian Bureau of Statistics. Cat 1383055001. Measures of Australia's Progress: Summary Indicators, 2008.

Unemployment in Australia is at its lowest level in more than 30 years (Figure 4). Up until recent months, Australia has been in a period of strong economic growth, prosperity for many and low unemployment. However, these trends will not continue. The sudden and dramatic turn of events in the financial markets around the world have major implications for Australia's economy. The exact consequences of the global financial crisis are difficult to predict, but economic growth will slow and unemployment will rise.

The relationship between economic factors such as prosperity and employment and illicit drug use is not clear. For example, economic downturns have been associated with lower alcohol consumption at a population level. However, illicit drug use is higher amongst those in poverty and unemployed. Social services are predicting that the global financial crisis is likely to have an acute impact on the most disadvantaged members of our society, including drug users.[6]

Figure 4: Unemployment rate, 1997-2007



Source: Australian Bureau of Statistics. Cat 1383055001. Measures of Australia's Progress: Summary Indicators, 2008.

Food for thought…

What are the implications of the global economic downturn for Australian trends in illicit drug use and the policy implications?

Do we require new thinking in illicit drug policy given the ageing Australian population?

[6] Access Economics. (2008, November). *The impact of the global financial crisis on social services in Australia.* An issues paper prepared by Access Economics for Anglicare Australia, Catholic Social Services Australia, The Salvation Army and UnitingCare Australia. Retrieved from http://catholicsocialservices.org.au/system/files/Impact_of_Global_Financial.pdf

1.2 The 2020 Summit

The 2020 Summit (April 2008) aimed to "harness the best ideas across the nation; apply those ideas…to secure our long-term future through to 2020...and provide a forum for free and open public debate". The Summit delegates were charged with producing ideas that could be shaped into specific recommendations for policy actions. Ten streams considered the following themes; the environment, health, productivity, community strengthening, the economy, rural and regional communities, indigenous people, the arts, governance, and security.

At the big picture level, federalism was discussed in at least three streams (governance, economy, and rural and regional communities) with focus on the problems associated with federalism (multiple levels of government, lack of coordination, overlap of processes and services). A major rethink of the structure of government in Australia was recommended (through a Federalism Commission). The economy stream focussed on mechanisms for better public policy making and collaborative governance, high quality public service, and vigorous public policy debate. This sets a positive frame for the illicit drug policy roundtable.

A Charter or Bill of Human Rights was debated in at least two of the Summit streams. Australia is alone among liberal democracies in not having a national charter of rights. Victoria's Charter of Rights and Responsibilities is one example – the impact of the Victoria Charter may be widespread, and certainly sets a standard for all health services. The federal government has just announced a consultation process on the issue of a national Charter or Bill of Human Rights.

Across all ten streams, there were recommendations with applicability to illicit drugs policy. Summit delegates noted a focus on early intervention and prevention services (community strengthening, indigenous and health streams), and the importance of parents and children's centres (productivity stream). Evidence-based allocation of health resources and "health impact statements" (both from the health stream) for all areas of government policy were recommended. The security stream noted the importance of a Pacific partnership (with the potential to impact on importation of drugs into Australia), and a transnational crime centre. Illicit drug users are marginalised and the proposed National Action Plan for Social Inclusion (community strengthening stream) would have significant ramifications for our client group.

The Government will be making a formal response to the 2020 Summit ideas early in the New Year.

Food for thought…

How can illicit drug policy harness some of the opportunities that the 2020 Summit recommendations represent?

1.3 National Preventative Health Taskforce

The National Preventative Health Taskforce has released its first discussion paper "Australia: The healthiest country by 2020" (October 2008).[7] It focuses on three priority areas: obesity, alcohol and tobacco. The key underlying principle is that Australia must reform its approach to the prevention of illness. The taskforce reinforces that health is "everybody's business" and identifies individuals, families, communities, industries, states and the nation as the key change agents to produce a healthy Australia in 2020. Moreover, it emphasises that behavioural change will be limited unless society as a whole provides and values healthier choices. This demands increased attention to the roles of schools, workplaces and community leaders in changing values and providing incentives to take up healthy behaviour. Governments are envisaged as drivers and coordinators of the policy changes in this framework.

Illicit substances will be considered by the Taskforce in 2009. However, many of their recommendations in relation to licit drugs are pertinent. Specific strategies are recommended: changing consumer demand/preferences, regulations and legislation, public education campaigns, primary health care/early intervention, and tailored approaches to closing the gap for disadvantaged communities. It is worth considering the ways in which these strategies can be applied to illicit drugs.

Food for thought...

Illicit drug use is not only an issue for government but for society as a whole including individuals, families, schools, workplaces and industry - how can these agents of change reduce the demand for illicit drugs along with reducing the harms arising from use?

Given the high profile of prevention (here and at the 2020 Summit) how can we harness the best prevention initiatives for illicit drugs? How could concepts related to prevention best be framed to achieve greatest effects in the domain of illicit drugs? Do we know what the best prevention initiatives are in this domain?

1.4 Social determinants of health

There is now a widespread focus on the underlying social determinants of health, which can include class, education, occupation, income/assets, gender, race, ethnicity, religion, age and residence.[8] Indeed, the National Preventative Health Taskforce discussion paper (see above) emphasises that improving health demands attention to the structural determinants of health including culture, media, social cohesion, access to services, income and wealth, education and employment. In January 2008 the Rudd Labour Government announced its intention to tackle

[7] National Preventative Health Taskforce (2008). *Australia: The healthiest country by 2020. A discussion paper*. Canberra: Commonwealth of Australia. Retrieved from http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/A06C2FCF439ECDA1CA2574DD0081E40C/$File/discussion-28oct.pdf

[8] Measurement and Evidence Knowledge Network. (2007, October). *The social determinants of health: Developing an evidence base for political action.* Final Report to World Health Organization Commission on the Social Determinants of Health. Retrieved from http://www.who.int/social_determinants/resources/mekn_final_report_102007.pdf

homelessness in Australia through the development of a comprehensive, long-term plan. The Green Paper on Homelessness W*hich Way Home?* (May 2008)[9] sought to promote public discussion. The Paper describes homelessness as one of the most potent examples of disadvantage in the community, and one of the most important markers of social exclusion with key drivers of homelessness including mental illness, domestic violence, family breakdown, drug and alcohol use, unemployment, financial stress and gambling. Service gaps for this population were identified as particularly problematic.

Social inclusion is on the Australian government agenda. The government "…aims to launch a new era of governance to mainstream the task of building social inclusion so that all Australians can share in our nation's prosperity".[10] The government has established a Social Inclusion Committee of Cabinet, and the Hon Julia Gillard is the Minister for Social Inclusion. The Australian Government has identified early priorities for social inclusion, which include:

- focusing on particular locations, neighbourhoods and communities to ensure programs and services are getting to the right places
- providing employment for people living with a disability or mental illness, and
- closing the gap for Indigenous Australians.

All of these priority areas are of relevance to illicit drugs policy.

Food for thought…

The burden of illicit drug use is unevenly distributed amongst various socially disadvantaged groups. How can our policies better address this burden?

How can we use the social inclusion agenda to better address the issues of illicit drug use/harm?

1.5 National Innovations Review

'Venturous Australia' is the title of the National Innovations Review report by Dr Terry Cutler (August, 2008).[11] The review is premised on innovation and entrepreneurship as essential for Australia to thrive. 'Venturous Australia' calls on government to identify and remove impediments to the conduct and uptake of innovative research through for example increasing access to and transparency of government generated information, research and content, facilitating collaboration, increasing opportunities for innovation that is bottom-up led and increasing attention to what is needed in the long term, not just short term.

Another key message in the report is that of seeing federalism as a benefit – in our case as a tool to foster better illicit drug policies and to evaluate new approaches

[9] Commonwealth of Australia. (2008, May). *Which way home? A new approach to homelessness*. Retrieved from http://www.facsia.gov.au/internet/facsinternet.nsf/vIA/new_approach/$File/full_report.pdf

[10] http://www.socialinclusion.gov.au/

[11] Cutler & Company Pty Ltd. (2008). *Venturous Australia: building strength in innovation*. Retrieved from http://www.innovation.gov.au/innovationreview/Documents/NIS_review_Web3.pdf

using the best available methods e.g. randomised trials, using common metrics, performance indicators and sharing of data across jurisdictions.

Moreover COAG will have a new role to play in fostering innovation through the COAG National Partnership payments. These incentive payments are designed to provide funding to states/territories to trial new approaches and encourage comparison and evaluation between states and territories. Through doing so they seek to "make the most of our federation by encouraging a virtuous circle of innovation, experimentation and evaluation amongst states and territories". These incentive payments are designed to drive reforms by supporting the delivery of specific projects, facilitate reforms or to reward jurisdictions that deliver nationally significant reforms. The first round of National Partnership payments, which begin in 2009, includes 'preventative health' and various social determinants of harmful drug use, including homelessness – these potentially have implications for illicit drug policies and interventions.

Innovative reform in the drug field may be difficult to achieve when there is reluctance by policy makers to make brave decisions. The ongoing pilot nature of the Medically Supervised Injecting Centre in Sydney exemplifies the problem. If nothing else, 'Venturous Australia' provides a rationale for new solutions to old problems.

Food for thought…

What would be an innovation in Australian drug policy?

What opportunities does the new COAG funding create for Australian drug policy? How should the Commonwealth/states/territories make use of this?

Federalism is a high profile topic (e.g.: 2020 Summit, Innovations Review) – to what extent do we grasp the complexity of the variation across jurisdictions in drug policy? And how can this be harnessed to improve illicit drug policy?

Can we and/or should we have consistent illicit drug policies across all Australian jurisdictions?

2. Australian drug policy

This section describes the current drug policy environment in Australia, including the National Drug Strategy, governance arrangements, the international drug policy environment, parliamentarians' views and media on drugs in the last year.

2.1 The National Drug Strategy

The first national drug strategy was adopted in 1985. Termed the National Campaign Against Drug Abuse, the founding principle was harm minimisation which aimed to "minimise the harmful effects of drugs on Australian society".[12] Such an objective was described by The Hon Neal Blewett, the then Minister for Health:

> 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.[13]

Since that time the national drug strategy has undergone a number of iterations resulting in the current strategy: the National Drug Strategy: Australia's Integrated Framework 2004-2009 (MCDS 2004).[14] While harm minimisation has remained the principal objective, support for the term waned notably under the previous Coalition Government, as evidenced in the 2007 House of Representatives Standing Committee on Family and Human Services inquiry.[15]

The current National Drug Strategy is due to expire in 2009. An evaluation of the Strategy is underway with reporting to the Department of Health and Ageing due to occur at the end of December 2008. A report will be presented to the Ministerial Council on Drug Strategy (MCDS) in May 2009. Details about how the new National Drug Strategy will be developed are not available.

Evaluators of the NDS have, over the years, highlighted both the positive and negative features of the Strategy. One of the issues the current evaluators are likely to note is that while the current NDS Framework document includes an explicit commitment to develop 'a prevention agenda' during the 2004-2009 period this has not happened. Addressing this failure gains new prominence in light of the current National Health Preventative Taskforce emphasis.

Food for thought…

There are many aspects to the National Drug Strategy worthy of review and reflection:

- Is the overarching framework still relevant and appropriate after more than 20 years of 'harm minimisation'?

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[12] Department of Health. (1985). *National Campaign Against Drug Abuse*. Canberra: Australian Government Publishing Service.

[13] Blewett, N. (1987). National Campaign Against Drug Abuse (NCADA): Assumptions, arguments and aspirations. *Monograph Series No. 1.* Canberra: Australian Government Publishing Service.

[14] MCDS. (2004). *The National Drug Strategy: Australia's integrated framework 2004-2009*. Canberra: Ministerial Council on Drug Strategy.

[15] Parliament of the Commonwealth of Australia, House of Representatives, Standing Committee on Family and Human Services. (2007). *The winnable war on drugs: the impact of illicit drug use on families*. Canberra: Commonwealth of Australia.

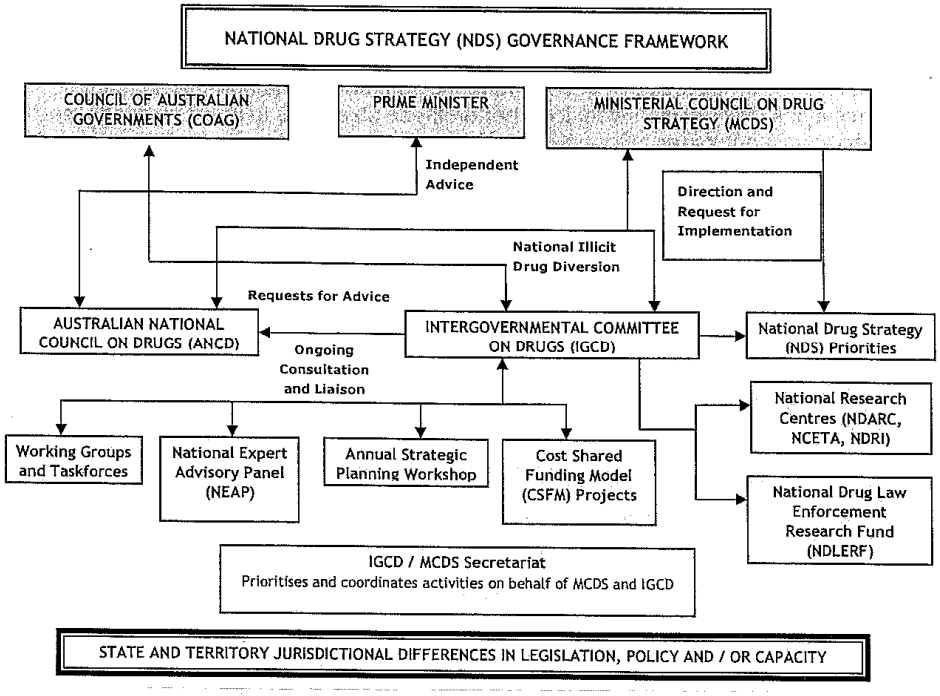
- Has the "harm minimisation" term and/or the concept reached its use-by date in Australian drug policy? If so, what is the alternative and what are the implications of adopting a different term?
- To what extent does the NDS foster partnerships, innovation and evidence-based practice?
- What has been learned from the Howard Government's NIDS 'Tough On Drugs' program operating in parallel with the harm minimisation focus of the NDS?

2.2 Governance of Australian drug policy

Governance of Australian drug policy involves an array of ministerial, bureaucratic and ad hoc structures at the Commonwealth and state/territory level (see Figure 5). The specific policy and decision making body is the Ministerial Council on Drug Strategy (MCDS) comprised of state, territory, Commonwealth and New Zealand Health and Law Enforcement Ministers, as well as the Commonwealth minister responsible for education. This has been supported by a structure of senior officers, the Inter-Governmental Committee on Drugs (IGCD), comprised of health and law enforcement bureaucrats from the state, territory and Commonwealth, and the Commonwealth Department of Education, Employment and Workplace Relations
An inter-sectoral committee also operates, providing advice direct to the Commonwealth Government: the Australian National Council on Drugs (ANCD). It is comprised of experts from the government and non-government sectors, including law enforcement, research, education, Indigenous affairs, local government and drug treatment. The governance structures also include a large number of time-limited committees and working groups mostly appointed by IGCD. Other structures also feed into this core group such as the Council of Australian Governments (COAG) which is responsible for initiating, developing and monitoring the implementation of whole of government approaches.

In recent years COAG has become directly involved in drug policy, most notably in establishing the Illicit Drug Diversion Initiative in 1999, the COAG National Action Plan on Mental Health in 2006 and, more recently, the youth binge drinking initiatives.

Figure 5: The advisory structures supporting the NDS and their relationships



Source: Inter-Governmental Committee on Drugs, 2007

At the Commonwealth level, illicit drugs are the responsibility of the Minister for Health and Ageing, the Hon Nicola Roxon MP. Senator the Hon Jan McLucas, Parliamentary Secretary to the Minister for Health and Ageing is responsible for Alcohol and Tobacco.

Evaluators of the National Drug Strategy have long recognised that, given the federal system and multiple stakeholders, the governance of Australian drug policy is a challenge.[16] While the partnership between health and law enforcement has received much praise, the governance process has been critiqued for the lack of transparency of decision making, the inconsistent use of the evidence base and the lack of a public face for the NDS.[17]

[16] Stephenson, E., Brown, H., Hamilton, M., McDonald, D., & Miller, M. (1988). *The National Campaign Against Drug Abuse 1985-1988: Report of the Task Force on Evaluation*, Ministerial Council on Drug Strategy, Canberra.; MCDS. (1992). *No Quick Fix: An Evaluation of the National Campaign Against Drug Abuse.* Second Task Force on Evaluation, Ministerial Council on Drug Strategy, Canberra.; Single, E. & Rohl, T. (1997). *The National Drug Strategy: mapping the future, an evaluation of the National Drug Strategy 1993-1997 commissioned by the Ministerial Council on Drug Strategy*. Australian Government Publishing Service, Canberra.; Success Works (2003). *Evaluation of the National Drug Strategic Framework 1998-99 - 2003-04*, Success Works Pty Ltd, Canberra.

[17] Success Works (2003). *Evaluation of the National Drug Strategic Framework 1998-99 - 2003-04*. Canberra: Success Works Pty Ltd.

Food for thought...

To what extent is the formal advisory structure as drawn by the IGCD representative of the governance of Australian drug policy?

What roles do peak bodies like the Alcohol and other Drug Council of Australia, APSAD and AIVL play? What other organisations could or should play a role (such as Australian Drug Foundation, Drug Free Australia, Ted Noffs Foundation)?

What are the implications of the increasing involvement of COAG in illicit drug policy for the current NDS governance processes and their outcomes?

2.3 International drug policy

In 1998 the United Nations held a General Assembly Special Session (UNGASS) on drugs. Resolutions included targets for the reduction and elimination of cultivation of illicit drugs within 10 years. Ten years on, thematic debate at the 2008 Commission on Narcotic Drugs (see below for Dr Antonio Maria Costa's comments) and a series of expert working groups held this year will culminate, in March 2009, with a new declaration made by a high level meeting at the Commission on Narcotic Drugs. The non-government sector around the world has been active in preparing for the 2009 declaration and has prepared a Declaration and Resolutions document (July 2008)[18] which unsurprisingly focuses on the important role of the NGO sector in contributing to reductions in drug use and harms and a call for more resources for demand reduction and drug treatment.

At the Commission on Narcotic Drugs (March 2008), the Executive Director of the UNODC (Dr Antonio Maria Costa) presented an overview of progress by governments in achieving the objectives as set out in the 1998 UNGASS.[19] There are some surprising and noteworthy points within the report including:

- Reinforcement of the importance of treatment and harm reduction as part of the drug responses
- Recognition of the important balance between demand reduction and supply reduction: for example Dr Antonio Maria Costa noted that "We must bring public health – the first principle of drug control – back to centre stage" (page 13).
- The acknowledgement of the unintended effects of drug policies. Displacement was one highlighted unintended effect - geographic displacement of drug problems; displacement (substitution) between substances; and policy displacement away from public health and into law enforcement. Other unintended negative consequences identified included stigma and marginalisation of active drug users and the existence and harms associated with a black market.

This seems to set the stage for the possibility of a shift in United Nations approaches to drug control, with a greater focus on treatment and understanding and responding to the negative unintended consequences of drug policies.

[18] www.vngoc.org
[19] http://www.unodc.org/documents/commissions/CND-Session51/CND-UNGASS-CRPs/ECN72008CRP17.pdf

The European Union Drugs Strategy (2005 to 2012) and its associated action plans, the most recent of which is the EU Drug Action Plan for 2009-2012 highlights the European drug policy agenda[20]: reinforcing the balance between supply and demand reduction; the importance of considerations of human rights; coordination and cross-border actions; and the importance of 'citizens' in drug policy responses.

The United States of America remains a powerful player on the drug policy front, and continues to advocate zero tolerance approaches on the international stage. The White House Office of National Drug Control Policy (ONDCP) has issued its 2008 report on the National Drug Control Strategy. The overarching goal of the current Strategy is to reduce drug use in America through a balanced approach that focuses on "stopping use before it starts, healing America's drug users, and disrupting the market for illegal drugs".[21]

Food for thought…

Is there really an appetite for change of drug control approaches/frameworks at the international level? Is this more than rhetoric?

If yes, how can Australia contribute to/ride the change wave?
If no, should Australia take a leading role in reform? And what would that reform look like?

To what extent, and in what ways, do the international drug conventions/treaties impact on Australian illicit drug policy? Do they matter?

2.4 Current Australian parliamentarians' views on illicit drugs

It is difficult to ascertain the stance of current federal politicians to illicit drugs. At the last federal election (Nov 2007) illicit drugs were not a significant part of the campaigns. The Liberal policy, as articulated in the implementation of 'Tough on Drugs' presumably reflected that Party's views. Only one statement on illicit drugs was made by the ALP: "…Australia needs new ideas and fresh thinking when it comes to dealing with critical and continuing problems such as drugs and crime. But our response must be tough, targeted and evidence-based".[22]

Since the opening of the 42nd Parliament illicit drug issues have not been a high priority topic of debate. Little has been said in either house that could be construed as a comprehensive policy statement on illicit drugs. There has been some discussion of drug issues in the Parliamentary Committees. Primarily this discussion has taken place in the Senate Standing Committees.

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[20] http://ec.europa.eu/justice_home/fsj/drugs/docs/com_2008_567_en.pdf
[21] ONDCP (2008). National Drug Control Strategy Annual Report. Retrieved from http://www.whitehousedrugpolicy.gov/publications/policy/ndcs08/intro.html
[22] Australian Labour Party. (2007, April 14). *Rudd Labor Government today vowed to get tough on Australia's escalating ICE epidemic*. Media statement from the Commonwealth Government.

Treatment issues were raised in the House of Representatives twice: Kay Hull calling for more funding for detoxification services; and a speech by the Member for Tangney, in support of Dr George O'Neil's naltrexone implant program asking for $10m for that program.

Senator Lyn Allison moved a motion in May 2008 to have the Senate note trials in a number of countries about the prescription of heroin as a treatment for opioid dependence and called on the Government to closely monitor these trials for consideration of conducting similar trials in Australia. On the issue of law enforcement, Senator Lyn Allison in May 2008, asked a question of Senator Chris Evans (Minister representing the Prime Minister in the Senate) and in response was told:

> "I am not sure I accept that law enforcement has been ineffective… I do think it is a question of having a mix of policies. … I think an evidence based approach to these matters is most important"

The National Drug Strategy has enjoyed bipartisan support – and this has been noted as one of the keys to its success. However, we note that at a state level interventions at the margins (for example injecting rooms, WA cannabis legislation) are subject to partisan politics. National evidence-based policies need to be protected from this.

Food for thought…

What do our current parliamentarians think about illicit drugs?

To what extent can we leverage the strong focus on evidence-based policy by the Rudd government?

How can we ensure that the bipartisan approach of the NDS continues?

2.5 Media portrayals of drug issues 2008

In a snapshot examination of drug issues in Australian media in 2008 (major metropolitan newspapers, Nov 2007 to Nov 2008), a search was conducted to capture those stories which featured alcohol and drugs. All headlines were searched for mention of alcohol, tobacco or illicit drugs and these were then subject to a simple content analysis through counting the number of mentions of each drug.[23]

[23] The analysis used a standardised method for media content analysis, the *Factiva* database of newspaper media and *Leximancer* software for the analysis.

The most mentioned drugs in this sample of media content were:

Drug type	# of mentions	% of total	% illicits only
Alcohol	1696	46%	-
Tobacco	231	6%	-
Cannabis	451	12%	25%
Heroin	392	11%	22%
Amphetamine	318	9%	18%
Cocaine	215	8%	18%
Ecstasy	314	6%	17%
TOTAL	3717	100%	100%

Clearly, media interest in drugs in 2008 has been dominated by alcohol, with around four times as many mentions as the next highest drug – cannabis. Within only the illicit drugs, the distribution of mentions is relatively even – one quarter cannabis (25%) and the remainder split reasonably equally between heroin, amphetamine, cocaine and ecstasy (last column, above table).

3. Australian trends in drug use and harms

The primary data source for examining trends in Australian drug use is the National Drug Strategy Household Survey (NDSHS). There are significant limitations with this survey for illicit drugs other than cannabis because low prevalence behaviours are not well detected in household survey methods. Furthermore, no careful analysis of the implications of the Survey's non-response rate has been published, although potential exists for the non-responses to introduce systematic biases. These significant limitations notwithstanding, we provide summative data from the NDSHS on trends in lifetime use and recent use (last 12 months). We then consider harms from drug use and examine other data sources on mortality, morbidity and law enforcement indicators.

3.1 Lifetime drug use

- In 2007, just over one third of Australians reported ever having used an illicit drug (38.1%, 14 yrs and over).
- The drug most commonly used at least once by Australians is cannabis (33.5% ever used, 14yrs and over, 2007 data).
- There was no significant change in the proportion of Australians reporting lifetime use of cannabis or heroin between 2004 and 2007.
- Between 2004 and 2007 the lifetime use of methamphetamine significantly reduced, while the lifetime use of cocaine and ecstasy significantly increased.

Figure 6: Ever used drugs: proportion of the population aged 14 years or older, Australia, 1993-2007

Source: National Drug Strategy Household Survey (NDSHS)
Inclusions: Ecstasy category included substances known as 'Designer Drugs' before 2004
Limitations: A change of wording occurred in 2001, such that between 1993-1998 respondents were asked about drugs that they had 'tried at least once' while between 2001-2007 they were asked about drugs 'used at least once'.

Food for thought…

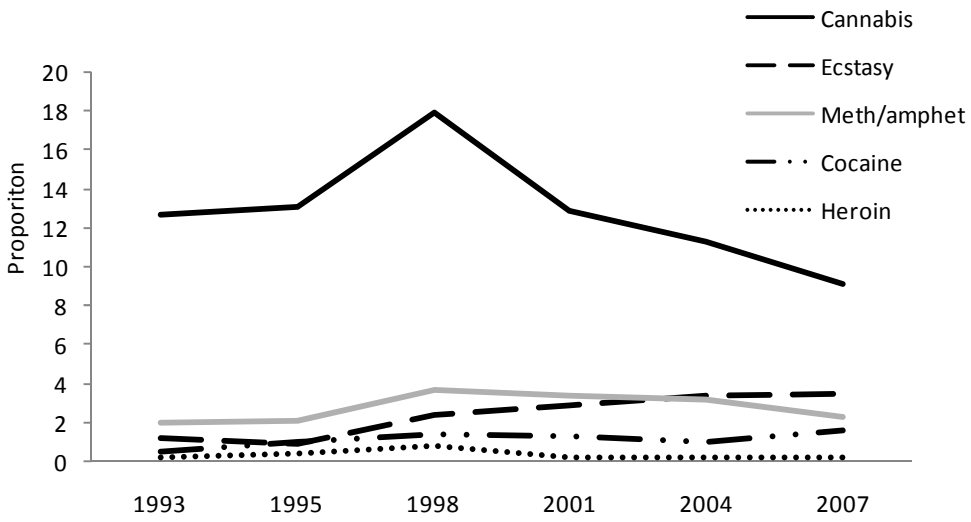
Lifetime use of drugs is one indicator of the success of prevention efforts - reducing the uptake of drug use among non-users. When lifetime use decreases, we assume this is partly due to reduced new initiation. Is the number of Australians commencing drug use decreasing or changing? For which drugs?

What will be the new emerging drug(s) in Australia over the next 10-20 years? Can we design effective, generic policy that is responsive to whichever new drugs emerge?

3.2 Recent drug use (last 12 month use)

- The most commonly reported illicitly used drug in the previous 12 months was cannabis (9.1%), followed by ecstasy (3.5%), painkillers/analgesics (2.5%) and methamphetamine (2.3%).
- Recent use of cannabis declined significantly between 2004 and 2007. During the same period there was also a significant reduction in the recent use of methamphetamine.
- Recent use of cocaine increased significantly between 2004 (1.0%) and 2007 (1.6%).
- Over the last 15 years ecstasy use has increased, but there was no significant change in recent use between 2004 (3.4%) and 2007 (3.5%).

Figure 7: Recent drug use: proportion of the population aged 14 years or older, Australia, 1993-2007



Source: National Drug Strategy Household Survey (NDSHS)
Inclusions: Ecstasy category included substances known as 'Designer Drugs' before 2004

The National Drug Strategy Household Survey 2007 First Results seem to imply "good news" – recent use of both cannabis and methamphetamine decreased significantly along with recent use of pain killers/analgesics. There was also no significant increase in the use of ecstasy or heroin. However, not all concur that we can interpret this as "good news" – some query the validity and reliability of the data; others argue that rates of use are less meaningful than harms; and others that substitution between drugs, including alcohol[24], means that trends in single drug use are not meaningful.

[24] However, note that alcohol use rates in the NDSHS have significantly reduced between 2004 and 2007.

Food for thought...

If one agrees that illicit drug use, notably cannabis and methamphetamine, are decreasing in Australia, what are the policy implications?

The trend in self-reported cocaine use is in the opposite direction from that observed for most other illicit drugs. Why, and what are its implications for harms and interventions?

To what extent is there substitution between different drugs (including alcohol); and to what extent is consideration of the patterns of harms more important than rates of use?

3.3 Harms from drug use

Changing prevalence and incidence of drug use in Australia appears to be occurring based on the above NDSHS figures. However, it is not reasonable to assume that decreases in prevalence are necessarily associated with decreases in harm. In addition, for the low prevalence drugs such as heroin and methamphetamine, examination of trends in harms from drug use can reveal important policy information. Here we examine a limited number of health-related harms:

Mortality
Hospitalisations
Infectious diseases (HIV and HCV)

Mortality

- Opioids are associated with the highest risk of death. Indeed, 98.6% of all directly attributable illicit drug deaths (dependence, abuse and poisonings) are attributable to opioids.[25]
- Accidental opioid related deaths remain lower than in the late 1990's when heroin use and harms were increasing (Figure 8).
- The major causes of death amongst drug users are drug overdoses, disease, suicide and trauma.

Figure 8: Number of accidental deaths due to opioids among those aged between 15-54 yrs

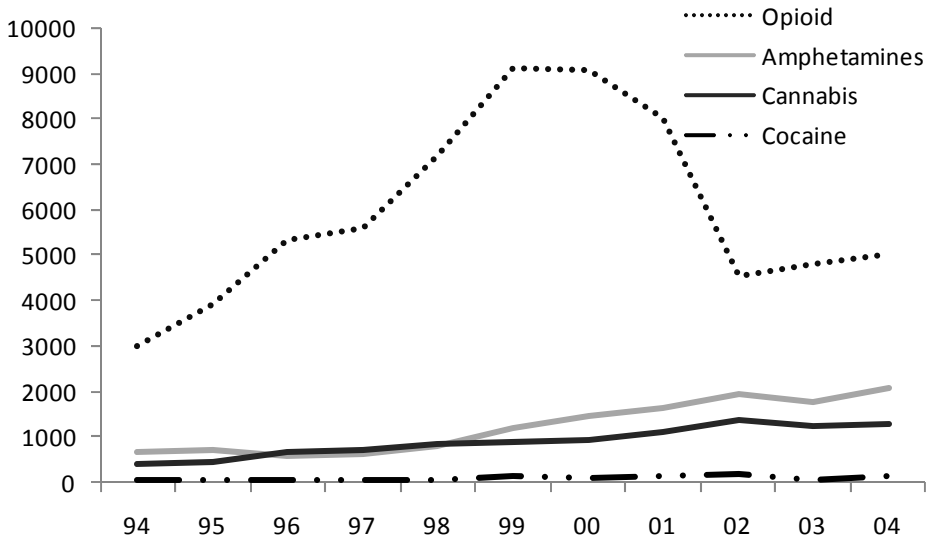
Source: Degenhardt, L., and Roxburgh, A. (2007). Accidental-drug induced deaths due to opioids in Australia, 2005. Sydney: National Drug and Alcohol Research Centre.
Inclusions: Deaths recorded here only include those in which it was considered that opioids such as heroin, morphine, pethidine, methadone and codeine were primarily responsible for the person's death.
Exclusions: 2005 data excludes ACT and NT
Limitations: Prior to 1997, the COD data were coded according to ICD-9. Since 1997 COD data were coded according to ICD-10.

[25] Ridolfo, B., & Stevenson, C. (2001). The quantification of drug-caused mortality and morbidity in Australia, 1998. AIHW cat. No. PHE 29. *Drug Statistics Series No.7*. Canberra: AIHW. We note that these data relating to 98.6% of all illicit drug deaths attributable to opioids comes from 1998 data – now considerably dated.

Hospitalisations

- Since the late 1990's hospital separations where opioids were coded as the principal diagnosis have declined.
- Cocaine related principal separations have more than tripled from 1994 (n=42) to 2004 (n=159) although in real numbers, remain low.
- Amphetamine related principal separations have increased from 652 in 1994 to 2,066 in 2004.
- Principal cannabis related separations more than tripled from 424 in 1994 to 1,358 in 2002 but have remained stable since.

Figure 9: Number of principal diagnoses 1994-2004



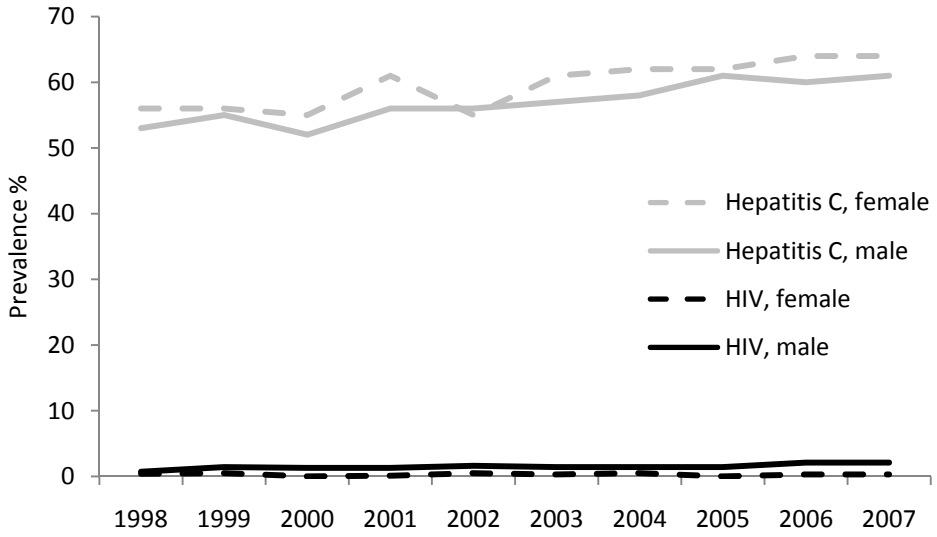
Source: Degenhardt, L., and Roxburgh, A. (2006). Hospital stays related to illicit drugs in Australia 1993-2004. NDARC Technical Report Number 261.
Inclusions: Separations where opioids, cocaine, amphetamines or cannabis were included in either the principal or one of the 31 additional diagnoses.
Limitations: Since 1998 data were coded using ICD-10-AM apart from in SA, WA and QLD where ICD-10-AM coding began in 1999. Prior to this data were coded using ICD-9-CM.

Hepatitis C and HIV

- At the end of 2007, an estimated 207,600 people were living in Australia with chronic hepatitis C infection.
- In 2007 there were 520 newly diagnosed cases of hepatitis C. The number of newly acquired hepatitis C infections has fluctuated between 355 and 520 per annum for the last five years.

- HIV prevalence among people attending needle and syringe programs has remained stable at around 1% over 1998-2007.[26]
- Hepatitis C prevalence among people attending needle and syringe programs has remained at high levels of between 50 per cent and 60 per cent over 1998-2007.

Figure 10: HIV and hepatitis C prevalence among users of needle and syringe programs by year and sex



Source: HIV/AIDS, viral hepatitis and sexual transmissible infections in Australia. Annual Surveillance Report 2008. Figure 31 page 23.
Inclusions: Information on sexual behaviour, history of injecting drug use and HIV and hepatitis C testing history was obtained by client completion of a questionnaire administered at 48 needle and syringe programs in 2003, 44 sites in 2004, 52 sites in 2005, 45 in 2006 and 53 in 2007.
Limitations: These data represent the proportion of the NSP population HIV and/or Hepatitis C positive, not the proportion of the entire injecting drug using population.

Food for thought…

Trends associated with opioid use suggest harms have stabilised or decreased. Have we become complacent about opioids owing to the heroin shortage earlier this decade? Are there other trends in illicit opioid use that are overlooked?

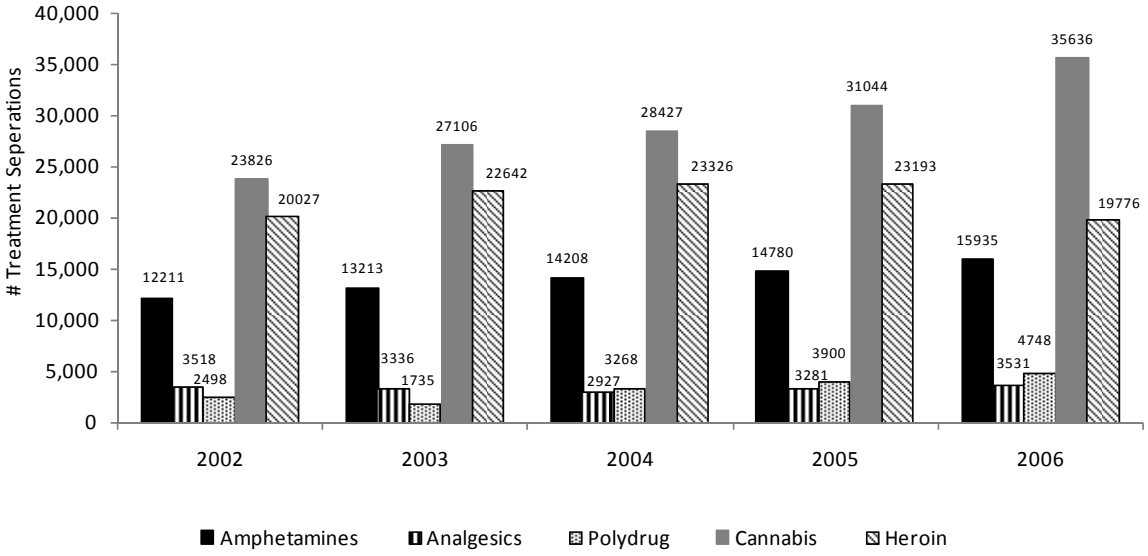
Are there better strategies for reducing the prevalence of Hepatitis C in the injecting drug using population?

[26] The rate of infection in people attending needle and syringe programs is used to estimate the rate of infection in the entire injecting drug use population, as we do not have any other data about rates of infection in the total population.

3.4 Treatment seeking behaviour

- The greatest proportion of treatment sought for illicit drugs among alcohol and drug treatment agencies (those reporting to the National Minimum Data Set) is for cannabis disorders; the next largest is for heroin disorders (see Figure 11).[27]
- There are approximately 38,000 opioid dependent people in pharmacotherapy maintenance treatment in Australia.[28]

Figure 11: Yearly number of treatment separations by drug



Source: Closed treatment episodes: client profile by principal drug of concern. 2001-02 AODTS-NMDS data, 2002-03 AODTS-NMDS data, 2003-04 AODTS-NMDS data, 2004-05 AODTS-NMDS data, 2005-06 AODTS-NMDS data and 2006-07 AODTS-NMDS data. Alcohol and other drug treatment data cubes.
Exclusion: Pharmacotherapy maintenance (methadone and buprenorphine) provided by GP's. Other treatments provided by GPs in primary care settings. Treatment episodes for clients seeking treatment for the drug use of others (e.g. parents seeking treatment for their child). Alcohol, Nicotine.
Limitations: The data rely on accurate agencies/organisation reporting.

Food for thought…

To what extent is there sufficient drug treatment capacity in Australia? What is the overall unmet demand for treatment in Australia?

[27] The number of treatment episodes is not adjusted by population prevalence of each drug type – and hence conflates treatment numbers with prevalence of dependence.
[28] Australian Institute of Health and Welfare AIHW (2008) 'National Opioid Pharmacotherapy Statistics Annual Data collection: 2007 report' AIHW Bulletin No 62 (http://www.aihw.gov.au/publications/index.cfm/title/10586)

Given rising rates of cannabis treatment seeking, are we on the right track? Are cannabis diversion programs primarily responsible for this increase in rates?

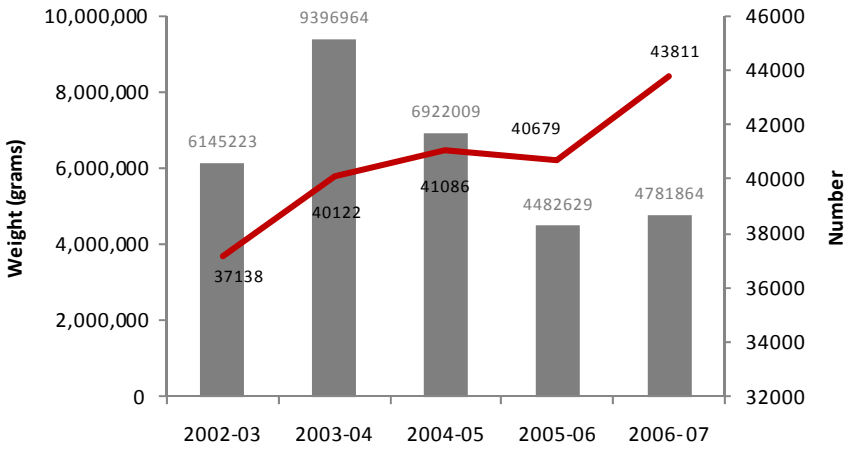
How do we ensure the most effective and efficient treatment service provision through the mechanisms available to government (contracting out, government providers, non-government providers)?

3.5 Law enforcement indicators: seizures and arrests

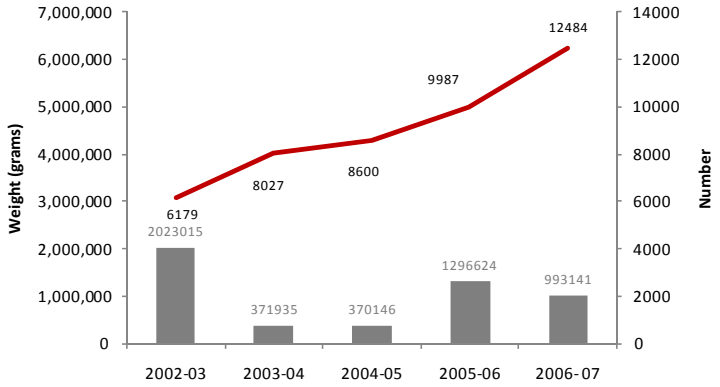
- The number of seizures of cannabis and amphetamine type stimulants has increased over time (see Figure 12a and 12b) but there has not been a corresponding increase in total weight seized.
- The number and total weight of heroin seizures has been stable (Figure 12c).
- The total weight of cocaine seized nationally increased by approximately 13 fold, but the number of seizures has been stable (Figure 12d).

Figure 12: Weight by number of seizures by drug type

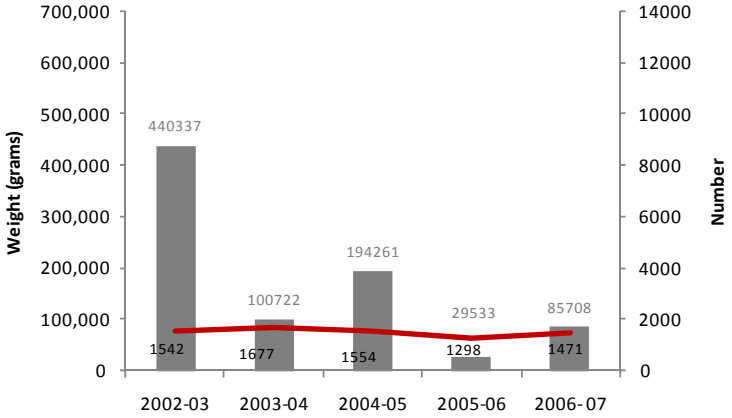
12a: Cannabis



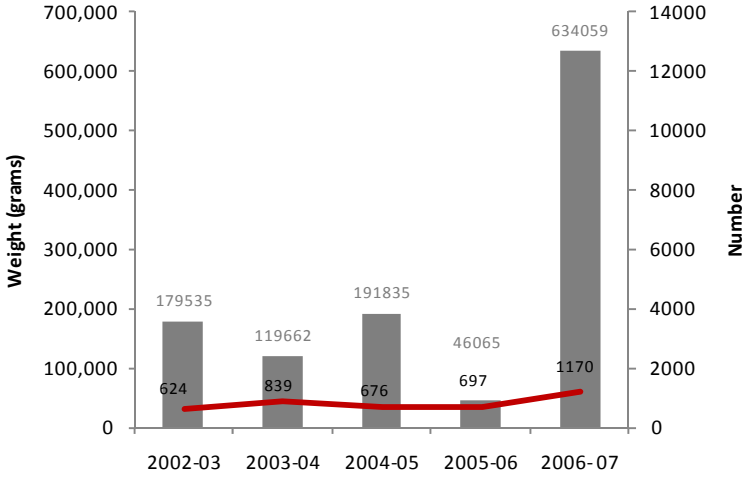
12b: Amphetamine type stimulants



12c: Heroin



12d: Cocaine



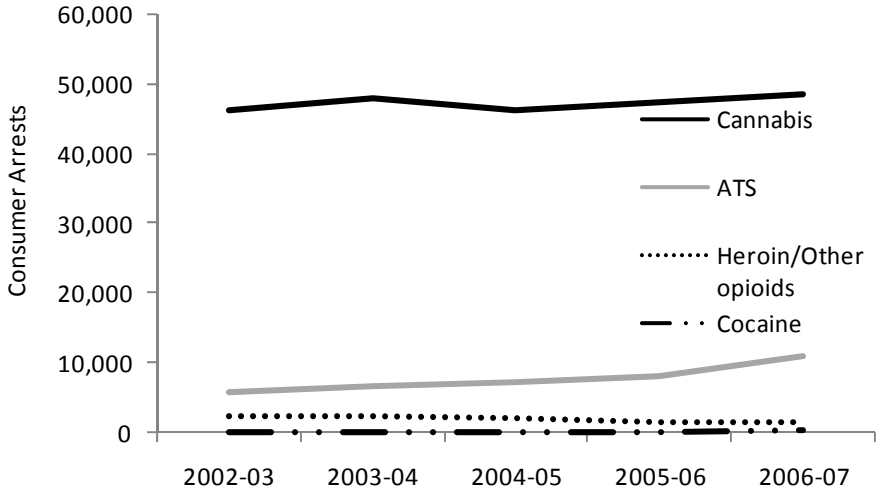
Sources: Table 2.1 p. 41 IDDR 2002-2003; Table 27 p. 7 IDDR 2003-2004; Table 27 p. 87 IDDR 2004 - 2005; Table 28 p. 91 IDDR 2005-2006; Table 29 p. 113 IDDR 2006-2007.
State police and AFP data was summed.
Inclusions: 12b: Amphetamine type stimulants (ATS). ATS includes amphetamine, methylamphetamine and phenethylamines (MDMA, MDEA, MDA, DMA and PMA).
Exclusion: Other Opioids, Steroids, Hallucinogens, Other and Unknown drugs.
Limitations: Includes only those seizures for which a drug weight was recorded. There is at present no way to adjust for double counting of some seizures resulting from joint operations between the AFP and state and territory police services.

Arrests for drug offences

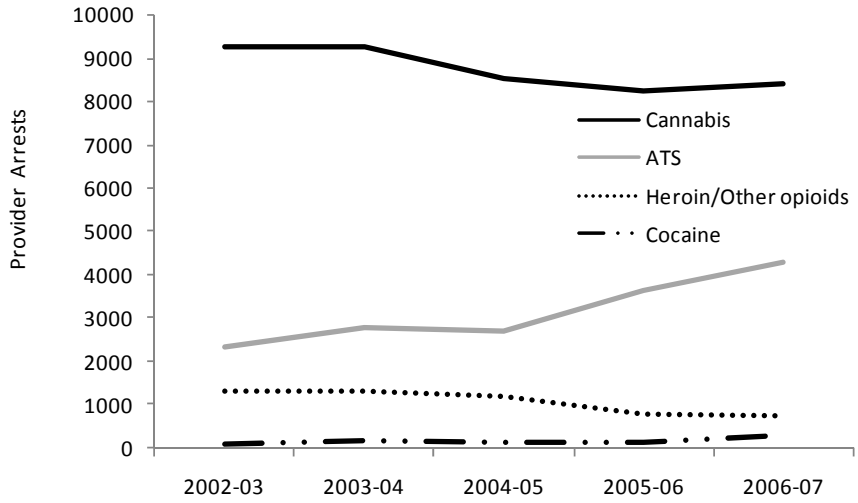
- Cannabis provider arrests for drug offences account for 53% of all provider drug offences.
- Cannabis provider arrests have declined but cannabis consumer arrests have remained stable (see Figure 13a and 13b).
- Both consumer and provider ATS drug offences have increased. Between 2002-03 and 2006-07 consumer arrests increased 84%, while provider arrests rose 83%.
- Both consumer and provider heroin drug offences have decreased.
- Consumer and provider cocaine arrests remain negligible but have increased by over 100% from 2002-03 (n=145 and 105 respectively) to 2006-07 (n=380 and 315 respectively).

Figure 13: Arrests for drug offences

13a: Consumer arrests



13b: Provider arrests



Source: Table 27: All arrests: consumers and providers, by drug type, 2002-03 to 2006-07. Australian Crime Commission. Illicit Drug Data Report 2006-07. ACC
Inclusions: 'Arrest' incorporates all recorded law enforcement action against a person for suspected unlawful involvement in illicit drugs. It incorporates enforcement action by way of arrest, summons, diversion program, cannabis expiation notice in SA, simple cannabis offence notice in the ACT, drug infringement notice in NT, and 'notice to appear' in Queensland. Some charges may subsequently have been dropped or the defendant may have been found not guilty.

Food for thought…

Law enforcement is one of the central platforms in the Australian response to illicit drugs, but the primary measures of activity/success are arrests, seizures and to a lesser extent changes in price and purity. What other indicators could/should we be using, e.g. drug availability?

How many offences and what quantity of drugs are *not* being detected?

What is the optimum balance of law enforcement efforts across all levels of the supply/demand chain? Should this differ for different drugs? If so how/why?

Do we apply different standards or expectations for the evidence-base for law enforcement versus treatment? If so, what are its implications for policy and its implementation and evaluation?

4. Responses to illicit drug use and harms: policy options

Policy options available to respond to illicit drugs fall into four categories[29]:

1. Law enforcement: reducing the supply of drugs and the criminal activity associated with drug use
2. Prevention: preventing the commencement of drug use by young people
3. Treatment: helping existing drug dependent people
4. Harm reduction: reducing harms to drug users and the community

The only detailed estimate of government spending on illicit drug responses for the year 2002/2003 indicated that Australian governments spent: [30]

56% in law enforcement
23% in prevention
17% in treatment
3% in harm reduction.

There is almost universal agreement that an effective policy response involves some combination of each of the four categories – that is, that good drug policy must include a balance of these four elements. In an ideal world of evidence-based policy, the assessment of the balance between the four categories would be driven by evidence that can inform decisions about allocative efficiency.

There is also substantial further consideration within each of these four categories as to best mix of policy responses. DPMP has developed a list of possible interventions within each of the four categories.[31] The list of interventions is provided as an attachment to this document. What remains unknown is the relative mix within each policy e.g. within prevention, what mix of mass media campaigns, drug education in schools and community strengthening programs is best?

Evidence is only one of the influences underpinning the policy decision process with public opinion, individual beliefs and attitudes and the historical context all playing significant roles in political decision making. In relation to public opinion, for example, there is increasing public support for harm reduction initiatives such as needle exchange facilities. At the same time, most Australians do not approve of illicit drug use, and there is decreasing public support for cannabis law reform.[32]

Government has available a number of policy instruments for responses to illicit drug use and associated harms. These include legislation, service provision and information. Good policy involves consideration of multiple policy levers and the interactions between them. We provide two checklists (Attachment 2) as prompts for delegates in considering innovative policy responses.

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[29] This is the Drug Policy Modelling Program preferred nomenclature for drug policy responses - the 'four pillars' approach.

[30] Moore, T. J. (2008). The size and mix of government spending on illicit drug policy in Australia. Drug and Alcohol Review, 27, 404-413.

[31] Ritter, A. & McDonald, D. (2005). Monograph No. 2: Drug policy interventions: a comprehensive list and a review of classification schemes. DPMP Monograph Series. Fitzroy: Turning Point Alcohol and Drug Centre.; Ritter, A. & McDonald, D. (2008). Illicit drug policy: scoping the interventions and taxonomies. Drugs: Education, Prevention and Policy, 15(1), 15-35.

[32] Matthew-Simmons, F., Love, S. and Ritter, A. (in press). Monograph No. 17: A review of Australian public opinion surveys on illicit drugs. DPMP Monograph Series. Sydney: National Drug and Alcohol Research Centre.

Food for thought…

What should be the most appropriate balance between law enforcement, treatment, harm reduction, and prevention policy responses?

What criteria would we use to assess the appropriate mix of investment?

Within each pillar, how do we assess the mix of interventions? For example within law enforcement how much should the focus be on supply country control, or interdiction or local policing? Within treatment, how much treatment should be delivered for withdrawal, maintenance, rehabilitation? And so on.

How can we improve the quality of the public debate on illicit drugs; and encourage a better informed general public?

Attachment 1: Drug interventions by the four pillars

Prevention

- Mass media campaigns
- Targeted media campaigns to at-risk groups
- Media advocacy*
- Employment
- Reducing poverty
- Improving overall public health
- School-based drug education (SBDE) programs – education and information
- Affective education programs in schools
- Resistance skills training programs in schools
- Generic skills training/competency enhancement programs in schools
- Social influence programs in schools
- Community/system-wide school programs
- Community-building / neighbourhood enhancement programs
- Community programs for young people
- Crime prevention through environmental design (CPTED)
- Infancy and early childhood programs for at-risk groups
- At-risk family interventions
- At-risk youth programs
- Post-natal support for drug dependent mothers*
- Parenting skills for drug dependent women
- Proactive classroom management & school policy
- Mentoring and peer support programs
- Renewal programs
- Drug Action Teams
- Screening in health settings
- Drug testing in schools

Law enforcement

- Drug-free zones
- International treaties and conventions
- Bilateral and multilateral international agreements and operations
- Prohibition
- Decriminalisation
- Prescribed availability of drugs*
- Licensed availability of drugs*
- Legalisation of drugs
- Crop eradication programs
- Crop substitution programs
- Customs and border control
- Multi jurisdictions taskforces against trafficking
- Crackdowns
- Raids
- Undercover operations
- Intensive policing
- Zero tolerance policing
- Police management reform
- Health and welfare systems management reform*
- Asset forfeiture

Financial controls and monitoring re money laundering detection and prevention
Controls on precursor chemicals
Crime mapping technology
Multi agency taskforces/partnerships
Community policing
Civil remedies, third party policing, drug nuisance abatement
Police discretion
Cautioning only
Cautioning with compulsory drug education/treatment
Pre-trial court diversion
Pre-sentence court diversion
Post-sentence court diversion
Drug courts
Restorative justice programs
Detention of intoxicated drug user
Neighbourhood Watch groups
Drug driving programs
Monitoring of drug use by inmates

Treatment

Drug monitoring programs
Drug detection devices (home testing kits)
Brief interventions
Telephone information and counselling services
Withdrawal treatment: Opioid agonist mediation
Withdrawal treatment: Alpha adrenergic medication
Withdrawal treatment: Opioid antagonist medication
Withdrawal treatment: Symptomatic medication
Withdrawal treatment: Other (e.g.: acupuncture)
In-custody withdrawal services
Methadone maintenance
Buprenorphine maintenance
Heroin maintenance
Naltrexone maintenance
LAAM maintenance
Morphine maintenance
Therapeutic community
Supported accommodation programs
Relapse prevention programs
CBT (individual and group)
Family therapy
Psychodynamic psychotherapy
Work/industry programs
Dual diagnosis programs
Services for pregnant women - pre-natal
Narcotics Anonymous
NARAnon
Drug education in prison
Treatment programs in prison
Parole programs
Post-release programs

Harm reduction

Peer-led advocacy and support programs

Needle Syringe Programs
Outreach programs
Peer education for users
Regulations (and/or legislation) in relation to drug paraphernalia
Overdose prevention programs
Peer administered naloxone
HIV prevention and education programs
HIV/hepatitis voluntary counselling & testing programs
Supervised Injecting facilities
Tolerance zones
NIROA

* interventions more difficult to classify.

Reproduced from:

Ritter, A. & McDonald, D. (2005). Monograph No. 02: Drug policy interventions: a comprehensive list and a review of classification schemes. *DPMP Monograph Series*. Fitzroy: Turning Point Alcohol and Drug Centre.

Ritter, A. & McDonald, D. (2008). Illicit drug policy: scoping the interventions and taxonomies, *Drugs: Education, Prevention and Policy*, *15*(1), 15-35

Attachment 2: Policy instruments

Government has available a number of policy instruments for responses to illicit drug use and associated harms. These include legislation, service provision and information. Good policy involves consideration of multiple policy levers and the interactions between them. We provide two checklists as prompts for delegates in considering innovative policy responses.

Policy instruments[33]

- Policy through advocacy: educating or persuading
- Policy through network: leveraging relationships within and across government and with external partners
- Policy through money: using spending and taxing powers
- Policy through direct government action: delivering services through public agencies
- Policy through law: legislation, regulation and official authority

Policy levers[34]

- Taxes: e.g. new tax, increase old tax, change tax base
- Regulation: e.g. new regulation, change existing, close loopholes, raise or lower sanction level
- Subsidies and grants: e.g. add new subsidy to stimulate market
- Service provision: e.g. fund new service, expand existing service, change intake criteria, improve access
- Information: e.g. display standard info, require disclosure
- The structure of private rights: e.g. adjusting laws – contract law, criminal law, corporate law
- Framework of economic activity: e.g. encourage competition, control prices
- Education and consultation: e.g. warn, educate, provide technical assistance
- Finance and contracting: e.g. create/abolish market, alter reimbursement rates, alter loan arrangements
- Bureaucratic and political reforms: e.g. changing public service, constitutional law

[33] Althaus, C., Bridgman, P., & Davis. G. (2007). *Australian policy handbook* (4th ed.). Sydney: Allen & Unwin.

[34] Bardach, E. (2005). *A practical guide for policy analysis: The eightfold path to more effective problem solving* (2nd ed.). Washington, D.C.: CQ Press.

Attachment 3: The Drug Policy Modelling Program

The DPMP aims to improve Australian illicit drug policy. We do this by undertaking research and practice that will assist policy makers develop sound, evidence-informed decisions. The DPMP does not have a predetermined view of what that drug policy should be – rather our core goal is to help generate effective Australian drug policy based on the best research findings.

The Drug Policy Modelling Program (DPMP) receives its core funding from a private Australian philanthropic trust, the Colonial Foundation Trust and is independent from government. DPMP is led by NDARC, UNSW in partnership with The Australian National University, Griffith University, McFarlane Burnet Institute and HEMA Consulting.

The goals of the DPMP are to:

1. Build systems and approaches to enhance evidence-informed illicit drugs policy
2. Develop and adapt new tools and methods for policy-makers
3. Show the value of these tools by dealing with specific problems raised by policy-makers
4. Generate new ideas and insights that can lead to new policy
5. Conduct rigorous research that provides independent, balanced and non-partisan analysis and improves the quality of the evidence
6. Evaluate the effectiveness of the tools, methods, policy support and new interventions

We aim to achieve our goals through three key activities:
1. generating new research evidence;
2. providing tools for policy makers to understand and use research evidence; and
3. studying how policy actually gets made.

All of the work is underpinned by a focus on capacity-building: encouraging scientists from other areas to work in the illicit drugs domain; bringing international expertise to Australia; supervising and mentoring students; providing consultancy and support to policy-makers to improve their use of research evidence; working in partnership with existing drug research centres and teams across Australia; and disseminating our work to researchers, policy makers and the public.

1. Generating new research evidence
Illicit drugs policy consists of decisions regarding the best ways to:

- reduce the supply of drugs and criminal activity associated with drug use (law enforcement);
- prevent the commencement of drug use by young people (prevention);
- help existing drug dependent people (treatment), and
- reduce harms to drug users and the community (harm reduction).

These four 'streams' – law enforcement, prevention, treatment, and harm reduction – form the foundation of good illicit drugs policy.

There is much more to be known about what works within each 'stream", in which circumstances and in what combinations. Evidence is also lacking about the optimal balance of government investment across these four streams. The DPMP is

undertaking sound innovative research and developing new tools so that we will be better able to compare prevention, policing, treatment and harm reduction.

2. Providing tools for policy makers to use evidence
Generating new evidence is not enough. Part of our mission is to harness effective methods and tools from other disciplines and content domains and put them to use for illicit drugs policy.

DPMP is investigating new ways to get evidence to policy makers. To do this DPMP is concentrating on the use of models to aid decision-making. Models, or simulations, can show policy makers the potential consequences of different choices. The models we are concentrating on are particularly useful for exploring 'what if' scenarios.

The DPMP models are based on a systems perspective. This integrated systems approach allows us to seriously explore the four streams as they dynamically interact. In developing these models DPMP will work directly with policy makers to assist in developing innovative responses to current policy problems.

3. Studying policy making
Creating the evidence for better Australian drug policy and developing tools to apply that evidence in practice with policy makers assumes that the only driver of drug policy is evidence. This is clearly not true.

Drug policy is influenced by the research evidence, but also by politics, lobby groups, public opinion, and the various windows of opportunity that arise from media attention.

The DPMP is alive to the contexts in which policy decisions are made. Our research program includes work to better understand how policy gets made in Australia and the opportunities for and threats to evidence-informed policy