



## Priority Areas in Illicit Drug Policy: Perspectives of Policy Makers

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

The results are of interest to funding bodies and committees that consider illicit drug policy. It is also rich fodder for those seeking a relevant research topic – it will hopefully excite a new researcher to engage in a drug-related research area. Finally, it provides a snapshot as at 2006 – in a few years time we will be able to assess progress on relevant research, or review the extent to which priorities have changed over time.

The senior drug policy bureaucrats in health and police for the seven states/territories and the Commonwealth were interviewed (N=39). Interviewees were asked open-ended questions about priority areas for illicit drug policy (“what do you see as the priority areas for policy over the next 5 to 10 years?”). They were also prompted to reflect on some of the more complex policy issues (“what are some of the outstanding puzzles?”). A restricted definition of ‘policy maker’ was used here – government officials (bureaucrats) who develop and implement policy. This is not to imply that there are not others substantially influential in the “policy community” including practitioners and researchers, members of government advisory bodies, elected officials and other significant policy advice groups. The choice to focus only on public servants was deliberate: policy making is core business for this group and theirs is a voice often not solely focused on.

It would be interesting to conduct a corollary study of the other members of the policy community and assess the degree of similarity and difference from the views identified here.

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

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

Many priority areas were identified, including specific research questions on individual drugs; the call for new methods and comparative analyses; questions about the structures of services; and policy decision making. This Bulletin provides a list of the priority areas – the full results can be found in:

Ritter, A. (2007). Monograph No.15: Priority areas in illicit drug policy: Perspectives of policy makers. *DPMP Monograph Series*. Sydney: National Drug and Alcohol Research Centre.

### The ‘usual suspects’– those priority areas that would not surprise

#### Methamphetamine

- Need for accurate data and information;
- Methamphetamine market operations;
- Impacts of methamphetamine for law enforcement practices;
- Prevention and treatment interventions for methamphetamine.

#### Prevention

- Need for clear conceptual framework;



- Research into efficacy, effectiveness and returns on investment (cost-benefits, cost-effectiveness);
- Research into mass media campaigns;
- New prevention interventions.

### **Diversion**

- Research into the effectiveness and cost-effectiveness of diversion.

### **Cannabis**

- Some ambivalence about a focus on cannabis;
- Effective prevention strategies for cannabis;
- Greater analysis of effective harm reduction measures;
- Models for cannabis legislation;
- Cannabis market research;
- Harms associated with cannabis (cannabis and psychosis, driving).

### **Data and information**

- Better, more timely data and of greater precision;
- Data collections that are part of routine operations or practice;
- Better exchange of information and data between sources;
- Need for methodological advances.

### **Mental health**

- GPs – detection, screening, uptake and referral pathways;
- New models for dual diagnosis service provision;
- Effectiveness of different approaches to organising and delivering mental health and A&D services.

### **Return on investment**

- Need for economic evaluation including analysis of returns on investment, cost-effectiveness, cost benefit analysis and cost savings analysis;
- Improved methodological approaches;
- Comparative analyses (between drug types, interventions).

### **Treatment**

- More head-to-head trials of different interventions;
- Australian treatment outcome studies;
- Policy analysis of the treatment alternatives (broadening out the comparative criteria from efficacy and cost-effectiveness);
- Evaluation of treatment models in practice, and return on investment studies on usual care;
- Pharmacotherapies research, especially regarding service models and patient co-payments;
- Treatment seeking processes, treatment access, clinical guidelines.

### **Indigenous and remote communities**

- Drug policy initiatives need to be integrally linked to broader social policies;
- Hidden drug use, large drug production sites, access to services and the need for more analysis of drug substitution in remote communities.

### **Drugs and crime and policing**

- Better strategies for reducing drug-related crime;
- Sustainable policing solutions that deal with displacement of the problem to other areas/locations;
- Better interventions for interdiction, production and supply disruptions, and links to organised crime;
- Increasing the options available to police to respond to immediate crises (including intoxicated and violent people), road safety, and public order issues.

### **The 'difficult conundrums' - areas where we have not made much headway**

#### **Measuring success**

- The overall success of drug policies (What are we trying to achieve? What are realistic goals? Are we making a difference or merely keeping it at bay?);



- Lack of agreed or shared outcomes across the sector or across the community;
- Evaluations of success: processes that undermine evaluation (e.g. policy change before evaluation results come out); vague scope and outcome expectations from the start; difficulties acting upon evaluation results;
- Measuring success in prevention and law enforcement;
- Development of methods and conceptual advancement required.

### Harm minimisation

- Conceptual confusion continues (deliberately placed to avoid debate?);
- Perception and politics of harm minimisation;
- The need for complex public messages (e.g: drug use is harmful and an offence but there are ways to reduce harms);
- Establishment of a stronger and clearer evidence-base in relation to the influence/impact of overarching frameworks;
- Analysis of the costs and benefits associated with zero tolerance and harm minimisation policies.

### Service planning and funding

- Methods for estimating demand for treatment and relationship between supply and demand;
- Funding formulae and benchmarks in relation to purchasing services;
- Role of the commonwealth vis-à-vis the states in funding services;
- Research into the structure of services, including the different service types and providers;
- NGO versus government treatment services – the relative merits of NGO versus government sector service provision, including corporate and clinical governance; client outcomes, professional clinical qualifications and the potential downstream implications of a continued competitive tendering approach;
- Continuity of care.

### Service providers

- Need for research to examine the provision of interventions by a specialist versus generalist service system (What level of specialisation is required to produce good clinical outcomes?);
- Best investment mix between specialist and generalist services;
- To what extent has the establishment of a 'specialist' service system been advantageous (expertise/knowledge/skills) versus disadvantageous (lack of systems view, less flexibility)?
- Workforce development.

### Structures for policy making

- Jurisdictional structures for drug policy;
- Structures for policy decision-making coordination.

### Policy analysis – need for more complexity

- Need for greater and more complex analytic research, e.g: polydrug use;
- Unintended consequences of policies;
- When should a policy be abandoned?
- Timeliness of such policy analysis;

### The 'sacred cows' - priority areas that are difficult to raise or deal with in the usual settings.

During the course of the interviews, policy makers discussed some of the more taboo and complex topics in drug policy. This bulletin cannot do justice to the nuance in this section of the report. The priority questions are listed here but should be read in conjunction with the monograph:

- Is the goal of a balance of elements (law enforcement, treatment, prevention, harm reduction) appropriate? What should that balance be?
- What are the costs and benefits associated with focusing policy on one domain (treatment, law enforcement, prevention)?
- How can we implement effective 'whole of government' policies?



- What would real policy using a social determinants of health framework look like?
- What would we invest in? How can we overcome the funding boundaries?
- Is the threat of being dissolved or replaced by new structures and power-bases standing in the way of innovative drug policy?
- How do we get traction on policies arising from the evidence-base regarding risk and protective factors?
- Do our policy processes err towards a compromise, and result in lowest common denominator decision-making?

For more information about this work see:

Ritter, A. (2007). Monograph No. 15: Priority areas in illicit drug policy: Perspectives of policy makers. *DPMP Monograph Series*. Sydney: National Drug and Alcohol Research Centre.