

UNIVERSITY
OF TASMANIA

A Dialogue of the Deaf:
The rise and stall of harm reduction policy
in Australia from 1980 to 2000.

Jackie Hallam
B.A. (Hons)

Submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

University of Tasmania

November 2006

Declaration:

This thesis does not contain any material which has been accepted for a degree or diploma by the University or any other institution, except by way of background information and duly acknowledged in the thesis. To the best of my knowledge and belief, this thesis does not contain any material previously published or written by another person except where due acknowledgement is made in the text.



Jackie Hallam

23/11/06

Date

Authority of Access:

This thesis may be made available for loan and limited copying in accordance with the *Copyright ACT 1968* after 24/11/2006.



Jackie Hallam

23/11/06

Date

Abstract

A Dialogue of the Deaf: The rise and stall of harm reduction policy in Australia from 1980 to 2000.

In the 1980s, a new policy approach to illicit drug use was established. This philosophy of 'harm reduction' was in stark contrast to traditional abstinence-oriented drug policy and was developed primarily by medical professionals working with affected communities. Since its implementation, harm reduction has attracted criticism, with the suggestion that such services that reduce the risk of illicit drug use, in contrast with policy that encourages abstinence toward illicit drugs, result in socially pathological results for society. Debates between supporters of harm reduction and abstinence-oriented approaches often result in a deadlock, given such fundamental disagreement over 'deep core' values.

This research applies the Advocacy Coalition Framework (ACF), developed by Paul Sabatier and Hank Jenkins-Smith, to explain the pattern of implementation of harm reduction policies in Australia in the period from 1980 to 2000. The ACF is principally focused on explaining how major policy change occurs, with emphasis on the role of technical information in learning between coalitions. The ACF has largely been applied to examination of environmental policy development, and this research evaluated the utility of the ACF to comprehending change in social policy systems.

The ACF was generally an adequate theory to comprehend illicit drug policy developments between 1980 and 2000. The theory adequately described policy oriented learning between coalitions, the notion of advocacy coalitions and explaining major policy change. This research found that discord between coalitions regarding the validity of information in subsystems occurred at a deeper level than expected. Moreover, the nature of the problem area was subject to more change than allowed for in the ACF's emphasis on stable system parameters. The thesis concludes by offering some direction for future developments with regard to the ACF when applied to analysing change in social policy arenas.

Acknowledgments

Thanks very much to Dr. Marcus Haward, who supervised the project clearly and cogently through to completion. Your support was truly invaluable as was the number of 'yep exactlys' you dealt out during regular progress meetings. It was also fun working with you on this thing and I wish you to the best of everything in the future. Basically, thanks A LOT dude.

Other staff in the Department of Government also contributed, such as Dr. Aynsley Kellow who encouraged me to attend the 2001 International Harm Reduction Association conference in Albuquerque, USA. Moreover, thanks be to the secretarial contingent of the Department of Government, Louise Darko and Nilar Hlaing, who were always entirely approachable, a lot of fun and very quick to help even when they didn't have to.

Thanks to Tom Hay who jumped to my aid one time on the internet and provided a word that I couldn't remember.

Thanks also to my parents, Leon and Val Hallam who sacrificed a lot (a long time ago) to get me where I am.

On a personal note thanks to the love of my life Dr. Raimondo Bruno, who not only proof read numerous drafts but who also put up with lots of whining about completing this thing. I really appreciate your personal conviction and support of this project and myself throughout it.

Table of Contents

Declaration:	ii
Authority of Access:	ii
Abstract	iii
A Dialogue of the Deaf: The rise and stall of harm reduction policy in Australia from 1980 to 2000.	iii
Acknowledgments	iv
Table of Contents	v
List of Tables, Figures and Boxes:	ix
Acronyms	x
Acronyms	x
Introduction	1
Aims of the research.....	3
Why Illicit Drug Policy? Why the Advocacy Coalition Framework?	4
Research Design.....	7
What is harm reduction?.....	11
So what is harm reduction in practice?	16
Dissenting Views: The Moral-Abstinence Approach	19
Illicit Drug Policy Before 1980	26
Structure of the Thesis.....	32
Chapter 2: Advocacy Coalitions and Australian Illicit Drug Policy	36
Introduction	36
The Advocacy Coalition Framework	37
Figure 1. Diagram of ACF	43
The Policy Subsystem	44
Advocacy Coalitions	44
Guidance Instruments.....	47
The Policy-Making Cycle	48
Exogenous Variables	49
Relatively Stable Parameters.....	50
External System Events.....	54
Types of Policy Change	55
Minor Policy Change	57
Major Policy Change.....	60
An Advocacy Coalition Framework For Analysing Illicit Drug Policy 1980 to 2000	64
Table 1: An Advocacy Coalition Framework for Analysis of the Illicit Drug Policy Subsystem 1980 – 2000	65
Chapter 3: The Emergence of a Coalition for Harm Reduction	70
Introduction	70
The Origins of Harm Reduction.....	71
The Identification of the ‘Drug Problem’	73
1970s - The Era of the Royal Commission	74
The Genesis of a Coalition for ‘Harm Reduction’ in Australia	80
The National Campaign Against Drug Abuse (NCADA).....	82
The Role of HIV/AIDS in the Emergence of Harm Reduction Policy	86

National HIV/AIDS Strategy 1989	97
The 1989 NCADA Evaluation	98
Explaining Illicit Drug Policy Change Through the Advocacy Coalition Framework	101
ACF Concepts 1 & 2: Advocacy coalitions and policy core beliefs.....	102
ACF Concept 3: Guidance instruments.....	103
ACF Concept 4: Policy brokers in strategic positions.....	106
ACF Concept 9: Conditions of ‘major’ policy change?.....	107
ACF Concept 10: How did major policy change occur?.....	112
How to classify HIV/AIDS in the ACF?.....	113
Conclusion.....	114

Chapter 4: Harm Reduction Policy Stagnation and Police Innovation in Australia between 1990 and 2000.....	117
Introduction	117
Harm Reduction in the 1990s.....	118
Hepatitis C: The ‘Poor Cousin’ of HIV.....	128
Changes to Law Enforcement: the Softening of Prohibition?.....	136
Advocating Prescription Heroin and Supervised Injecting Centres.....	146
Heroin trial	147
Supervised Injecting Centres.....	147
The Softening of Harm Reduction?.....	149
Explaining Policy Change through the Advocacy Coalition Framework	155
ACF Concept 1 & 2: Advocacy Coalitions & Policy Core Beliefs	156
ACF Concept 3: Guidance Instruments.....	157
ACF Concept 7 & 8: Policy oriented learning and policy change.....	159
Coalition strategising.....	164
Conclusion.....	166

Chapter 5: Moral entrepreneurs and the undeserving: advocating prescription heroin and supervised injecting rooms in Australia in the 1990s	168
Introduction	168
The Heroin ‘Problem’	170
Table 2: Recent use of heroin: proportion of the population aged 14 years and over	171
Prescription Heroin.....	175
Advocating prescription heroin in Australia	178
Box 1: A brief history of the prescription heroin feasibility study	179
Table 3: Public support of prescription heroin	183
Supervised Injecting Centres.....	186
Not just for the ‘undeserving’: advocating SICs in Australia.....	190
‘Health’ arguments for SICs.....	191
‘Social’ arguments for SICs	193
‘Economic’ arguments for SICs.....	197
‘Legal’ arguments for SICs	199
Moral arguments for SICs	199
Helping the undeserving leads to more of them: advocating against SICs.....	203
‘Health’ arguments against SICs.....	204
‘Moral and Social’ arguments against SICs.....	204
‘Economic’ reasons against SICs.....	206
‘Legal’ arguments against SICs	207
Debates and Outcomes: a trial of a medically supervised injecting centre in Kings Cross	209
Heroin Prescription and Supervised Injecting Rooms: Is the ACF adequate to explain policy success and failure?.....	214
ACF Concept 1: Advocacy Coalitions	214

ACF Concept 3: Guidance Instruments.....	217
ACF Concept 6: Policy oriented learning and types of data.....	218
ACF Concept 8: Policy oriented learning and professional forums	219
Explaining policy failure.....	220
ACF Concept 4: Policy Brokers in strategic policy posts	221
Role of policy brokers.....	222
Conclusion.....	223
 Chapter 6: 20 years of Epistemological Struggle over Illicit Drugs: Can the ACF Explain Illicit Drug Policy Change?	225
Introduction	225
Advocacy Coalitions	226
Research Question 1.1: What type of actors constituted the harm reduction and moral abstinence coalitions?	226
Research Question 1.2: Was there any change in the type of actors over a 20 year period in illicit drug debates?.....	228
Coalition Genesis (early 1980s).....	229
Crisis time (mid-1980s).....	229
Post-HIV/AIDS (late 1980s –2000).....	230
Research Question 1.3: What was the nature of the change? Gradual or sudden?	231
Policy Beliefs	232
Research Question 2.1: Did the harm reduction coalition display consensus on policy core over 20 years?.....	232
Guidance Instruments.....	234
Research Question 3.1: How did the harm reduction coalition capitalise on changes that occurred external or within the subsystem?	234
Research Question 3.2: Did these conform to Sabatier’s taxonomy of guidance instruments?.....	237
Ongoing research and information gathering and opportunistic policy ambush	238
Policy Brokers	241
Research Question 4.1: Do policy brokers have membership of any coalition?	241
Figure 2: Policy broker axis of role and influence	243
Figure 3: Policy broker axis of role and influence	244
Research Question 4.2: To what extent do policy brokers ‘make’ policy? Do policy brokers receive conflicting strategies? Do policy brokers reach compromise between coalitions?	245
External Variables	246
Research Question 5.1: Were such phenomena, as categorised in the ACF, stable from 1980 to 2000?.....	246
Emergence of a new language.....	247
Emergence of a new disease and reconfiguration of the ‘problem’	249
Ever-changing drug trends between 1980 and 2000	249
Research Question 5.2: Did coalitions target these parameters for reform?.....	252
Policy Oriented Learning	253
Research Question 6.1: What was the role of quantitative data/information in policy oriented learning.....	253
Research Question 6.2: Was such data accepted by both coalitions?.....	255
Research Question 6.3: If not what were the barriers to its acceptance?.....	255
Research Question 7.1: In cases where policy oriented learning occurred, did the conflict concern secondary aspects of both coalitions or between the secondary aspect of one coalition and the policy core of the other?	258
Research Question 8.1: What were the type of forums that facilitated policy oriented learning?	259
Policy Change.....	260
1. ‘Major’	260
2. ‘Secondary’	261
3. ‘Gradual and systemic’	262
Involvement of injecting drug users in the development of policy	262
Harm minimisation policing.....	263

Research Question 9.1: In cases of changes to the policy core, was there an external shock to the subsystem?	264
Research Question 9.2: How did coalitions integrate such external events into strategies to realise policy objectives?	264
Major Policy Change – Condition 2	266
Research Question 10.1: In cases of changes to policy core, did the subsystem coalition that instituted the program remain in power?	266
Research Question 10.2: If yes, then was the change imposed by a hierarchically superior jurisdiction?	266
Research Question 10.3: What was the outcome of major policy change regarding the relative power of coalitions within the illicit drug policy subsystem?	266
Conclusion	267
 Conclusion	 273
 Bibliography	 286

List of Tables, Figures and Boxes:

Figure 1. Diagram of ACF 43

Table 1: An Advocacy Coalition Framework for Analysis of the Illicit Drug Policy
Subsystem 1980 – 2000.....65

Table 2: Recent use of heroin: proportion of the population aged 14 years and over
..... 171

Box 1: A brief history of the prescription heroin feasibility study 179

Table 3: Public support of prescription heroin..... 183

Figure 2: Policy broker axis of role and influence 243

Figure 3: Policy broker axis of role and influence 244

Acronyms

ACF	Advocacy coalition framework
ACMD	Advisory Council on the Misuse of Drugs
ACT	Australian Capital Territory
ACT	Australian Capital Territory
ACTIV	ACT Intravenous Drug Users League
ALP	Australian Labor Party
AMA	Australian Medical Association
AMSAD	Australian Medical Society on Alcohol and Drugs
ANCD	Australian National Council on Drugs
BBV	Blood borne virus
CBFD	Central business district
DACA	Drug Advisory Council of Australia
HCV	Hepatitis C virus
HIV/AIDS	Human immunodeficiency virus and acquired immune deficiency syndrome
IGCD	Intergovernmental Committee on Drugs
MDCS	Ministerial Council on Drugs
MMT	Methadone maintenance treatment
NCADA	National Campaign on Drug Abuse
NDRI	National Drug Research Institute
NDS	National Drug Strategy
NIROA	Non-injecting routes of administration
NSP	Needle and syringe programs
NSW	New South Wales
SIC	Supervised injecting centre
USA	United States of America
WHO	World Health Organisation

Introduction

There is little doubt that the dominant response to the proliferation of injecting drug use in most Western states is one underwritten by a moral philosophy that regards such use as both indulgent and highly dangerous to both the individual and society. Similarly, there is little doubt that this perspective will continue to remain the dominant approach taken by Australian governments, at least in the medium term. This is because prohibition of drugs is a highly entrenched policy position that enjoys a considerable degree of support from the electorate. The policy of prohibiting drugs such as heroin and amphetamines, as an approach to reduce their supply into society, has largely been unchallenged since its inception in the early twentieth century. Indeed, there seems to be widespread and ongoing consensus from both the public and policy-makers that prohibition is a highly necessary policy instrument.

An alternative policy approach does, however exist, and poses (at least in the early stages of its development) a challenge to prohibition. This *harm reduction* approach, (whereby services are provided that have an overall aim to reduce the risks of illicit drug use without requiring a reduction in use), entered the drug policy arena in the early 1980s in several Western states amid a public health crisis and reports of increasing health and social problems associated with drug use. While the harm reduction approach has a relatively secure place in illicit drug policy, it often faces challenges from a section of stakeholders that suggest the very foundations of the approach generate socially pathological effects. The controversy surrounding the philosophy of harm reduction programs often compromises so-called rational debate and scholarly exchange of research and information. The issue of illicit drug use is often underwritten by highly emotive opinions and ideas borne from linkages of the

issue to religious and cultural systems. Indeed, the illicit drug policy arena is a dynamic system in which rational information (such as that borne from scientific research) competes with faith and morality-based notions, with the latter carrying more political weight than in most other policy arenas.

Currently in Australia, illicit drug policy is at an impasse, and has arguably been so for close to a decade. While harm reduction programs instigated in the 1980s in response to HIV/AIDS continue to operate, more recent efforts to implement further programs have been unsuccessful. In contrast to transmission rates of human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS), the prevalence of the hepatitis C virus (HCV) has skyrocketed among injecting drug users. It seems that there are limits to the capacity of harm reduction policy (enacted in the Australian context) to not only contain transmission of HCV but also to expand to implement initiatives beyond that initiated in the 1980s. The advocacy coalition framework (ACF), developed by Paul Sabatier and Hank Jenkins-Smith¹ will be employed to examine the development, implementation and advocacy of harm reduction policy in Australia in the period 1980 to 2000. Of particular interest are instances of successful and unsuccessful bids by proponents of harm reduction programs at achieving policy change, with the overall aim of examining the strategies employed by supporters of harm reduction in order to convert beliefs into policy.

¹ Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe', *Journal of European Public Policy*, 5:1, March, p99.

Aims of the research

This thesis has three key aims. First, the research seeks to understand the nature of policy change in the illicit drug policy subsystem in Australia between 1980 and 2000. More specifically, it provides an examination of how harm reduction approaches became incorporated into Australian federal and state public policy. A key focus of the research is an identification of the strategies used by advocates to realise policy objectives. This research is principally concerned with the way in which key ideas of harm reduction have been accepted or rejected and the factors affecting policy change. Policy change will be analysed through the lens of the ACF that facilitates an identification of the stakeholders, their ideas and strategies used to realise policy. Such an endeavour contributes further to the literature on both illicit drug policy making, as well as the development of (illicit drug) public policy in the Australian context.

In a second aim, this thesis seeks to provide direction on possible further development of the ACF with regard to its application to social systems. The vast majority of applications of the ACF have been with regard to natural systems such as water or forestry policy. Thus, this research will provide an evaluation of the ACF when applied to social policy settings (for example: arenas such as health, unemployment, welfare or drug policy) which are characterised by discussions of human nature and in which the underlying causes of policy problems are highly contested. Moreover, such social phenomena are not always conducive to measurement (due to the illegality of some behaviours), and further, consensus on the appropriate epistemological tools to evaluate policy is often the topic of disputes. Such social policies can be contrasted to policy directed at natural systems whereby

the scientific approach is accepted as the mechanism to understand the nature of the policy problem.

The third aim of this thesis is to provide insight into the theory and practice of harm reduction ideas, identifying and evaluating the triumphs and defeats of those that advocate for such an approach. Through this endeavour, the 'political limits' of such a controversial policy approach will be discussed. Moreover, the evolution of the concept when integrated into mainstream drug policy will also show how such ideas 'fit' when acting as a reluctant bedfellow with prohibition ideas. As such, the application of the ACF in this policy context is novel, and will extend existing work in this area.

Why Illicit Drug Policy? Why the Advocacy Coalition Framework?

Injecting drug use is a contentious and ongoing issue in Australia as the severity of drug related problems has not decreased (and in some cases increased substantially) since the mid-1980s, with little progress predicted on the horizon. While there have been minor changes to policy in the previous decades, the overarching outlook of policy has not evolved much since the mid-1980s despite changes to illicit drug markets, the identification of new diseases and harms associated with drug use and the production of much research and scientific endeavour devoted to this subject area. Indeed, since the 1970s, drug-related problems have been evaluated in many Royal Commissions, reviews, Inquiries and have periodically been subject to a high level of interest from the media and various state and federal Governments in Australia. In the 1980s, major policy change occurred in the illicit drug policy subsystem whereby implementation of a national framework enshrined the 'harm

minimisation' approach. In this context the harm minimisation approach consisted of a combination of supply (law enforcement), demand (anti-drug education) and harm reduction (services for those that continue to use drugs).

The combination of the seemingly antagonistic policy mix of prohibition (an approach that seeks to reduce the instance of drug use) and harm reduction (an approach that provide services for existing drug users) combined to produce a policy that at times seems both incoherent and a shrewd political device that represents the majority of diverse stakeholders. Arguably, harm reduction's place in the overall policy schema is at odds with the dominant disposition of drug policy that is geared to reducing the supply of drugs and prevalence of use. This thesis seeks to explore this uneasy relationship with a focus on the politics of harm reduction. Such an exploration will provide insight into why harm reduction policy has stagnated in Australia and the barriers to further policy change. Such research is worthy of the attention of scholars in this field in order to better understand the nature of this policy deadlock.

Another reason for conducting this research is to fill a substantial research gap - namely the analysis of Australian illicit drug policy through the lens of public policy theory. While much writing on Australian illicit drug policy has occurred, the majority has been descriptive, with a relative dearth of critical analyses using public policy theory. Trevor King has examined types of public policy tools when applied to drug policy² and indeed wrote a thesis on comparing methadone policy

² King, T., 1998, 'The Search for Rationality in Illicit Drug Policy', in M., Hamilton, A., Kellehear & G., Rumbold (Eds), *Drug Use in Australia: a harm minimisation approach*, Oxford University Press, Melbourne, p145-158.

development in several countries.³ Apart from these examples, theories of public policy have not been applied to analyse policy change in the Australian illicit drug policy arena. The ACF has never been applied to analyse any policy system in Australia, and has only been employed to analyse drug policy in a single country, namely Switzerland in the work of Kubler.⁴ Moreover, to date, the ACF has been largely utilised to examine natural systems such as particular aspects of environmental policy (water and forest policy to name two).⁵ The ACF is relevant to this highly contentious subject area because of its particular focus on the interplay between beliefs, ideas and the role of technical information in terms of policy change.

Traditionally, drug policy is typically underwritten by morality based information with rational/scientific information increasingly playing a role in recent decades, however, the influence of scientific/rational information is still somewhat limited, especially when contrasted to that in natural systems. Ergo, this research should challenge the model of the ACF when examining the debate regarding differing epistemological stances in drug policy, especially as the ACF makes key assumptions on the role of quantitative/technical information in policy change. Moreover, this research should contribute to an exploration of how the ACF performs in arenas whereby quantitative information and scientific endeavour are relatively less compelling in comparison to other systems. Sabatier has contended that the ACF should perform well when applied to social systems.⁶ This thesis

³ King, T., 1994, *A Comparative Analysis of Methadone Policy Development in the US, the UK, the Netherlands and Victoria, Australia*, MA Thesis, La Trobe University, Melbourne.

⁴ Kubler, D., 2001, 'Understanding policy change with the Advocacy Coalition Framework', *Journal of European Public Policy*, Volume 8, No. 4, pp623-641.

⁵ Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe', *Journal of European Public Policy*, 5:1, March, p100-101.

⁶ Sabatier, P., & Jenkins Smith, H., 1999, 'The Advocacy Coalition Framework: An Assessment', *Theories of the Policy Process*, P., Sabatier (Ed), Westview Press, Boulder.

examines that assertion in depth by both evaluating a number of the core principles of the ACF and its utility to explain changes to illicit drug policy.

Indeed, the subjects discussed in this thesis often go beyond that of illicit drug policy to examine wider concepts such as the types of groups in society that are deserving or undeserving of public funds and the nature of morality based arguments when contrasted with rational/scientific ones. In sum, this research examines the limits of political acceptability of harm reduction ideas and the seemingly inability of Governments to curb and contain HCV and other drug related problems through the lens of the ACF. Thus, the identification of the limits of harm reduction and the role of scientific/rational information in drug policy debates will provide insight into the deadlock in illicit drug policy that often characterises debates regarding solutions to ongoing drug-related problems.

Research Design

This research employs the advocacy coalition framework as a theoretical lens to examine illicit drug policy in Australia from 1980 to 2000. This theory seeks to engender a coherent understanding of all the major steps (problem definition, policy formulation, implementation and revision) that feature in the policy process. The ACF is principally geared to allow examination of policy change in discrete policy subsystems and provides a framework for determining the conditions in which change occurs.

Implicit within the ACF is the importance of the examination of information that is used to support various policy alternatives in key texts. Such texts use such information to both describe the rationale of, and approach to, a given problem.

Theories of the policy process need to address the role that technical information concerning the magnitude and facets of the problem, its causes, and the probable impacts... of various solutions play in this process. This is what the vast majority of discussion among policy elites is about and, assuming a modicum of rationality on their part, it must be important.⁷

Key documents used in this thesis include: primary accounts from bureaucrats, key actors and stakeholders (some expressed in secondary sources) as well as secondary sources such as: the numerous Royal Commissions into drugs; National Drug Strategies; Evaluations of National Drug Strategies (1989 and 1997); National HIV/AIDS Strategies (1989 and 1996); National Methadone Policy; National Hepatitis C Strategy; reviews of HCV policy; state and territory government reports on drug policy and position papers; Australian Bureau of Criminal Intelligence reports; reports from Parliamentary committees; reports from international groups such as the World Health Organisation; conference papers; Hansard records; transcripts of discussions that occurred in peak meetings (for example the 1999 NSW Drug Summit); media articles; electronic sources such as websites from lobby groups; reports from local councils in Australia; research and commentary in journal articles and books written on the subject. Such position papers are subject to textual analysis to understand the way in which policy problems were defined and the prescription of solutions.

⁷ Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe', *Journal of European Public Policy*, 5:1, March, p99.

The subject of this research is illicit drug policy in Australia and more specifically, policy concerned with injecting drug use in particular, therefore, cannabis policy is not included. While many injecting drug users are often cannabis users, this association does not hold in the reverse. Indeed the Australian Health and Welfare Institute in the *2004 National Drug Strategy Household Survey* estimated that 33.6% of Australians have used cannabis in their lifetimes in comparison to an estimate of 2.3% of Australians that have tried heroin at least once in their lifetimes.⁸ Moreover, harms resulting from cannabis use generate, to a degree, a different risk profile to intravenous drug use- for example, the transmission of blood borne viruses (BBVs) is not associated with cannabis use. The predominant illicit drugs of interest in this research are hence of the injectable variety, such as heroin and other opiates (for example morphine), amphetamines, and to a lesser extent, benzodiazepines. This thesis is not concerned with an analysis of each particular drug type listed above and the associated drug related harms and policy responses, rather it subsumes all injectable drugs under one category unless stated otherwise. The issue of injecting drug use was chosen to test the merits of the ACF when applied to the analysis of social problems because this activity attracts a high level of emotive and morally-driven exchanges between policymakers and stakeholders, concerning highly marginalised people. Indeed, this thesis is focused on examining the most confronting aspect of illicit drug use, being the practice of intravenous administration, and the policy responses from Government agencies toward this activity. As such, this thesis examines the politics of advocating for services to make injecting drug use less risky, which for some is considered unacceptable as it is considered a first step of normalising such an activity. A definition of the illicit drug policy subsystem under examination is offered in chapter two.

⁸ Australian Institute of Health and Welfare, 2004, *National Drug Strategy Household Survey*, Drug Statistics Series, No. 16, Canberra.

The research also takes a focus on a particular drug policy instrument, being the harm reduction approach. The research does not seek to explain in depth all facets of drug policy such as law enforcement, treatment modalities, or demand reduction interventions such as school drug education. Specifically, this research is concerned with an examination of the emergence and evolution of harm reduction theory and practice. While such an approach has origins (explored in chapter three) in medical-scientific fields, it is a distinct approach to, for example, the medical model of addiction whereby dependencies are regarded as a type of illness. It is clear however that proponents of harm reduction support the notion that drug use is a health issue rather than a criminal issue, and moreover, seek to ameliorate public health issues that may arise from illicit drug use. Ultimately this research is focussed on harm reduction rather than generic 'medical' approaches to drug use.

Similarly, in this thesis, there are numerous references to law enforcement, prohibition and the idea of a coalition of actors that support 'moral abstinence' oriented approaches to drug policy. While all three terms are linked, it is not assumed that all law enforcement personnel support all abstinence-oriented drug policy (whether this refers to abstinence-oriented treatment, drug laws or anti-drug education). It is recognised, however, that the overall aim of prohibition as a policy instrument is to reduce (with the absolute aim of eliminating) the supply of illicit drugs into society. Thus prohibition and law enforcement are the operational manifestation of 'moral abstinence' ideas in drug policy that seek to eliminate the instance of injecting drug use. Within the moral abstinence approach to drug policy there are, of course, many degrees of intensity in theory and practice. Indeed, it is

the section of supporters of this approach that directly opposes harm reduction ideas that is the main focus of interest.

A synthesis of the analysis of both federal and state policy occurs in chapters three to five. While states have the authority to make policy such as whether to instigate initiatives such as supervised injecting centres (SICs), needle and syringe programs (NSPs) or to change drug laws, the Australian Government⁹ does provide a national framework in which health and law enforcement sectors collaborate to make policy and/or set policy directions. At times, in this thesis however, particular Australian states are granted more attention as the debate or issue being discussed is located within their jurisdiction.

What is harm reduction?

The notion of harm reduction is often used interchangeably with the term ‘harm minimisation’, however, in Australia the terms have distinct meanings in illicit drug policy. In the context of federal policy, ‘harm minimisation’ refers to an overarching philosophy or principle that is used to describe the mixture of policy tools deployed in Australian illicit drug policy. As mentioned above, harm minimisation describes the mixture of supply, demand and harm reduction tools. Therefore, law enforcement and drug education in schools as well as NSPs are all subsumed as part of the overarching philosophy of harm minimisation. Indeed, the very mix of these tools is considered to constitute Australia’s ‘harm minimisation approach’ to drug policy. In contrast, harm reduction refers to a specific set of ideas manifested in policies and programs such as NSPs, safer drug using education, SICs and

⁹ ‘Australian Government’ refers to the national level of Government, formerly known as the ‘Commonwealth Government’.

methadone maintenance treatment (MMT). Such a term does not encompass law enforcement or drug education in which the overall aim is reductions in the prevalence of drug use. Rather, the key principle of harm reduction is reducing the risks for *current* drug users and this is conducted through measures such as the provision of: sterile injecting equipment to discourage the instance of needle sharing and consequently the transmission of BBVs such as the human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS) and Hepatitis C virus (HCV); safe places to inject in order to to reduce overdoses and the hazards of public injection; and, education about how to limit the risks when injecting.

While there are many different perceptions of what the term harm reduction means, five core principles of harm reduction can be identified. First, at the core of harm reduction is a focus on addressing the consequences of drug use as a greater goal than reducing the prevalence of the activity:

...the essential feature of harm reduction is the attempt to ameliorate the adverse health, social, or economic consequences associated with the use of mood-altering substances without necessarily requiring a reduction in the consumption of these substances.¹⁰

In contrast to traditional approaches to drug use, staff in harm reduction programs do not attempt to dissuade injecting drug users from their illicit drug use, rather the focus is on reducing the negative consequences of illicit drug use. Second, harm reduction theory and practice espouses a value-neutral position on drug use, whereby the use of illicit drugs (including the practice of injecting drug use) and the drugs themselves are not endowed with negative or positive connotations. Again, such a position contrasts with law enforcement interventions that seek to reduce the supply

¹⁰ Inciardi, J., & Harrison, L., 2000, 'Introduction: The Concept of Harm Reduction', in Inciardi & Harrison (eds), *Harm Reduction: National and International Perspectives*, Sage, California, pviii.

of illicit drugs into the community on the basis that such drugs are inherently destructive. Related to this value-neutral position of harm reduction regarding drug use is an underlying morality in which the drug user is treated with respect. Again, this is in contrast with other approaches that have the effect of marginalising and penalising drug users through incarceration or other sanctions in an effort to affect behavioural change in drug users towards abstinence.

Third, harm reduction interventions are informed by evidence-based information. Evaluations of the efficacy of programs and scientific approaches to understanding drug use and associated harms are the cornerstone of harm reduction practice. Indeed, alongside the development of harm reduction theory and practice has been the production of a suite of rigorous peer-reviewed research to better understand the complex issue of drug use. This is in contrast with other morality-based approaches (such as law enforcement and anti-drug education) whereby scientific information is less persuasive or at least occupies a submissive role to morality-based information. Fifth, harm reduction also has a different view towards the phenomena of drug use in society. To an extent, supporters of harm reduction believe that some level of drug use is inevitable and normal in society. Moreover it is also recognised by some harm reduction writers that drugs provide not only costs to the user but also clear benefits.¹¹ This last contention, about the nature of drug use, is a somewhat controversial point and is a major point of difference between those interested in drug policy. Moreover, harm reduction advocates (at least in the academic realm) note the ongoing occurrence of drug use through time and reflect on the human's attraction to mind-altering substances as a relatively normal activity.

¹¹ Riley, D., O'Hare, P., 2000, 'Harm Reduction: History, Definition and Practice', in Inciardi & Harrison (eds), *Harm Reduction: National and International Perspectives*, Sage, California, p6.

Indeed, the extent to which harm reduction is a political movement with an underlying agenda to affect widespread change in the populace regarding attitudes to drugs (rather than simply a term to describe certain policies and programs) is a key ongoing question for advocates. When thinking about the concept of harm reduction, some writers suggest that harm reduction is a political movement that seeks to change mainstream thinking about illicit drugs in its own right:

...harm reduction accepts the reality of both the desire for drugs by millions of people and the related fact that many of these individuals may be harmed by their use of drugs... people should be allowed to make choices – to use drugs in either relatively harmless ways or in very destructive ways, or to use no drugs at all. Regardless of their choice, they must not be treated as enemies of the state if they encounter trouble as a result of their drug use, help should be available to them.¹²

Others regard harm reduction as complementary to traditional approaches to illicit drug use and perceive:

...harm reduction as an alternative to both drug prohibition and drug legalization. Harm reduction...seeks to preserve prohibition while softening some of its harsh consequences... as such harm reduction is a compromise position with the aim of reducing aspects of drug related harm.¹³

In this view, harm reduction is limited to ameliorating the consequences of drug related problems without any longer term political agenda. Others regard harm reduction as a goal rather than as a policy or program:

¹² Trebach, A., & Inciardi, J., 1993, *Legalize it? Debating American drug policy*, American University Press, Washington DC, p77.

¹³ Inciardi, J., & Harrison, L., 2000, 'Introduction: The Concept of Harm Reduction', in Inciardi & Harrison (eds), *Harm Reduction: National and International Perspectives*, Sage, California, pviii.

Harm reduction is a goal for policies and programs; it is a willingness to trade potential increases in drug use for potential decreases in drug related harm.¹⁴

In this example, harm reduction is seen as a measurable outcome for policies and programs. The second part of the quote points to a potential (longer term and very controversial) outcome whereby harm reduction (in theory) may result in an increase in the number of drug users while concurrently reducing aggregate risk of the activity for all users. Harm reduction can also be a theoretical framework whereby the harms from both licit and illicit drug use can be calculated:

The harm reduction approach attempts to identify, measure and minimize the adverse consequences of drug use at a number of levels, not just that of society as a whole. In a harm reduction framework, the term risk is used to describe the probability of drug-taking behaviour resulting in any of a number of consequences. The terms harm and benefit are used to describe whether a particular consequence is viewed as positive or negative. In most cases drug taking behaviours result in several kinds of effects: beneficial, neutral and harmful. The consequences of drug use can be conceptualized as being three main types: health (physical and psychological), social and economic. The consequences can be said to occur at three levels: individual; community (family, friends, colleagues etc.) and societal (the structures and functions of society). They can also be broken down with respect to the time of their occurrence, into short-term and long-term effects...the harm reduction framework can be used as a means of better objectifying the evaluation process with respect to both drug programs and policies by allowing the identification of harms...¹⁵

Therefore, the meaning of harm reduction is often contested, subjective and contingent on the context in which it is deployed. Descriptions of harm reduction programs and services follow in order to illustrate the manner in which harm reduction ideas are applied in policy.

¹⁴ *ibid.*

¹⁵ Riley, D., O'Hare, P., 2000, 'Harm Reduction: History, Definition and Practice', in Inciardi & Harrison (eds) *Harm Reduction: National and International Perspectives*, Sage, California, p2.

So what is harm reduction in practice?

Needle and syringe programs (NSPs), methadone maintenance treatment (MMT) and supervised injecting centres (SICs) are examples of harm reduction programs and services directed toward current injecting drug users. All these services aim to make injecting drug use less risky for both the individual and society. The quintessential harm reduction service is the NSP. First established in Europe in the mid 1980s,¹⁶ such programs provide sterile injecting equipment to injecting drug users with the aim of reducing transmission rates of BBVs. Moreover, NSPs also provide other services such as safer using education (for example: how to inject properly to avoid BBV transmission and vein damage), referrals to mainstream services and general outreach services.¹⁷ The provision of sterile injecting equipment and safer using education is regarded as an effective way to reduce transmission rates of HIV/AIDS and HCV, moreover, such reductions should mean savings in public health budgets in the longer term.

Many studies have reinforced the link between increased syringe availability and a decrease in risk (for example, less sharing of injecting equipment) as well as decreases in harm (for example, a lower incidence of HIV/AIDS infection, or increased access by marginalised people to medical practitioners).¹⁸ Safer using education material (both

¹⁶ The first NSP was enacted to respond to rising rates of Hepatitis (not Hepatitis C) in the Netherlands. Riley, D., O'Hare, P., 2000, 'Harm Reduction: History, Definition and Practice', in Inciardi & Harrison (eds), *Harm Reduction: National and International Perspectives*, Sage, California, p10.

¹⁷ *ibid.*

¹⁸ Hart, G., Carvell, A., Woodward, N., et. al., 1989, 'Evaluation of needle exchanges in central London: Behaviour change and anti-HIV status over 1 year', *AIDS*, 3, pp261-265; Jurgens, R., 1996, 'HIV/AIDS in prisons: Final report', Canadian HIV/AIDS Legal Network and Canadians AIDS Society, Montreal; Lurie, P., & Reingold, A., (eds), 1993, *The public health impact of needle exchange programs in the United States and abroad*, University of California Press, Berkley; Rana,

written and verbal) are core strategies used by staff at NSPs to instruct the user about how to reduce the risks associated with injecting drug use such as: where to inject (for example: difference between veins and arteries) and how to keep healthy (for example: filtering drugs to avoid vein damage, using a sterile syringe every time to avoid transmission of HIV/AIDS or HCV). Such an approach is based upon:

...a knowledge and means approach to behavioural change: People are provided with information about the changes that are needed and also with the means to bring about this change (sterile needles, syringes...and condoms).¹⁹

MMT is another harm reduction strategy, the aim of which is stabilisation of the lifestyle and drug use of opiate dependent people and eventual reintegration back into the mainstream. The chaotic lifestyles of opiate dependent people often means that the process of procuring the drug is associated with harms such as: committing crime to pay for the drug; associating with criminal networks; and that the illegality of the activity leads to injecting quickly in public places to avoid detection, sharing needles and so on. Many studies have shown that MMT is effective at reducing morbidity, mortality, HIV/AIDS transmission and users' involvement in crime.²⁰

S., 1996, 'Harm reduction in Asia', *AHRN Newsletter*, 1, pp4-6; Robertson, J., 1990, 'The Edinburgh epidemic: A case study', in J. Strang & G. Stimson (eds), *AIDS and drug misuse*, Routledge, London, pp95-107; Stimson, G., 1989, Syringe exchange programs for injecting drug users, *AIDS*, 3, pp253-260; Stimson, G., 1997, *Harm Reduction in practice: How the UK avoided an epidemic of HIV infection in drug injectors*, paper presented at the Eighth International Conference on the Reduction of Drug Related Harm, Paris; Stimson, G., Alldritt, L & Dolan, K et. al., 1988, *Injecting equipment exchange schemes, Final Report*, Monitoring Research Group, Goldsmiths' College, London; van den Hoek, J., van Haastrecht, H., Coutinho, R., 1989, 'Risk reduction among intravenous drug users in Amsterdam under the influence of AIDS', *American Journal of Public Health*, 79, pp1355-1357; Wodak, A., 1990, 'AIDS and injecting drug use in Australia: A case control study in policy development and implementation', in J. Strang & G. Stimson (eds) *AIDS and drug misuse*, Routledge, London, pp132-141; Wodak, A., 1996, *Harm Reduction works*, Paper presented at the Harm Reduction Satellite to the XIth International Conference on AIDS, Vancouver.

¹⁹ *ibid.*, p10.

²⁰ Ball, J., & Ross, A., 1991, 'The effectiveness of methadone maintenance treatment', Springer-Verlag, New York; Dole, A., 1989, 'Methadone treatment and the AIDS epidemic', *Journal of the American Medical Association*, 262, pp1681-1682; Fazey, C., 1992, 'Heroin Addiction, crime and treatment', in P O'Hare, R Newcombe, A. Matthews, E Buning & E Drucker (eds), *The reduction of drug related harm*, Routledge, New York, pp154-161; Gossop, M., 1978, 'Review of the evidence for methadone maintenance as a treatment for narcotic addiction', *Lancet*, 1, pp812-815; Newman, R., 1987, 'Methadone maintenance: it ain't what it used to be', *British Journal of Addiction*, 71, pp183-

In all countries one of the key factors underlying the success of methadone as a harm reduction measure is that it brings the user back into the community rather than treating him or her like an outsider or a criminal. This not only allows for rehabilitation of the user but it also means that the drugs and crime cycle can be broken.²¹

Following the same rationale, in the United Kingdom doctors have prescribed such drugs as oral methadone and, to a lesser extent, injectable methadone, injectable heroin or amphetamines, cocaine and other drugs.²²

SICs are another example of harm reduction ideas in practice. Such facilities have been operational in Europe since the 1980s²³ and provide a place to inject illicit drugs under medical supervision. Increasing rates of fatal overdoses and public order issues associated with public heroin injection are two reasons why SICs were initiated.²⁴ These facilities dispense sterile injecting equipment and are staffed by qualified professionals (usually with medical backgrounds) who provide information and referrals for drug users to mainstream services if requested.²⁵ In the European context

186; Newman, R., 1987, Methadone treatment, *New England Journal of Medicine*, 317, pp447-450; Rana, S., 1996, *Harm Reduction in Asia*, AHRN Newsletter, 1, pp4-6; Wodak, A., 1990, 'AIDS and injecting drug use in Australia: A case control study in policy development and implementation', in J. Strang & G. Stimson (eds) *AIDS and drug misuse*, Routledge, London., pp132-141; Wodak, A., 1996, *Harm Reduction works*, paper presented at the Harm Reduction Satellite to the XIth International Conference on AIDS, Vancouver; World Health Organisation, 1989, *The uses of methadone in treatment and management of opioid dependence*, World Health Organisation, Geneva; World Health Organisation, 1990, *The content and structure of methadone treatment programs: A study in six countries*, World Health Organisation, Geneva.

²¹ Dole, A., 1989, 'Methadone treatment and the AIDS epidemic', *Journal of the American Medical Association*, 262, pp1681.

²² HIT, 1996, *Reducing drug related harm in the Mersey region*, HIT, Liverpool; O'Hare, P., 1992, 'Preface: A note on the concept of harm reduction', In P O'Hare, R. Newcombe, A. Matthews, E Buning & E Drucker (eds), *The reduction of drug related harm*, Routledge, New York; Riley, D., 1993, *The policy and practice of harm reduction*, CCSA, Ottawa; Riley, D., 1994, *The harm reduction model*, The Harm Reduction Network, Toronto.

²³ Dolan, K., Kimber, J., Fry, C., Fitzgerald, J., McDonald, D & Trautmann, F., 2000, *Drug consumption facilities in Europe and the establishment of supervised injecting centers in Australia*, *Drug and Alcohol Review*, 19, p337.

²⁴ Dolan, K., Kimber, J., Fry, C., Fitzgerald, J., McDonald, D & Trautmann, F., 2000, *Drug consumption facilities in Europe and the establishment of supervised injecting centers in Australia*, *Drug and Alcohol Review*, 19, p337.

²⁵ *ibid.*

SICs are located in primary care facilities where staff adopt a holistic approach, offering access to health and welfare programs and other services, with the SIC located in a discrete room.²⁶

NSPs, SICs and MMT are three examples of harm reduction services currently operating in Australia. Each of these services has met, and continues to meet, opposition from groups claiming that such programs promote and encourage drug use. Indeed such harm reduction programs regularly face opposition from some sections of the conservative right and supporters of morality based drug policy. What follows is an outline of the type of opposition that harm reduction supporters regularly encounter. This is further background information to concepts used throughout the thesis.

Dissenting Views: The Moral-Abstinence Approach

Proponents of the 'moral-abstinence' approach to illicit drug use regard abstinence as the appropriate primary goal of drug policy. Historically such an approach was underwritten by the notion of the user as a 'sinner'.²⁷ Substance dependencies were seen as the result of an inherent moral weakness and lack of willpower whereby the *intention* to get intoxicated and the failure to resist temptation was regarded as sinful.²⁸ Another theory that can be used to advocate for abstinence-oriented drug policy is articulated in the disease theory of addiction, whereby particular people are

²⁶ *ibid*, p339.

²⁷ Kellehear, A., & Cvetkovski, S., 1998, 'Grand theories of Drug Use', in M., Hamilton, A., Kellehear & G., Rumbold (eds) *Drug Use in Australia: a harm minimisation approach*, Oxford University Press, Melbourne, p51.

²⁸ Henry-Edwards, S., & Pols, R., 1991, *Responses to Drug Problems in Australia*, AGPS, NCADA Monograph, 16; Brower, S., Stetson, B., & Beatty, P., 1989, 'Cognitive and Behavioural Features of Adolescent Coping in High-Risk Drinking Situations', *Addictive Behaviours*, 14, pp43-52.

regarded as genetically prone to addiction. It is thought that people with this predisposition have less control when it comes to substances and as there is not a cure, this 'disease' of addiction is a lifetime ailment.²⁹ According to the disease model, the central problem is the alleged inherent nature of the pharmacology of drugs. In this sense some drugs are regarded as inherently harmful and as such, use leads to the inevitable physical, moral and social decline of humans.³⁰ People with substance dependencies are labelled as 'sick'.³¹ Ergo, it logically follows, (according to the perspective of the moral-abstinence advocate), that abstinence from drugs is best way to avoid inevitable problems associated with drug use.

The manifestation of this approach is the policy of prohibition of some drugs. Such a policy seeks to reduce the chance that individuals will be tempted by, and thereby experience problems due to, drugs through a reduction in their supply into the community. Additionally, prohibition is also aimed at creating disincentives (in the form of legal penalties) for people to either use or manufacture/traffic illicit drugs. The priority of moral abstinence approaches is a reduction in the prevalence of illicit drug use.³²

²⁹ Erickson, C., 1992, 'A Pharmacologist's Opinion – Alcoholism: the Disease Debate Needs to Stop', *Alcohol and Alcoholism*, vol. 27, No. 4, pp325-8; Peele, S., & Brodsky, A., 1991, *The Truth About Addiction and Recovery*, Simon and Schuster, New York; Brower, K., Blow, F., & Beresford, T., 1989, 'Treatment Implications if Chemical Dependency Models: An Integrative Approach', *Journal of Substance Abuse Treatment*, No. 6., pp147-57.

³⁰ Kellehear, A., & Cvetkovski, S., 1998, 'Grand Theories of Drug Use', in M., Hamilton, A., Kellehear G., & Rumbold (Eds) *Drug Use in Australia: a harm minimisation approach*, Oxford University Press, Melbourne, p52.

³¹ The label of the sick person is part of the medical approach to drug use. This can also be used to justify harm reduction programs as well as moral abstinence programs.

³² Riley, D., O'Hare, P., 2000, 'Harm Reduction: History, Definition and Practice', in Inciardi & Harrison (eds) *Harm Reduction: National and International Perspectives*, Sage, California, p2.

The Dialogue Between Coalitions

This thesis does not focus on criticisms of prohibition policy by harm reduction advocates, however, such comments are at times relevant to the discussion and feature sporadically throughout this manuscript. The notion of what constitutes drug related harm is often a source of disagreement between coalitions. For example, is the principal source of harm from drugs themselves or from prohibition instruments that pervert elements of the illicit drug markets (for example: the effects of prohibition on price and purity of some drugs)?

According to supporters of harm reduction, drug law enforcement can actually *increase* the instance of drug related harms. Indeed, it is claimed that such attempts to reduce the supply of drugs can be counterproductive and have the potential to create harms worse than the effects of drugs themselves.³³ Some harm reductionists further argue that prohibition has perverted the nature of the drug market (with regard to price and purity of drugs) and the social context in which drug use occurs, thus making the activity highly dangerous and ultimately creating physical harms for the drug user.

...the success of supply restriction, often judged by the extent to which street drug prices are kept high and purity kept low, increases the likelihood of drug injection as the preferred mode of administration. High prices and low purity of street drugs are likely to discourage drug users from substituting non-injecting routes of administration,

³³ Erickson, P., 1992, 'Political Pharmacology: Thinking about drugs', *Daedalus*, Summer, pp239-267; Nadleemann, E., 1993, 'Progressive legalizers, progressive prohibitionists and the reduction of drug related harm', in N Heather et. al. (eds) *Psychoactive drugs and harm reduction: from faith to science*, Whurr, London, pp34-35; O'Hare, P., 1992, 'Preface: A note on the concept of harm reduction', in P O'Hare, R., Newcombe, A., Matthews, E., Buning & E Drucker (eds), *The reduction of drug related harm*, Routledge, New York; Riley, D., & Oscapella, E., 1997, Canada's new drug law: Some implications for HIV/AIDS prevention in Canada, *International Journal of Drug Policy*, 7:3, pp180-182.

which are not known to be associated with the risk of HIV transmission.³⁴

Ergo, prohibition policies may be responsible for creating the type of problematic drug users increasingly evident since 1980s. Social harms generated by prohibition include the demonisation of injecting drug users that results in their marginalisation and ostracism from the mainstream (both in terms of familial and societal groups). Such a dynamic means that efforts to engage such populations in treatment or education are hampered by the reluctance to disclose their injecting drug use status. Moreover, the illegality (and demonisation) of the activity of injecting drug use means that often the preparation and injection practices are made even more unsafe due to rushed preparation and administration of the drugs in public areas. Thus, according to some harm reduction advocates, the illicit nature of the activity is regarded as contributing to the sharing of injecting equipment and other unhealthy practices that subsequently results in the spread of BBVs and poor health of injecting drug users.³⁵

Moreover, harm reduction advocates note the high cost of law enforcement and the seemingly ineffectiveness of it to restrict the supply of illicit drugs:

Despite seventy years of increasing restrictions, and in the case of heroin seizures almost forty years of absolute prohibition, by all measures the consumption of illegal drugs in Australia has continued to grow. Despite – or perhaps because of – these policies, the costs of enforcement borne by the taxpayer and other costs borne by residents at large have continued to grow.³⁶

³⁴ Wodak, A., 1992, 'HIV Infection and injecting drug use in Australia: responding to a crisis', *The Journal of Drug Issues*, 22:3, p555.

³⁵ *ibid.*

³⁶ Marks, R., 1992, 'The costs of Australian drug policy', *The Journal of Drug Issues*, 22 (3) p535.

Moreover, prohibition also creates incentives for people to engage in the production of illicit drugs due to the high financial return from the activity. High prices and low purity mean enormous profits for those willing to take the risk. Sophisticated and international criminal networks that have formed around the lucrative industry of illicit drugs are a result of incentives created by prohibition instruments. While such harms that result from prohibition are unintended results of the policy, most of the time, this dynamic is forgotten, sidelined or considered an unfortunate side effect of a necessary policy. Such a distinction between those harms that are attributed to the nature of the drug itself and those that are manufactured by the context in which drug use occurs is critical to determining the nature of the drug problem. Often discrete elements of the drug problem (for example: fluctuating drug purity which is a chief contributor to overdose) is attributed to the pharmacology of a drug without any recognition that such a problem might have either been created or at least exacerbated by the approach to drug use undertaken by governments.

An example of a lobby group that supports the moral-abstinence approach to drugs is the Drug Advisory Council of Australia (DACA).³⁷ The group outlines policy positions on a number of drug policies and programs and also suggests directions for future drug policy. In contrast to harm reduction, groups such as DACA regard the notion of a drug free society as an appropriate (and one assumes attainable) goal for drug policy, and support diversion of current injecting drug users into mandatory treatment. The following statements were listed on the DACA website as key policy principles:

³⁷ Drug Advisory Council of Australia, accessed on 12/3/06
<http://www.daca.org.au/injecting/HIV.htm>

- A drug free Australia
- The elimination of the harm from illicit drug use
- The illegality of illicit drugs
- The scientific evidence that marijuana is a harmful and dangerous drug and must remain illicit
- The suppression of the supply of illicit drugs
- A national campaign to say no to illicit drugs
- Diversion of illicit drug users into detoxification and rehabilitation by court order and supervision³⁸

For DACA, policy approaches such as mandatory treatment, anti-drug education and prohibition of illicit drugs were two key instruments to reduce the prevalence of illicit drug use. Like many supporters of the moral-abstinence approach, DACA expressed concern about the effect of harm reduction programs such as NSPs and SICs and suggested that such programs increased both rates of drug use and the incidence of BBVs in society:

The high number of injecting drug users with Hepatitis C is evidence of the failure of NSPs to reduce sharing of equipment.³⁹

Maintaining injecting drug use by providing injecting rooms and free syringes assists in spreading blood borne diseases.⁴⁰

The latter quote is a common criticism of harm reduction programs whereby they are seen to entrench the behaviour (injecting drug use) in existing users and in turn, increase the spread of BBVs. From this perspective, NSPs and SICs are seen as being responsible for the prevalence of BBVs and represent a public health threat. Another argument against harm reduction programs espoused by DACA was regarding the perceived social impact on the communities in which they are located:

³⁸ Drug Advisory Council of Australia, *About DACA*, accessed on 12/3/06
<http://www.daca.org.au/injecting/HIV.htm>

³⁹ Drug Advisory Council of Australia, accessed on 12/3/06
<http://www.daca.org.au/injecting/HIV.htm>

⁴⁰ Drug Advisory Council of Australia, *Injecting drugs leads to HIV and Hepatitis C*, accessed on 12/3/06 <http://www.daca.org.au/injecting/HIV.htm>

Like the US and Canada Australia's syringe distribution programs and injecting rooms are not policed leaving drug pushers free to trade.⁴¹

This is known in the literature as the so-called 'honeypot effect' whereby programs for drug users are perceived as attracting drug vendors and associated crime to the area in which the service is located. Again in this argument, such programs are seen to exacerbate an existing problem. While this is only one example of a lobby group that espouses the moral abstinence rhetoric, such a group has been active in Australian politics, most recently providing input into the influential Road to Recovery report released in 2003.⁴²

We support the comments that harm reduction programs maintain illicit drug users in their use. Drug programs must be aimed at getting illicit drug users completely off drugs. Drug dependent persons should be sent for detoxification and rehabilitation through the justice system as an alternative to incarceration.⁴³

In sum, harm reduction and moral abstinence supporters have entirely different viewpoints on fundamental questions in relation to the role of drug use in society. At their core, both groups regard the other's approach as responsible for, and likely to exacerbate, existing drug related harms in the future. While this section provided a brief excursion into the nature of the dialogue between coalitions, the impasse is at a much deeper, epistemological level which is discussed in greater depth in chapters three to six. Next is a brief examination of the development of Australia's approach to drug use prior to 1980 in order to provide further background information leading up to the period of analysis from 1980 to 2000.

⁴¹ Drug Advisory Council of Australia, *Harm Minimisation Slammed*, accessed on 12/3/06 <http://www.daca.org.au/injecting/HIV.htm>

⁴² Standing Committee on Family and Community Affairs, 2003, *Road to recovery: report on the inquiry into substance abuse in Australian communities*, Commonwealth of Australia, Canberra.

⁴³ Drug Advisory Council of Australia, *Abstinence Drug Rehabilitation Works*, accessed on 12/3/06 <http://www.daca.org.au/injecting/HIV.htm>

Illicit Drug Policy Before 1980

Drug use has been a constant phenomenon throughout human evolution. What has altered over time are the types of drugs available and societal attitudes and responses toward use. The prevalence of alcohol (in the form of beer and wine) is thought to date back at least 8000 years.⁴⁴ Similarly, opium originated in Mesopotamia approximately 7000 years ago and then quickly spread throughout Asia and the Mediterranean.⁴⁵ Cannabis seeds and by-products also have a long history, dating back to the:

...earliest strata of human habitation, and the thousands of names by which it is known in hundreds of languages testify to its long history across the planet...⁴⁶

Likewise, references to hallucinogenic mushrooms are sourced in ancient Hindu texts, whilst archaeological evidence dates peyote use to at least 7500BC. While drug use has existed throughout the ages, conversely, prohibition of use is a relatively new phenomenon.

In Australia, the policy approach of prohibiting drugs began in the 1800s. In 1857, the governments of New South Wales and Victoria imposed a duty upon the importation of opium that was intended to be smoked or chewed. Neither medicinal use nor opium intoxication itself was the subject of the duty, indeed, consumption of opium by individuals other than Chinese immigrants was not even considered. Concealed by medical use, Anglo-Saxon Australians distinguished Chinese opium

⁴⁴ Lang, E., 1998, 'Drugs in Society', in Hamilton, M., Kellehear, A., & Rumbold, G., (eds), *Drug Use in Australia: A Harm Minimisation Approach*, Oxford University Press, Melbourne, p1.

⁴⁵ *ibid.*

⁴⁶ *ibid.*

use (whereby the substance was smoked) from their own (where the substance was usually imbibed in the form of a drink).⁴⁷ South Australia (which then administered the Northern Territory) passed an opium prohibition act in 1895.⁴⁸ Debates in the South Australian parliament revealed a lack of consensus about the harms associated with opium. Indeed, a member for Gladstone commented on the positive effects of opium suggesting that it enabled Chinese porters to perform great feats of strength and dismissed any link between opium and crime.⁴⁹ Another proposed that it was immoral to use opium yet questioned whether it merited the institution of a new crime.⁵⁰ One Legislative Council member argued that opium use was a matter of personal choice, however, conceded that supplying opium to others was unacceptable.⁵¹ Much of the drive underwriting the laws developed to prohibit opium was to demonise Chinese immigrants, who were considered a threat to European values:

Disease, defilement, depravity, misery and crime - these are the indispensable adjuncts which make the Chinese camps and quarters loathsome to the sense and faculties of civilised nations...Wherever the pig-tailed pagan herds on Australian soil, they introduce and practise vices the most detestable and damnable - vices that attack everything sacred in the system of European civilisation.⁵²

⁴⁷ Manderson, D., 1993, *From Mr Sin to Mr. Big: A History of Australian Drug Laws*, Oxford University Press, Melbourne, p22.

⁴⁸ Lonie, J., 1979, *A Social History of Drug Control in Australia*, Royal Commission into the Non-Medical Use of Drugs, Research Paper 8, South Australia, p7.

⁴⁹ South Australian Parliamentary Debates, 1895, 19 December, p3024.

⁵⁰ *ibid*

⁵¹ *ibid*.

⁵² Manderson, D., 1993, *From Mr Sin to Mr. Big: A History of Australian Drug Laws*, Oxford University Press, Melbourne, p19-20.

After years of debate, the importation of opium into Australia was prohibited in 1905. Lang⁵³ argued that increased smuggling and illegal use was soon detected, with some of the non-Chinese population grasping the opportunity for quick profits.

International controls on opium developed further over the next thirty years resulting in the (Hague) *Opium Convention of 1912* and the *International Convention on Illicit Traffic in Dangerous Drugs*. The 1912 convention, initiated by the United States Government, committed Australian Governments and other signatories to introducing laws that prohibit the use of opium for non-medicinal purposes. This policy stance was further consolidated and extended when the United States began to play a greater role in global organisations such as the United Nations in the early twentieth century.⁵⁴

Following the ratification of the 1912 Opium Convention, the Australian Government subsequently extended import controls to other substances as well as opium.⁵⁵ The Australian Government signed the 1925 Geneva Convention (the *International Convention Adopted by the Second Opium Conference*) that committed the signatories to ensure that there were laws that limited the sale, use, importation and export of opiates, cocaine, and Indian hemp exclusively to scientific and medical purposes. Following the 1925 Geneva convention, the Australian Government signed a series of other international agreements in relation to drugs. Notably the *Convention for Limiting the Manufacture of and Regulating the Distribution of Narcotic Drugs 1931* which established an international compliance regime, the

⁵³ Lang, E., 1998, 'Drugs in Society', in Hamilton, M., Kellehear, A., & Rumbold, G., (eds), *Drug Use in Australia: A Harm Minimisation Approach*, Oxford University Press, Melbourne, p7.

⁵⁴ For a comprehensive treatise on the expansion of prohibition regimes and the role of the United States of America see Nadleman, E., 1993, *Cops Across Borders: The Internationalization of U.S. Criminal Law Enforcement*, The Pennsylvania State University Press, Pennsylvania.

⁵⁵ Manderson, D., 1993, *From Mr Sin to Mr Big: a History of Australian Drug Laws*, Oxford University Press, Sydney, pp513-14.

Paris Protocol 1948 which granted the World Health Organisation the power to categorise new substances as 'dangerous drugs' for the purpose of the 1931 Convention, and the *Single Convention on Narcotic Drugs 1961* that further extended and reinforced control over drug trades across international borders and within domestic arenas.⁵⁶ Other Conventions, such as the *Convention on Psychotropic Substances 1971*, further consolidated international controls to include other synthetic drugs in the expanding array of prohibited substances.

The 1961 signing of the *Single Convention on Narcotic Drugs* in New York symbolised the international consensus and commitment to prohibition as a chief policy instrument to address drug use. This Convention established the International Narcotics Control Board, the main roles of which involved the administration of the estimates system (that limits a country's annual production of controlled substances according to that needed for medical purposes). The scope of the Single Convention was immense in comparison to previous legislation, establishing more detained controls on international and domestic drug use than any prior convention.⁵⁷

The signing of the Convention and subsequent ratification in 1967, bound Australia more tightly to a system of control that had been steadily entrenched over several years.

The Single Convention symbolised the orthodoxy that prevailed in the international community, the power that community exerted over Australian policy, and the strength of the United States within it.⁵⁸

⁵⁶ Brereton, D, 2000, 'The History and Politics of Prohibition', in Stokes, G., Chalk, P., & Gillen, K., (eds.), *Drugs and Democracy*, Melbourne University Press, Carlton South, p90.

⁵⁷ Manderson, D., 1993, *From Mr Sin to Mr Big: a History of Australian Drug Laws*, Oxford University Press, Sydney, p138

⁵⁸ *ibid.*

Prior to the late 1960s, drugs were not a salient issue in Australian society. The decision to ban cannabis and heroin (1925 and 1953 respectively) for non-medical purposes happened at a time when heroin and cannabis use were unrecorded and seemingly minimal. Alongside this expansion of prohibition regimes in many states around the world in the twentieth century, another concept, namely the 'medical model of addiction', was being promoted by medical professionals, social workers and other health intervention workers that had personal experience with drug dependent persons.⁵⁹ The drug dependent person, in this model, was regarded as not necessarily responsible for her/his own drug dependency, rather, they were at the whim of substance addiction. The behaviour of drug traffickers, however, was still seen as related to individual choice and thus, they were still regarded as responsible for their actions. Legislation, aimed at traffickers, assumed that law enforcement (and in particular stiffer penalties, broader search powers, and complicated provisions for the forfeiture of assets) was seen as the solution to restricting the supply of illicit drugs and thus ameliorating the 'problem' of the rising prevalence of drug use.⁶⁰ Conversely, legislation regarding those persons that use illicit drugs had been amended to reflect the medical model of addiction with penalties lessened and/or use of other extralegal alternatives gaining favour. Desmond Manderson summed up the different attitudes expressed in legislation towards drug users and manufacturer/sellers:

After the first opium laws had been enacted, drug use has been seen as a sin because it challenged the sanctity of the law. In later years, as the medical model of addiction gained favour, addicts came to be characterised as persons whose obsession robbed them of the power of intention. Their illegality was not their fault. For them, according to Woodward, 'the inability to choose or act wisely, or to modify behaviour, is limited or eliminated'. But traffickers

⁵⁹ *ibid*, p181.

⁶⁰ *ibid*.

were still seen as sinful; their illegal behaviour was a choice and they were responsible for their actions. Thus [there was]...enactment of two separate pieces of legislation in order 'to reflect the distinction between criminal exploitation of drug abuse and the social plight of the individual drug user'. The proposed Drugs of Dependence Act punished minor offences including possession and use. It accepted that users were sick and in need of help; penalties were relatively slight, and the emphasis was placed on treatment and community services. The Proposed Drug Trafficking Act was designed to facilitate the detection and punishment of trafficking. It assumed that the drug problem was a question of law enforcement requiring stiff penalties, broad search powers, and complicated provisions for the forfeiture of assets. Illness and vice were treated in isolation as if the problems they addressed were unrelated.⁶¹

As Manderson eluded, notions of illness and vice applied in this manner reflected a one dimensional view of the illicit drug issue through an avoidance of the instance of the recreational (one that consumes at irregular and sporadic intervals and is not dependent) drug user and the possibility of small scale commercial transactions between friendship groups and other nuances of illicit drug markets. Such a one dimensional conception of the illicit drug market and players within it lead to a mixture of policy instruments premised on these core notions whereby drug users are endowed with the label of 'sick' and traffickers and vendors are labelled as 'predatory' and 'evil'. Illness and vice are core underlying principles of Australian illicit drug policy leading into 1980, indeed, it is these core notions that advocates of harm reduction have had to either incorporate in order to conform to prevailing orthodoxy or attempt to dismantle in an effort to provide a more detailed and accurate view of the nuances of drug markets. The choice between these responses has the capacity to have profound impacts upon the nature of the harm reduction policy, as is discussed in the following chapters.

⁶¹ *ibid*, p181.

In sum, previous to 1980, the main policy instrument was the regime of regulatory instruments directed at preventing and/or reducing use. Moreover, the medical model of addiction was also a common theory applied to drug treatment and also affected drug laws. Both of these tools were underwritten by the perception that drug use was an inherently dangerous activity, and, consequently Government regulatory instruments served to prevent and or restrict access to them. In this sense, Government policy followed a simplistic line that a decrease in the prevalence of illicit drug use meant a decrease in drug-related harm. By the end of the 1970s and start of the 1980s however there was a new approach being developed that espoused a different view towards illicit drug use. This harm reduction approach, as noted earlier, was not premised on the notion of drug use as an immoral act or necessarily something that would lead to sickness in users. As mentioned earlier, that authors of such an approach would critique prohibition and abstinence-oriented treatment, as well as advocate for services to make illicit use less risky, heralded the start of an antagonistic relationship between various stakeholders in the illicit drug policy subsystem. Indeed, it is the rise of harm reduction in public policy and its relationship with traditional moral approaches towards drugs between 1980 and 2000 that is the subject of this thesis.

Structure of the Thesis

To recap, this thesis is focussed upon examining both the subject of illicit drug policy with emphasis on the experience of harm reduction advocates and their success in translating key ideas into policy, and also at evaluating a public policy theory, namely the advocacy coalition framework. Illicit drug public policy between 1980 and 2000 in Australia will be analysed as well as key texts, research and primary

commentaries on events that took place. The thesis is comprised of seven chapters, the outline of each follows.

Chapter two begins with a description of key aspects of the ACF, as articulated by Sabatier in conjunction with Jenkins-Smith. The ACF is a subsystem approach to the study of public policy with a particular focus on examining policy change. Key concepts such as the notion of advocacy coalitions, the role of policy brokers and hypotheses concerning contributing factors, and conditions conducive to, policy change as articulated in the ACF are described and subsequently applied to the study of illicit drug policy. A definition of the illicit drug policy subsystem model is also offered. The chapter ends with a set of research questions that are used to both evaluate the ACF and its applicability to illicit drug policy, and also to understand the evolution of drug policy between 1980 and 2000. These research questions are examined in the subsequent chapters of the thesis.

Chapter three charts the origins and development of harm reduction as an approach to drug use in Australia between 1980 and 1990. Moreover key events in illicit drug policy in this time are described. During this period, Australian illicit drug policy underwent significant change: first, with the advent of a National Drug Strategy that facilitated greater collaboration between law enforcement and health sectors regarding key aspects of policy; and second, the emerging issue of HIV/AIDS in Australia produced substantial impact on drug policy. These issues are discussed through an analysis of policies and other relevant texts produced during this period. In this decade, a coalition for harm reduction began to crystallise, achieving some success in realising policy objectives by the close of this period. Sabatier's hypotheses on major policy change in the ACF model are evaluated as well as core

notions of advocacy coalitions, guidance instruments and policy brokers as a means of understanding the events that occurred between 1980 and 1990.

Following on from chapter three, chapter four charts developments in harm reduction theory and practice in following decade (1990 to 2000). In this period, a cross-pollination of ideas between health and law enforcement sectors was evident with subsequent changes apparent in law enforcement practice. In contrast, the dialogue between supporters of harm reduction and moral-abstinence oriented policy were less than collegial. By the close of the century, the Federal Government had changed from being led by the Australian Labour Party (ALP) (that instigated harm reduction policies) to being led by the Federal Liberal party headed by a Prime Minister who was a highly vocal supporter of abstinence-oriented approaches in drug policy. Attempts to implement further harm reduction policies such as SICs and prescription heroin were largely rejected in this period. Similarly, the limits of the acceptability of the harm reduction approach were apparent through the analysis of policy responses to HCV. In this chapter, there is a focus on the hypotheses in the ACF on policy-oriented learning between health and law enforcement sectors.

Chapter five centres on two specific debates in Australian drug policy, SICs and prescription heroin, that occurred between 1990 and 2000. Predominantly, this chapter focuses mainly on debates between supporters of harm reduction approaches and those that advocate for moral-abstinence oriented strategies in drug policy. Whereas chapters three and four examined the instance of harm reduction in illicit drug policy more generally, the focus in this chapter is a specific examination of two particular harm reduction policy initiatives. Key arguments for and against both policy initiatives are described as well as key events and outcomes of deliberations.

This chapter identifies the nature of the debates between harm reduction and moral abstinence advocates and in particular addresses epistemological differences that contribute to the fundamental deadlock in illicit drug policy debate.

Chapter six provides a synthesis of the results from chapters three to five and responds to research questions posed in chapter two. Trends, themes and dynamics in illicit drug policy across the 20 year period of analysis from 1980 to 2000 are identified and analysed in the context of the ACF. The general aims of this research such as evaluating the utility of ACF as applied to social systems such as drug policy, understanding the nature of drug policy making in Australia and also assessing the way in which supporters of harm reduction strategise to turn beliefs into policy are addressed and answered. The chapter closes with a discussion regarding potential additions and/or directions for further development of the ACF, especially in relation to its application to 'social' problems. The conclusion chapter provides a reflection of the dilemma of how harm reduction 'fits' within the dominant framework and the compromises that have been made by harm reduction advocates in the name of policy expediency.

Chapter 2: Advocacy Coalitions and Australian Illicit Drug Policy

Introduction

This chapter outlines the approach used in this thesis to provide a framework to analyse Australian illicit drug policy, namely the advocacy coalition framework (ACF) as developed by Paul Sabatier in collaboration with Hank Jenkins-Smith. Such a framework places ‘subsystems’ as a primary unit of analysis and focuses on the role of ideology as an independent variable in affecting policy change. The analysis of illicit drug policy is expected to represent a challenge to the framework as the majority of applications of the ACF have been in the context of environmental policy or similar subsystems in which discussion revolves around phenomena in the ‘natural’ world and whereby the scientific method is considered *the* credible method. In contrast, debates in relation to the illicit drug policy subsystem feature discussion about social phenomena and hence scientific facts compete with morality-based arguments.

Despite often having being used predominantly in entirely different policy spheres, the ACF has been successfully used in analysis of illicit drug policy previously by one author, Daniel Kubler, who examined policy change in Swiss drug policy.⁶² The ACF has been chosen for analysis in this thesis because of its focus on ideology as a key factor in policy making and change, which is particularly relevant to illicit drug policy due to the convergence of different types (for example: scientific and morality based) of knowledge in policy debates. Further, the ACF also provides a

⁶² Kubler, D., 2001, ‘Understanding policy change with the Advocacy Coalition Framework’, *Journal of European Public Policy*, 8:4, pp623-641.

comprehensive map of a political system allowing analysis of socio-cultural values, constitutional structures and other parameters of any political system as well as focusing on external events and their role in policy change. Ultimately the ACF provides a robust model to examine policy change in subsystems providing many testable hypotheses. The research questions developed at the end of this chapter will serve two functions: first, results will allow an evaluation of the ACF when applied to analyse illicit drug policy and generate directions for future development of the framework. Second, it is expected the framework will generate useful insights into the way in which harm reduction policy has been implemented and also on the techniques employed by the harm reduction coalition when advocating for 'politically difficult' policy.

The following section outlines the key concepts of the ACF and relates these to the illicit drug policy subsystem. Following this, a framework to analyse illicit drug policy from 1980 to 2000 is constructed in Table 1 to apply to the analyses in chapters three, four and five of this thesis.

The Advocacy Coalition Framework

The advocacy coalition framework (ACF) was developed initially by Paul Sabatier in the early 1980s, and refined in subsequent years by Sabatier in collaboration with Hank Jenkins-Smith. The ACF has been the subject of numerous books and articles (Sabatier 1987⁶³, Sabatier 1989⁶⁴, Sabatier & Jenkins-Smith 1993⁶⁵, Sabatier &

⁶³ Sabatier, P., 1988, 'Knowledge, Policy-Oriented Learning and Policy Change: an advocacy coalition framework', *Knowledge, Creation, Diffusion, Utilisation*, 8:4, June, pp649-692.

⁶⁴ Sabatier, P., A., 1989, 'An advocacy coalition framework of policy change and the role of policy-oriented learning therein', *Policy Sciences*, 21, 129-168.

⁶⁵ Sabatier, P., & Jenkins Smith, 1993, 'The Advocacy Coalition Framework: An Assessment', *Policy Change and Learning: An Advocacy Coalition Approach*, Westview Press, San Francisco.

Jenkins-Smith 1994⁶⁶ and Sabatier 1998⁶⁷) and also by other authors that have utilised the framework in a number of different policy contexts and/or offered theoretical revisions⁶⁸. The reader is referred to these for a detailed description of the model.

The main function of the ACF is to provide a framework to explain policy change. Sabatier stated that the ACF is based on five assumptions about policy,⁶⁹ formulated from literature on policy implementation and the role of technical information in public policy. The first premise Sabatier articulated is the importance of recognising the role of technical information in the process of defining the policy 'problem' by both delineating the scope and facets of a particular policy issue and then in prescribing the associated causes and impacts of probable solutions. Such technical information creates a mutual language that not only defines membership of particular coalitions but also is highly instrumental in the process of defining the nature of the problem and consequently, the brokerage of solutions. The type and nature of technical information, or persuasive language, used by coalitions to advocate a particular position will be examined and evaluated throughout this thesis. The second premise underpinning the ACF concerns the appropriate length of time to study the process of policy change. Sabatier suggested that understanding the process of policy change requires a focus on a decade or longer so as to facilitate a reasonable assessment of policy impacts. The current analysis of illicit drug policy concentrates on a 20 year period starting at 1980, with the first signs of the emergence of the harm reduction advocacy coalition in illicit drug policy, and

⁶⁶ Sabatier, P., A., & Jenkins-Smith, H., 1994, 'Evaluating the Advocacy Coalition Framework', *Journal of Public Policy*, 14:2, pp175-203.

⁶⁷ Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe', *Journal of European Public Policy*, 5:1, March, pp1350-1763.

⁶⁸ There have been approximately 33 applications of the ACF. For a comprehensive list of authors that have utilised the ACF see Sabatier, P., A., 1998, 'The advocacy coalition framework: revisions and relevance for Europe', *Journal of European Public Policy*, 5:1, March, p100-101.

⁶⁹ *ibid*, pp98-130.

finishing the analysis around the year 2000, albeit with a postscript or two on some issues that occurred post-2000 where relevant.

The third premise of the ACF as stated by Sabatier, is that the policy domain or subsystem is a useful unit of analysis in order to understand the overall policy process. Such an approach has origins in the notion of the 'sub-government' in which societal and state actors were grouped into "...routinised patterns of interaction"⁷⁰ around a given issue. Sabatier⁷¹ suggested that the boundaries of a policy subsystem in Heclo's 'iron triangles'⁷² should be expanded from including administrative agencies, legislative committees and interest groups at a single level of government to include other actors at various levels of government as well as researchers, policy analysts and journalists. Sabatier posited that such actors were identified as being active in the development and implementation of policy and thus worthy of inclusion in a subsystem model.

According to Sabatier, a policy domain or subsystem consists of actors from public and private organisations who regularly seek to influence the policy direction of their domain.⁷³ In this thesis the 'illicit drug subsystem' is examined. In order to narrow the scope of analysis, the area of study will focus on a study of policy regarding the practice of *intravenous* drug use. Therefore the relevant drugs associated with that practice are as heroin and other injectable opiates (including methadone), and,

⁷⁰ Howlett, M., & Ramesh, M., 1995, 'Agenda Setting – Policy Determinants and Policy Windows', *Policy Cycles and Policy Subsystems*, Oxford University Press, Ontario, p125.

⁷¹ Sabatier, P., 1988, 'Knowledge, Policy-Oriented Learning and Policy Change: an advocacy coalition framework', *Knowledge, Creation, Diffusion, Utilisation.*, 8:4, June, p652.

⁷² The theory of iron triangles, formulated in the 1960s, described 'three sided' relationships between interest groups, executive government and the bureaucracy that were theorised to capture the policy making process. In this sense, notions of democracy were subverted and self interests of the three groups prevail over that of the public when formulating policy. Howlett, M., & Ramesh, M., 1995, 'Agenda Setting – Policy Determinants and Policy Windows', *Policy Cycles and Policy Subsystems*, Oxford University Press, Ontario, p125.

⁷³ Sabatier, P., & Jenkins-Smith, H., 1994, 'Evaluating the Advocacy Coalition Framework', *Journal of Public Policy*, 14:2, p178.

amphetamines. Clearly a number of drugs (legally or illicitly obtained) can be injected such as benzodiazepines, however the predominant types of drugs usually injected and thus at the centre of policy problems, tend to be opiate or amphetamine based. Thus, cannabis policy is not subject to analysis in this thesis except where relevant and complementary to the discussion in relation to drugs used intravenously. Thus, in this thesis the 'illicit drug subsystem' is defined accordingly:

The illicit drug subsystem is a policy subsystem that consists of actors (individuals and organisations) clustered around the issue of intravenous drug use in government policy. These actors are both proactive and reactive in illicit drug policy, united by vested interests, whether material, academic or personal. Actors in this subsystem are predominantly drawn from health, law enforcement and research fields as well as affected communities, the media, community -including non government- organisations and groups and religious bodies.

The fourth premise of the ACF as articulated by Sabatier states that these policy subsystems will include actors from several levels of government within a country and also actors from international organisations and other countries. The analysis in this thesis will predominantly focus on policy actors from within Australia, however, many sources and organisations external to Australia will also be included in order to complete the analysis of the ACF and policy making in the illicit drug policy subsystem. The final premise underpinning the ACF is that public policies and related programs provide a means through which beliefs, value priorities, perceptions of causal relationships and the efficacy of various policy instruments can be identified. More importantly Sabatier and Jenkins-Smith theorised that the relative influence of various actors over time and the role of technical information in policy

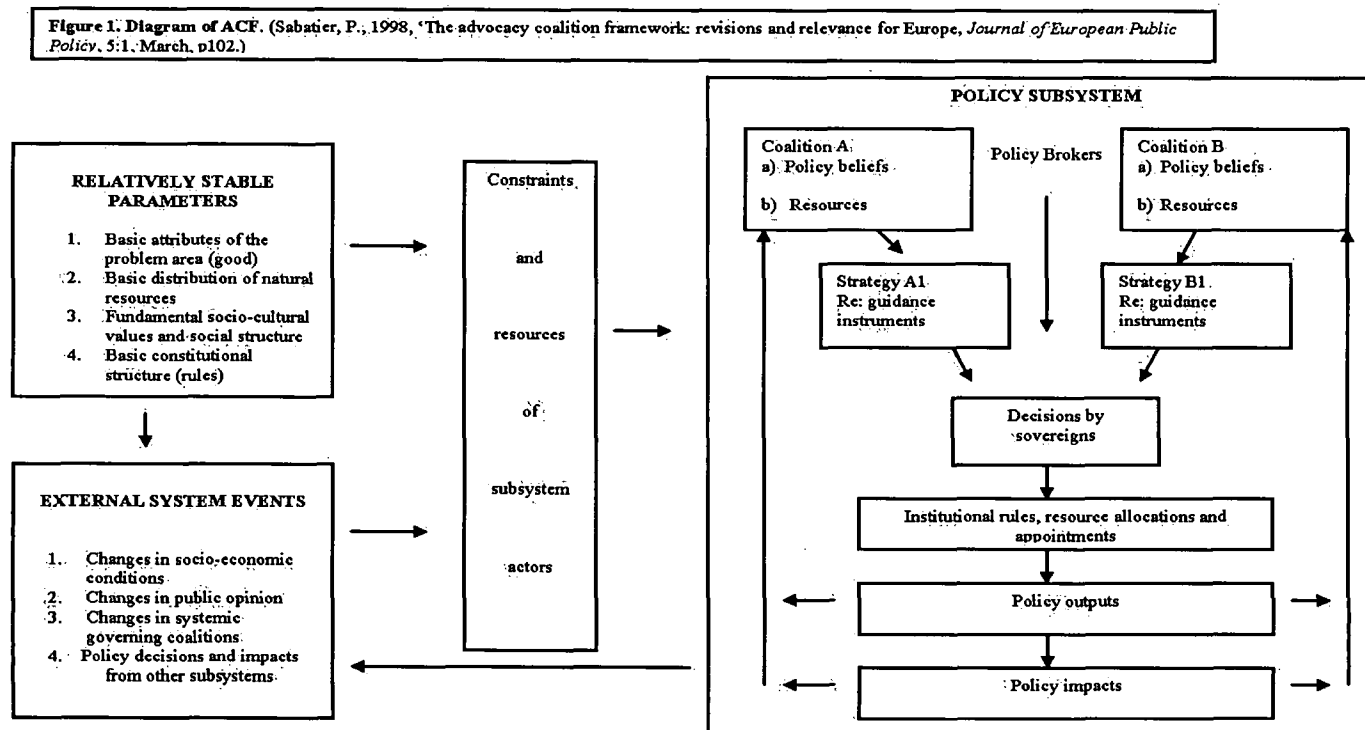
learning and change can also be assessed through such textual analysis.⁷⁴ This thesis will examine national and state public policies, Parliamentary committee reports, proceedings from Hansard and key meetings/conferences/summits, key actors' commentary from such proceedings, reports from health and law enforcement institutes, National reports and surveys, journal articles and websites from advocacy groups. Such primary and secondary sources will serve three functions: first, such material can be used to gauge the influence of coalition actors on policy over time. In this sense, the language in key government policies and documents as well as operational outputs in illicit drug policy will serve to reflect the dominance or otherwise of coalition belief systems in public policy. Clearly, state and federal policy documents and operational outputs/programs will be main barometer through which the testing of the relative influence of coalitions will be conducted. The second function of analysis of textual sources described above will be to examine the type, and role, of technical information in advocacy efforts. Analyses will determine the role and type of the information in defining the problem area, and consequently, the prescribing of solutions. The final function of the analysis of texts will engender an examination and critique of the general nature, and types of, strategies employed by advocacy coalitions.

These premises should be seen as constituting the bedrock of the ACF and will inform this analysis of Australian illicit drug policy. Below is an account of the ACF and the further development of the approach taken in this thesis to examine illicit drug policy between 1980 and 2000 in Australia. A visual representation of the ACF can be seen in Figure 1. In the ACF the policy subsystem is the arena in which debate, advocacy and policy making occurs. This process, however, is subject to and

⁷⁴ Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe', *Journal of European Public Policy*, 5:1, March, p99.

affected by external parameters depicted on the right as ‘relatively stable parameters’ and external system events’.

Figure 1. Diagram of ACF



The Policy Subsystem

Advocacy Coalitions

According to Sabatier and Jenkins-Smith, in any policy subsystem policy stakeholders are aggregated into a number of 'advocacy coalitions' that are composed of a variety of different actors from various levels of governmental and private organisations. Advocacy coalitions are conceptualised as including not only government officials and interest group leaders but also such individuals as legislators, researchers, the media and other community groups. Further, actors from peak organisations or umbrella groups that represent an entire sector, professional associations and also single issue organisations may also be included in a coalition. Moreover, other individuals that constitute the 'attentive public' (academics and journalists, foreign observers and other governments⁷⁵) also have the capacity to play a role in an advocacy coalition with the intent of influencing policy. Sabatier⁷⁶ acknowledged the existence of actors that are not aligned to a particular coalition, but suggests that these are of little importance over the analytical time frame used in the ACF because they either leave or are eventually subsumed into one of the coalitions. Sabatier hypothesised that the constituencies of advocacy coalitions are relatively fixed over time.

On major controversies within a policy subsystem when policy core beliefs are in dispute, the lineup of allies and opponents tends to be stable over periods of a decade or so.⁷⁷

⁷⁵ Pal, L., 1992, *Public Policy Analysis: an introduction*, Nelson, Ontario, p109.

⁷⁶ Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe', *Journal of European Public Policy*, 5:1, March, p103.

⁷⁷ *ibid*, p106.

In this analysis of Australian illicit drug policy, two broad advocacy coalitions are identified (as discussed in chapter one) namely the ‘harm reduction’ and the ‘moral-abstinence’ coalitions. As this thesis is primarily focused on the advocacy efforts of the former coalition, an analysis of the constituency and stability of the harm reduction coalition over two decades will take place in order to test the above hypothesis regarding consistent memberships of coalitions in the ACF.

In the ACF, such members of advocacy coalitions are grouped together through their assumed common beliefs and values about their policy issue of interest. Sabatier conceptualised these belief systems as hierarchically organised into three levels: ‘deep core’, ‘policy core’ and ‘secondary aspects’ of belief systems.⁷⁸ Deep core beliefs exist at the most fundamental level of belief systems and include basic ontological and normative ideas that are applicable across almost all policy domains. For example, deep core beliefs may include: the preference for government or market as an ordering device for social life or whether one considers themselves to be aligned with ‘left’ or ‘right’ political groups. At the intermediate level of belief systems are *policy core* beliefs that articulate basic normative convictions and causal perceptions. These include fundamental value priorities regarding a policy arena. For example in the illicit drug policy subsystem policy core beliefs might include: the belief that drug use is a medical issue and thus should be predominantly addressed within the framework of health services; perception of the nature of the illicit drug ‘problem’ and its associated causes; and a preference for policy instruments with the aim of realising deep core values. Sabatier suggested that policy core beliefs function as the ‘fundamental glue’ of a coalition as they represent basic normative and practical commitments specific to the policy domain. Further

⁷⁸ *ibid*, p103.

Sabatier suggests that coalitions are more able to reach consensus on policy core issues than secondary aspects.

Actors within an advocacy coalition will show substantial consensus on issues pertaining to the policy core, although less so on secondary aspects.⁷⁹

Secondary aspects of a coalition's belief system consist of a set of specific convictions (not subsystem wide) outlining, for example, the various importance of causal factors in particular cases, policy preferences for suitable regulations or the dissolution of existing regulations. For example, secondary aspects of a belief system might include the extent to which prescription heroin is regarded as having greater therapeutic value than MMT. Overall, in the ACF it is theorised that *deep core* beliefs are the most resistant to change, *policy core* beliefs are less rigidly held whilst *secondary aspects* are the most open to change in light of new facts, experience or changing strategic considerations. While not surveying policy actors directly, beliefs and ideas will be examined through the various texts outlined above. Specifically, an analysis of the convergence and discord between coalition members' policy core and secondary aspects of belief systems expressed in policy debates will also be undertaken where relevant and possible.

The notion of advocacy coalitions to conceptually group together different types of actors in terms of the development of Australian illicit drug policy will also be examined in chapters three, four and five. More specifically, the longevity and stability of members within a coalition will be identified. The presumption that coalition actors share normative and causal beliefs about a particular policy issue,

⁷⁹ *ibid*, p106.

and, engage in sustained, co-ordinated activity over time, will also be examined in order to ascertain the degree to which this occurs.

Guidance Instruments

Another key concept in the ACF is that of 'guidance instruments'. This concept refers to changes that occur, within or external to, the subsystem that provide opportunities for coalitions to realise policy objectives.⁸⁰ For example, this might include changes to rules, governments, budgets or information that can be exploited by coalition actors to realise policy objectives. At any given time, coalition members may choose to integrate such changes into advocacy strategies with the function of translating their policy core beliefs into official policy. Sabatier and Jenkins-Smith identified different types of guidance instruments that included the following:

(1) seeking to influence legislatures to alter the budgets and legal authority of administrative agencies through testimony and campaign contributions; (2) trying to change the incumbents of various positions, whether they be agency appointees, agency civil servants, or elected legislators and chief executives; (3) trying to affect public opinion ... via the mass media; (4) attempting to alter target group behaviour via demonstrations or boycotts... and (5) trying to gradually alter the perceptions of a variety of actors through research and information exchange.⁸¹

This thesis will examine the types of guidance instruments used by members of coalitions in illicit drug policy and then compare and contrast such strategies with those listed above. Moreover, the strategies employed by harm reduction coalition actors will also be reported and examined with the function of evaluating their effectiveness in realising policy objectives.

⁸⁰ *ibid*, p104.

⁸¹ Sabatier, P., & Jenkins Smith, 1993, 'The Advocacy Coalition Framework: An Assessment', *Policy Change and Learning: An Advocacy Coalition Approach*, Westview Press, San Francisco, p142.

The Policy-Making Cycle

Within the subsystem, the practice of policy making in the ACF is theorised to occur in the following terms: conflicting strategies (advocated by each coalition) are submitted to 'policy brokers', a group of actors that represent the Government and are responsible for reaching compromise and limiting conflict, whose:

...principal concern is to find some reasonable compromise that will reduce intense conflict. The end result is one or more governmental programs, which in turn produce policy outputs at the operational level.⁸²

In the ACF, such policy outputs (implementation of Government programs/policies) generate a variety of impacts on 'targeted problem parameters' as well as other consequences (intended and unintended). Each coalition then processes information based on the new developments, as well as any other new information, and then may revise its (usually secondary) beliefs and operational strategies. This type of approach sees policy making as a cyclical process with outputs in some cases reconfiguring the inputs from coalitions. This thesis will examine the role of 'policy brokers' who are conceptualised in most incarnations of the ACF as essentially neutral players who are charged with the task of brokering compromise between coalitions. The role of the bureaucracy (or their representatives acting as brokers) in the illicit drug policy subsystem will be analysed.

⁸² Sabatier, P., A., 1998, 'The advocacy coalition framework: revisions and relevance for Europe', *Journal of European Public Policy*, 5:1, March, p104.

Sabatier suggested that affecting this cyclical process of policy making within a subsystem are two sets of exogenous variables that impact upon the resources and constraints of subsystem actors. These external variables are described below.

Exogenous Variables

In Figure 1, the two boxes to the left of the policy subsystem represent two sets of exogenous variables, entitled ‘relatively stable system parameters’ and ‘dynamic system events’, that impact upon any policy subsystem. As their respective labels suggest, the former group of variables are relatively established phenomena and thus, Sabatier posits, are seldom the subject of coalition strategising. In contrast, dynamic system events can oscillate over the course of a few years or a decade.⁸³ Changes in this second group of variables, in particular, affect coalitions in two ways: first, such change has the capacity to alter the constraints and opportunities of subsystem actors, and secondly such flux also means that coalition members must anticipate change and respond to the change while remaining consistent with their basic beliefs and interests. Accordingly, in the ACF, this second set of variables is theorised as representing one of the key factors affecting policy change. Sabatier ruminated:

The process must be frustrating at times, as actors who have worked for years to gain an advantage over their competitors within a subsystem suddenly find their plans knocked awry by (external) events – such as the Arab oil boycott – over which they have little control.⁸⁴

⁸³ Sabatier, P., A., 1988, ‘Knowledge, Policy-Oriented Learning and Policy Change: an advocacy coalition framework’, *Knowledge, Creation, Diffusion, Utilisation.*, 8:4, June, p657.

⁸⁴ Sabatier, P., A., 1989, ‘An advocacy coalition framework of policy change and the role of policy-oriented learning therein’, *Policy Sciences*, 21, p136.

What follows is a discussion of both sets of exogenous variables and the further development of a framework to analyse Australian illicit drug policy.

Relatively Stable Parameters

In the ACF, 'relatively stable parameters' were described as highly resistant to change and encompassed such phenomena as: the constitutional structure, socio-cultural norms, basic attributes of the problem area and the resources of a political system. Two of those phenomena, namely, socio-cultural norms and basic attributes of the problem area, are particularly salient in illicit drug policy debates and thus merit further examination.

Chapter one provided an outline of the historical development of illicit drug policy in Australia. Socio-cultural norms regarding illicit drug use in Australian society echoed those in other western liberal democratic states such as the United Kingdom and United States of America (USA), in which alcohol and tobacco are the legal drugs of choice. Further, racist foundations⁸⁵ of such policy meant that certain drugs and types of drug use were granted legal status (alcohol, tobacco and drinking morphine were associated with anglo-saxons) whereas other drugs (smoking opium associated with Chinese immigrants) were granted illicit status. Two other factors were evident from analysis of the origins of Australian illicit drug policy: first, decisions regarding the legal status of various drugs (for example: heroin and cannabis) were not based upon extensive research/evidence as to their inherent capacity to manufacture drug related harms and second, these decisions were made in

⁸⁵ See chapter one for more information. One recurring theme of drug wars is "...the notion of a public menace whereby a certain drug use associated with a particular group as in the case of opium and the Chinese, or crack cocaine and young, urban blacks." From Lang, E., 1998, 'Drugs in Society: A Social History', Hamilton, Kellehear & Rumbold (eds), *Drug Use in Australia: A Harm Minimisation Approach*, Oxford University Press, South Melbourne, p10.

the absence of domestic problems linked to those drugs. Thus, the very basis of illicit drug policy was based upon seemingly arbitrary historical and political factors rather than on rigorous evidence and analysis in the context of domestic harm. Understandably, Australia's traditional socio-cultural values in relation to illicit drugs are still a highly influential variable that constrains illicit drug policy and will be a recurring feature in the analyses throughout this thesis.

Another stable system parameter was identified as the 'basic attributes of the problem area'. Typically the nature of debates regarding illicit drug policy engenders conflict between morality-based, traditional views on illicit drug use versus scientific, evidence-based approaches. Furthermore, the progressive suite of prohibition instruments applied to illicit drug policy in Australia during the twentieth century was a process driven by the USA via international treaties and conventions. As discussed in chapter one, such policies were based upon moral convictions (and in some cases racist ideas) regarding the nature of drug use in society. According to some proponents of the harm reduction coalition, the result is an inconsistent application of prohibition instruments that are neither based upon rigorous evidence nor a balanced application of regulations attached to substances based on their propensity toward drug related harm. The persistence of such moral arguments against the use of illicit drugs remains strong and often perverts scholarly information exchange in the illicit drug policy subsystem. The arguments of such moral entrepreneurs typically rely on "faith" or "common sense" precepts when constructing causal assumptions and consequently definitions of a problem area and are by their very nature, resistant to evidence that undermines their key assumptions. Moreover, such an approach to debate also has a significant bank of support in the media and the polity. Such social conditioning is well recognised.

...the influence of media coverage ensures the image of the problem fits the needs served by the drug war while at the same time helping to spread the problem, the perceptions of the problem, to a wider population.⁸⁶

This also serves other political purposes⁸⁷, the discussion of which remains outside the scope of this thesis. This is the very nature of illicit drug policy debate and different to some other policy subsystems, especially those that address natural systems whereby evidence-based technical information is one of the dominant mechanisms affecting policy change. Therefore this research shall examine the role and nature of these arguments by moral agents that seemingly have a rich reservoir of legitimacy borne from historical and cultural norms underwriting such approaches. Specifically, these arguments will be contrasted with the language and strategies from the harm reduction advocacy coalition.

In the ACF, other aspects of the problem/issue area may impact upon the degree of policy-oriented learning that can take place. Sabatier suggested that the type of information used to communicate coalition policy core beliefs might impact upon the type and degree of policy learning across coalitions and fields such as health and law enforcement.

...a problem's susceptibility to quantitative measurement affects the ability to ascertain performance gaps. The extent of learning is likewise contingent upon the feasibility of developing good causal models of the factors affecting a problem. One would thus expect more learning on air pollution than on mental health.⁸⁸

⁸⁶ *ibid*, p10.

⁸⁷ The vilification of so called deviant groups means that governments can ignore other social and economic factors. *ibid*, p11.

⁸⁸ Sabatier, P., 1988, 'Knowledge, Policy-Oriented Learning and Policy Change: an advocacy coalition framework', *Knowledge, Creation, Diffusion, Utilisation*, 8:4, June, p655.

Thus, Sabatier differentiated between *types* of subsystems and their relative propensities toward policy oriented learning across coalitions. The illicit drug policy coalition is one such ‘social’ subsystem (similar to the example of mental health as noted in the quote above) whereby consensus on causal models in relation to a policy problem is more difficult to achieve than in other subsystems based around natural phenomena. This point is reiterated by Sabatier in the following hypothesis:

Problems involving natural systems are more conducive to policy oriented learning across belief systems than those involving purely social or political systems because in the former many of the critical variables are not themselves active strategists and because controlled experimentation is more feasible.⁸⁹

Other basic attributes of the problem area specifically related to the illicit drug policy subsystem would be prevalence of drug use and illicit drug trends, the system of drug laws in a federal system such as Australia, the pharmacology of drugs and fundamental causal relationships (for example: the propensity of opiates to induce overdoses) that contribute to the ‘drug problem’. In sum, the illicit drug policy subsystem is a social system in which evidence-based, scientific approaches are more heavily contested on philosophical grounds than in debates regarding natural systems.

It is theorised in the ACF that coalitions rarely target these ‘relatively stable system parameters for reform’, except as Sabatier suggests, in the long term. Such factors in the illicit drug policy subsystem will be tested for their stability and consistency over the twenty-year period that this study examines.

⁸⁹ Sabatier, P., 1998, ‘The advocacy coalition framework: revisions and relevance for Europe’, *Journal of European Public Policy*, 5:1, March, p106.

External System Events

In contrast, the second set of exogenous variables theorised to impact upon a policy subsystem are entitled 'external system events' and, according to the authors of the ACF, constitute a critical prerequisite to major policy change.⁹⁰ Such events have implications for the policy subsystem and coalition actors. As discussed above, these variables can often change within a relatively short amount of time and present significant challenges to coalition actors. Sabatier articulated four categories of 'external system events' and these are elaborated on in turn below.

The first external system event expressed in the ACF was identified as 'changes in socio-economic conditions'. Sabatier and Jenkins-Smith theorised that changing social dynamics can potentially undermine or reconfigure causal assumptions of particular policy problems. Consequently, such changes can have the effect of realigning the political support for advocacy coalitions. In this sense, the rise of new social movements (for example the rise of gay activism around the issue of HIV/AIDS) and/or perceived economic marginalisation of particular groups (for example, identification of the marginalisation of intravenous drug users) can influence the direction of policy in the long term. The second external system event suggested in the ACF was 'changes in public opinion'. For example, changing opinions regarding the perceived seriousness of the policy problem might then alter perceptions of the relative efficacy of government spending priorities. The third category of events articulated in the ACF as external to the policy subsystem was identified as 'changes in the governing coalition'. Changes in executive Government through elections, whereby political parties with different approaches to

⁹⁰ *ibid*, p103.

particular issues come to power, provides and alters opportunities for coalitions to realise policy objectives. The final set of external events identified in the ACF was 'policy decisions and impacts from other subsystems'. Such changes in other arenas can affect the workings of the subsystem in question. For example, changes in social policy (such as adjustments to social security pensions or the instigation of new social services) can impact on the lifestyles and subsequent choices of drug consumers.

Types of Policy Change

The main function of the ACF is to provide a framework to account for, and explain, policy change. Within the ACF are criteria for distinguishing 'major' from 'minor' policy change. Sabatier suggested that the former was change in the policy core aspects of a governmental program whereas the latter was related to changes to secondary aspects of government policies and programs. In the ACF, the policy core is defined as relating to the "...fundamental policy positions concerning the basic strategies for achieving normative axioms of deep core"⁹¹ values within the subsystem. With regard to the illicit drug policy subsystem examples of policy core aspects would be the overarching philosophy of 'harm minimisation' as a guiding principle of drug policy; the basic choice of policy instruments being coercion through drug laws and the provision of health services to drug consumers; and the desirability of participation of particular segments of society in policy development and implementation, more specifically, whether these officials should be drawn from public versus elite arenas and/or the relative participation of experts versus elected officials in policy. The scope of major policy change is necessarily subsystem wide.

⁹¹ Sabatier, P., 1989, 'An advocacy coalition framework of policy change and the role of policy-oriented learning therein', *Policy Sciences*, 21, p145.

Thus for change to qualify as major it has to have impacts across the entire subsystem. In contrast, change to secondary aspects of subsystem policy refers to instrumental decisions (for example to implement a SIC or to change penalties regarding possession of drugs) and information necessary to implement the policy core for example: operational decisions, administrative rules, budgetary allocations, importance of various causal linkages and the information concerning the seriousness of the problem (for example increased rates of heroin overdose). Changes to secondary aspects only have impacts on part of the subsystem.

Throughout the ACF there is an emphasis on the role of ideas as catalysts for policy change within subsystems. Speaking globally about the ACF, Sabatier stated that:

...the framework argues that policy change is best seen as fluctuations in the dominant belief systems within a given policy area/subsystem over time.⁹²

Such belief systems can be regarded as independent variables in relation to policy making. Ideas are independent variables when they have the capacity to affect change through the construction of the policy problem and subsequently, prescription of solutions. Howlett and Ramesh note the relationship between ideas and policy making below.

It has long been noted that the ideas individuals hold on an enduring basis have a significant effect on the decisions they make. Although efforts have been made by economists, psychologists and others to reduce these sets of ideas to a rational calculation of self interest, it is apparent that traditions, beliefs and attitudes about the world and society also affect how individuals interpret their interests. These sets of ideas or ideologies, therefore, can be construed to have a significant impact on public policies,

⁹² Sabatier, P., 1988, 'Knowledge, Policy-Oriented Learning and Policy Change: an advocacy coalition framework', *Knowledge, Creation, Diffusion, Utilisation*, 8:4, June, p650.

for through these ideational prisms individuals conceive of social or other problems that inspire the demands of government action. In this view, the 'problems' which governments resolve are not considered to have an 'objective' base in the economy or material structure of society, so much as they are constructed in the realm of public and private discourse⁹³

In social policy arenas then, the role of such belief systems is even more important especially as such intellectual property has the innate capacity to define the "contours of the social world."⁹⁴ The nature of illicit drug policy as a social policy whereby moral debates regarding the inherent virtue or iniquity of certain behaviours means that certain ideas and beliefs manifested in policy become (in the eyes of some) immune to scientific scrutiny. Indeed, the ACF sees policy change as resulting from interaction between stakeholders in the subsystem and real world events (relatively stable system parameters and external system events) as described earlier.

Minor Policy Change

Minor policy change in the ACF is conceptualised as the result of policy oriented learning within or between coalitions. Policy oriented learning occurs when coalitions interact in a number of ways (committees, meetings, professional forums and the like). The process of constructive interaction, as theorised in the ACF, is one whereby information relating to the particular policy arena is exchanged, and produces the development of a better understanding of the factors affecting a specific policy area over time. Sabatier suggested this information is used to analyse policy,

⁹³ Howlett, M., & Ramesh, M., 1995, 'Agenda Setting – Policy Determinants and Policy Windows', *Policy Cycles and Policy Subsystems*, Oxford University Press, Ontario, p109.

⁹⁴ Eldman, M., 1988, *Constructing the Political Spectacle*, University of Chicago Press, Chicago, p12-13.

and moreover serves political purposes, namely to "...buttress and support..."⁹⁵ a particular policy position. Consequently, the process described above has the capacity to serve an ongoing advocacy function, whereby regular meetings between coalitions means that mutual education takes place regarding the ideas, research and associated causal assumptions that underpin their respective policy positions. The end result of this process is not necessarily consensus:

That does not mean that policy conflict has ceased. As long as actors with the requisite political resources find the costs of present policies unacceptable, then agreement on some aspects of the problem and on the probable consequences of some policy alternatives will not lead to a policy consensus. Instead the analytical debate among different coalitions will continue to refine actors' understanding of the seriousness of the problem, the importance of various causal relationships, and the consequences of various alternatives.⁹⁶

The consequence of such interchange between coalitions can be minor policy change to secondary aspects of policy or programs. Sabatier hypothesised that successful policy oriented learning was contingent on two factors.

Policy oriented learning across belief systems is most likely when there is an intermediate level of informed conflict between the two coalitions. This requires that:

- (a) Each has the technical resources to engage in such a debate; and that
- (b) The conflict be between secondary aspects of one belief system and core elements of another, or alternatively between important secondary aspects of the two belief systems.⁹⁷

⁹⁵ Sabatier, P., & Jenkins-Smith, H., 1994, 'Evaluating the Advocacy Coalition Framework', *Journal of Public Policy*, 14:2, p191.

⁹⁶ Sabatier, P., 1988, 'Knowledge, Policy-Oriented Learning and Policy Change: an advocacy coalition framework', *Knowledge, Creation, Diffusion, Utilisation.*, 8:4, June, p681.

⁹⁷ Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe', *Journal of European Public Policy*, 5:1, March, p106.

Sabatier developed further criteria that could affect the probability of policy oriented learning both occurring and resulting in policy change. Sabatier hypothesised that the nature of the forums in which coalitions exchange ideas and information was important.

Policy oriented learning across belief systems is most likely when there is a forum which is:

- (a) Prestigious enough to force professionals from different coalitions to participate; and
- (b) Dominated by professional norms.

Therefore, the forum has to have some kind of legitimacy in the views of coalition members that participate, and further, the kind of behavioural parameters that mediate such groups/committees/meetings must also satisfy, as much as possible, the expectations of key coalition participants. In sum then, policy oriented learning was theorised within the ACF, occurring as a result of ongoing dialogue, conducted in mutually satisfactory conditions, between opposing coalitions. This in turn has the capacity to lead to change in accepted information regarding the seriousness of the problem and decisions of public agencies. Moreover, as noted earlier, the nature of the policy arena and type of information is also another factor in the degree of success of policy oriented learning. As noted above, Sabatier hypothesised that in natural systems, policy debates are more conducive to cross coalition learning in contrast to social policy arenas. The likelihood of a “...dialogue of the deaf”⁹⁸ occurring whereby coalition members actively filter out information due to it conflicting with their fundamental presuppositions on the policy issue is more likely in arenas where moral debates are underwritten by historical and traditional factors:

⁹⁸ Sabatier, P., 1988, ‘Knowledge, Policy-Oriented Learning and Policy Change: an advocacy coalition framework’, *Knowledge, Creation, Diffusion, Utilisation.*, 8:4, June, p678.

Members of an advocacy coalition are always seeking to improve their understanding of variable states and causal relationships which are consistent with their policy core. Likewise they find it easy to convince each other that attacks on their core programs are based on invalid understandings of the world. When two cores conflict, however, the tendency is for each coalition to talk past each other and thus for a “dialogue of the deaf” to persist until external conditions dramatically alter the power balance within the subsystem.⁹⁹

The assumption that social systems are vulnerable to blockages in the process of policy oriented learning will be tested when applied to the illicit drug policy subsystem. With regard to policy oriented learning, this thesis will also analyse the following:

- (i) the nature of policy oriented learning in social subsystems;
- (ii) the role of technical information;
- (iii) the incidence of policy oriented learning (whether secondary or policy core); and,
- (iv) the types of forums in which such learning takes place within the illicit drug policy sector.

Sabatier added that policy oriented learning is one mechanism that can contribute to changes in such secondary aspects of policy, however such learning is not enough to affect major changes in the policy core of Government programs.¹⁰⁰

Major Policy Change

Major policy change in the ACF is theorised as being contingent on external ‘shocks’ to the subsystem that engender opportunities for advocacy coalition members. Such

⁹⁹ *ibid.*

¹⁰⁰ Sabatier, P., & Jenkins-Smith, H., 1994, ‘Evaluating the Advocacy Coalition Framework’, *Journal of Public Policy*, 14:2, p191.

opportunities, however, must be strategically exploited by coalitions hoping to realise their policy objectives. In the ACF, it was further theorised that there were several different processes in which the reconfiguring of the political power of coalitions within a subsystem occurs. The way in which these processes are theorised to occur within the ACF is discussed below.

In order for major policy change to occur, changes to exogenous factors of a subsystem, described above as 'external system events', must transpire:

While policy analysis and learning can strongly affect secondary aspects of such belief systems, fundamental changes in subsystem policy are usually the result of alterations in non-cognitive, systemic parameters.¹⁰¹

Sabatier hypothesised that such changes to non-cognitive events did not constitute the sole means that precipitated major policy change:

Significant perturbations external to the subsystem (e.g. changes in socio economic conditions, public opinion, system wide governing coalitions, or policy outputs from other subsystems) are a *necessary, but not sufficient*, cause of change in the *policy core* attributes of a governmental program.¹⁰²

Therefore this thesis will examine the above hypothesis by first identifying such external dynamic variables and secondly noting whether such phenomena are present in cases of major policy change to policy core of programs in relation to Australian illicit drug policy.

¹⁰¹ Sabatier, P., 1988, 'Knowledge, Policy-Oriented Learning and Policy Change: an advocacy coalition framework', *Knowledge, Creation, Diffusion, Utilisation.*, 8:4, June, p650.

¹⁰² Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe', *Journal of European Public Policy*, 5:1, March, p106.

The ACF also theorises that such changes in external system events create a 'window of opportunity' in which coalitions must then capitalise:

The basic argument is that such perturbations provide an opportunity for major policy change but such change will not occur unless that opportunity is skilfully exploited by proponents of change i.e. the heretofore minority coalitions.¹⁰³

In the ACF, skilful exploitation of opportunity occurs through the use of 'guidance instruments' as described earlier. Indeed as well as identifying the conditions around policy change occurs in the Australian illicit drug policy subsystem, the way in which coalitions capitalised on these changes is also examined in this thesis. Another of the conditions required for major policy change is a replacement of the dominant coalition with another. Sabatier hypothesised:

The policy core attributes of a governmental program in a specific jurisdiction will not be significantly revised as long as the subsystem advocacy coalition that instituted the program remains in power within that jurisdiction – except when the change is imposed by a hierarchically superior jurisdiction.¹⁰⁴

One of the criteria for analysis of the utility of the ACF for conceptualising illicit drug policy in the current thesis will be determining whether, in the event of policy core changes, the dominant coalition/s in the subsystem were succeeded by other coalitions. This thesis will examine the way in which coalitions integrated such external events into strategies to realise policy objectives. Sabatier described the reconfiguring of coalitions within a subsystem in several ways. First, the description of the replacement of one coalition by another:

¹⁰³ *ibid*, p118-9.

¹⁰⁴ *ibid*, p106.

Sometimes a tremendous surge of public concern with a problem leads to a process of competitive policy escalation by elected officials (or political parties) and thus the replacement of one coalition by another virtually overnight.¹⁰⁵

The second way concerns political manoeuvrings and compromise by one coalition to gain enough political capital to broker the desired results.

Far more frequent, we suspect, is a scenario in which the minority coalition increases in importance and attempts to take advantage of a window of opportunity opened by an external perturbation, but does not have the votes in the legislature to push through a substantial change in the policy core of governmental policy on its merits. Thus the minority coalition is likely to resort to *any* tactic that will garner additional votes, including 'pork barrel' benefits, trying to manipulate the dimensions of the issue to appeal to different constituencies, bribes, attaching the bill as a waiver to other legislation, etc. In short, obtaining major policy change usually requires that an advocacy coalition augment its resources by developing 'coalitions of convenience' with a variety of other groups.¹⁰⁶

The third process described a situation whereby one large coalition is formed from members from all coalitions. This type of arrangement sees political power being divided between coalitions.

In situations in which all major coalitions view a continuation of the current situation as unacceptable, they may be willing to enter negotiations in the hope of finding compromise that is viewed by everyone as superior to that status quo. ... We suspect that the conditions for such a successful consensus process – i.e. one that results in legally binding agreements viewed by everyone as an improvement – are similar to those for a successful professional forum

- (a) a stalemate wherein all coalitions view a continuation of the status quo as unacceptable

¹⁰⁵ *ibid*, p119.

¹⁰⁶ *ibid*.

- (b) the negotiations are conducted in private and last a relatively long time, e.g. more than six months
- (c) there is a facilitator (policy broker) respected by all parties and viewed as relatively neutral.

The end result is not a dominant coalition and several minority coalitions but what might be regarded as 'power sharing' among coalitions (analogous to a 'grand coalition' in parliamentary systems or the tradition of consensus negotiations in such countries as Switzerland or the Netherlands).¹⁰⁷

Sabatier further noted that such arrangements are likely to be unstable.¹⁰⁸ This research will seek to identify the outcome of major policy change ascertaining the relative power of coalitions in the illicit drug policy subsystem and whether coalitions reconfigured according to processes outlined above by Sabatier.

An Advocacy Coalition Framework For Analysing Illicit Drug Policy 1980 to 2000

Table 1 represents the model of analysis that will be applied in this thesis. The model lists key hypotheses and concepts within the ACF and also a list of research questions, formulated in order to facilitate a critique of the ACF when applied to social systems and also to act as a tool to understand policy making in the illicit drug subsystem in Australia. Moreover this model should also generate insight into the relative efficacy of coalition strategising around the issue of illicit drugs.

¹⁰⁷ *ibid*, p119-120.

¹⁰⁸ *ibid*, p120.

Table 1: An Advocacy Coalition Framework for Analysis of the Illicit Drug Policy Subsystem 1980 – 2000

ACF Hypothesis or Key Concept	Further information	Research Questions
<p>1. Advocacy coalitions:</p> <p>ACF Hypothesis: On major controversies within a policy subsystem when policy core beliefs are in dispute, the lineup of allies and opponents tends to be stable over periods of a decade or thereabouts.</p>		<p>Coalitions tested for constituency and stability</p> <p>1.1 What type of actors constitute the ‘harm reduction’ and ‘moral-abstinence’ coalitions?</p> <p>1.2 Was there any change in the type of actors over a 20 year period in illicit drug debates?</p> <p>1.3 (If applicable) What was the nature of the change (gradual or sudden)</p>
<p>2. Advocacy coalition belief systems</p> <p>ACF Hypothesis: Actors within an advocacy coalition will show substantial consensus on issues pertaining to the policy core, although less so on secondary aspects.</p>		<p>Consensus on policy core</p> <p>2.1 Did the harm reduction coalition display consensus on policy core beliefs?</p>
<p>3. Guidance Instruments</p> <p>ACF concept: This concept describes the way in which coalitions capitalise on changes that occur, within or external to, the subsystem that provide opportunities for coalitions to realise policy objectives. For example this might include changes to rules, governments, budgets or information that can be exploited by coalition actors to realise policy objectives.</p>	<p>Sabatier’s taxonomy of guidance instruments:</p> <ul style="list-style-type: none"> • seeking to influence legislatures to alter the budgets and legal authority of administrative agencies through testimony and campaign contributions; • trying to change the incumbents of various positions, whether they be agency appointees, agency civil servants, or elected legislators and chief executives; • trying to affect public opinion via the mass media; • attempting to alter target group behaviour via demonstrations or boycotts • trying to gradually alter the perceptions of a variety of actors through research and information exchange 	<p>The utility of guidance instruments</p> <p>3.1 How did the harm reduction coalition capitalise on changes that occurred external to or within the subsystem?</p> <p>3.2 Did these conform to Sabatier’s taxonomy of guidance instruments?</p>

ACF Hypothesis or Key Concept	Further information	Research Questions
<p>4. Role of policy brokers</p> <p>ACF concept: Conflicting strategies (advocated by each coalition) are submitted to 'policy brokers', a group of actors that represent the Government and are responsible for reaching compromise and limiting conflict, whose principal concern is to find some reasonable compromise that will reduce intense conflict. The end result is one or more governmental programs, which in turn produce policy outputs at the operational level.</p>	<p>Neutrality</p> <p>Policy brokers in the ACF have an implied neutrality to their role. A 1987 article suggested that policy brokers could be both coalition members and policy makers but this has not been emphasised in more recent writing on the ACF.</p>	<p>Policy brokers as neutral policy makers</p> <p>4.1 Do policy brokers have membership of any coalition?</p> <p>4.2 To what extent do policy brokers 'make' policy? Do policy brokers receive conflicting strategies? Do policy brokers reach compromise between coalitions?</p>
<p>5. Relatively stable system parameters</p> <p>ACF concept: such system parameters are stable over several decades and that coalitions rarely target these parameters for reform except in the long term. Such factors will also be tested for their stability and consistency over the twenty-year period examined in this thesis.</p>	<p>Four categories of relatively stable system parameters</p> <ul style="list-style-type: none"> • Basic attributes of the problem area • Basic distribution of natural resources • Fundamental socio-cultural values • Basic constitutional rules 	<p>Stability and consistency of relatively stable system parameters</p> <p>5.1 Were such phenomena as categorised in the ACF stable from 1980 to 2000?</p> <p>5.2 Did coalitions target these parameters for reform?</p>
<p>6. Policy-oriented learning – quantitative data</p> <p>ACF hypothesis: Problems for which accepted quantitative data exist are more conducive to policy oriented learning across belief systems than those in which data and theory are generally qualitative, quite subjective or altogether lacking.</p>	<p>As coalitions resist changing their policy beliefs or important secondary aspects, only solid empirical evidence is likely to lead them to do so. It is hypothesised in the ACF that such evidence is most likely to be developed and accepted in fields where quantitative data and consensual theories are available, a situation more common in the natural sciences than the social sciences. A problem's susceptibility to quantitative measurement affects the ability to ascertain performance gaps. The extent of learning is likewise contingent upon the feasibility of developing good causal models of the factors affecting a problem. One would thus expect more learning on air pollution than on mental health.</p>	<p>Technical information</p> <p>6.1 What was the role of quantitative data/information in policy oriented learning?</p> <p>6.2 Was such data accepted by both coalitions?</p> <p>6.3 If not, what were the barriers to its acceptance?</p>

ACF Hypothesis or Key Concept	Further information	Research Questions
<p>7. Policy oriented learning</p> <p>ACF hypothesis: Policy oriented learning across belief systems is most likely when there is an intermediate level of informed conflict between the two coalitions. This requires that:</p> <p>(a) Each has the technical resources to engage in such a debate; and that</p> <p>(b) The conflict be between secondary aspects of one belief system and core elements of another, or alternatively between important secondary aspects of the two belief systems.</p>		<p>Conflict between coalitions in professional forums</p> <p>7.1 In cases where policy oriented learning occurred, did the conflict concern secondary aspects of both coalitions or between the secondary aspect of one coalition and the policy core of the other?</p>
<p>8. Policy oriented learning – nature of professional forums</p> <p>Policy oriented learning across belief systems is most likely when there is a forum which is:</p> <p>(a) Prestigious enough to force professionals from different coalitions to participate; and</p> <p>(b) Dominated by professional norms.</p>		<p>Nature of professional forums</p> <p>8.1 What were the types of forums that facilitated policy oriented learning?</p>
<p>9. Major policy change – condition 1</p> <p>Significant perturbations external to the subsystem (e.g. changes in socio economic conditions, public opinion, system wide governing coalitions, or policy outputs from other subsystems) are a necessary, but not sufficient, cause of change in the policy core attributes of a governmental program</p>	<p>The basic argument is that such perturbations provide an opportunity for major policy change but such change will not occur unless that opportunity is skilfully exploited by proponents of change i.e. the heretofore minority coalitions</p>	<p>Changes to external events and major policy change</p> <p>9.1 In cases of changes to policy core, was there an external shock to the subsystem?</p> <p>9.2 How did coalitions integrate such external events into strategies to realise policy objectives?</p>

ACF Hypothesis or Key Concept	Further information	Research Questions
<p>10. Major policy change – condition 2</p> <p>The policy core attributes of a governmental program in a specific jurisdiction will not be significantly revised as long as the subsystem advocacy coalition that instituted the program remains in power within that jurisdiction – except when the change is imposed by a hierarchically superior jurisdiction</p>	<p>Process of major policy change</p> <p>Three processes described by Sabatier</p> <ul style="list-style-type: none"> • Replacement of one coalition by another • Form coalitions of convenience • Form grand coalition 	<p>Changes in the respective political power of coalitions in cases if major policy change</p> <p>10.1 In cases of changes to policy core, did the subsystem coalition that instituted the program remain in power?</p> <p>10.2 If yes, then was the change imposed by a hierarchically superior jurisdiction?</p> <p>10.3 What was the outcome of major policy change regarding the relative power of coalitions within the illicit drug policy subsystem?</p>

These research questions will be answered where appropriate throughout the next four chapters. Chapter Six directly answers the research questions and synthesises findings from chapters three to five. The following chapter traces the genesis and development of the harm reduction advocacy coalition in the period 1980 to 1990.

Chapter 3: The Emergence of a Coalition for Harm Reduction

Introduction

*"Look mate, there are no votes in buggers, druggies and prozzies!"*¹⁰⁹
State Ministerial colleague to Neal Blewett

This chapter examines the emergence of the harm reduction approach in the Australian illicit drug policy subsystem between 1980 and 1990. At the beginning of 1980, the main tools used in illicit drug policy were prohibition to limit the supply of drugs and abstinence-oriented treatment with the exception of MMT that had been in operation for many decades. By the close of the decade, harm reduction tools were firmly entrenched in policy with many Australian state governments having: implemented NSPs (that not only disseminated free sterile injecting equipment but also included education about safer injecting practices), expanded the number of MMT places available and also funded and invited illicit drug users to not only provide services but also supply input into Government policy. This chapter seeks to understand and explain how such controversial policies that provide services for people who continue to use illicit drugs (without any requirement for those users to become abstinent) initially became enshrined in Australian public policy.

This chapter describes: the genesis and crystallisation of a coalition of actors that supported the theory and practice of the harm reduction approach, key events that occurred in this decade in illicit drug policy, and, the way in which a group of actors advocated for harm reduction policy. Throughout the chapter is the identification of harm reduction ideas that appeared in Royal Commissions, key articles, national and

¹⁰⁹ Blewett, N., 2003, *Aids in Australia: Reflections on Australia's policy response to the AIDS Epidemic*, Australian Health Policy Institute, University of Sydney, p8.

state policies and evaluations before the approach was widely used in drug policy. Of principal importance to this chapter are those particular concepts of the ACF used to explain 'major' policy change. External shock/s to the subsystem and a shift in power between coalitions within the subsystem are two key conditions identified by the authors of the ACF as necessary prerequisites to policy change. Moreover, the composition of an 'advocacy coalition' for harm reduction and the idea of policy beliefs acting to unify actors is also identified. Other key concepts listed in Table 1. are also analysed and evaluated against the events between 1980 and 1990.

The Origins of Harm Reduction

First, do no harm.
- Hippocrates

Harm reduction principles and ideas as described in chapter one have a long tradition in medicine. The notion of reducing harm, while acknowledging that the behaviour that caused the harm may continue, is a fundamental principle applied to the treatment of many conditions. For example: patients with heart problems are not prohibited from having particular foods, instead they are encouraged to moderate dietary intake and adopt an exercise regimen. Harm reduction principles are also applied in public health settings. For example, the policy response to road fatalities has resulted in the provision of, and legal requirement to wear, seat belts and further, drivers are subjected to random breath testing as well as restrictions on speed. All of these examples are used to manage the risk associated with driving. The central premise with regard to these examples is that some human behaviour is both ongoing and dangerous, and, rather than prohibit such behaviour, the preferred practical response is to reduce harm associated with it as much as possible. Therefore, the

ideas and philosophy of harm reduction are well established in a number of arenas whereby management of a dangerous activity is seen to be more effective than prohibition of it.

With regard to illicit drug policy, there were few harm reduction principles employed before the 1980s. Indeed, MMT and prescription heroin (in the United Kingdom) were solitary examples that existed sporadically within the dominant regime of prohibition. MMT¹¹⁰ (and prescription of heroin) are designed to reduce the disruptions to a person's life when dependent on substances. Such programs work to reduce the association of the dependent person with criminal networks and the expense of a daily dependency,¹¹¹ facilitate the rebuilding of familial networks and re-entry into the workforce in some cases from illicit drug use. Thus such programs are underwritten with an understanding that dependencies can manufacture harms that extend beyond the scope of the pharmacological effects of the drugs themselves. Indeed, such harms often need to be addressed prior to, or concurrently with, the medical management of dependencies.

With regard to NSPs in Australia, there are accounts of pharmacies supplying syringes to drug consumers in the 1970s previous to any government run program. To an extent, these constituted the first recorded means of dissemination of needle and syringes in Australia, albeit occurring sporadically and at unknown frequencies.

¹¹⁰ Methadone treatment began in 1969 in Australia. Campbell, A., 2001, *The Australian Illicit Drug Guide*, Black Inc., Melbourne, p155. In the United Kingdom, the prescription of other drugs than methadone dates back to the 1920s, with a small few receiving injectable heroin. Riley, D., & O'Hare, P., 2000, 'Harm Reduction: History, Definition, and Practice', *Harm Reduction: National and International Perspectives*, Sage, London, p13.

¹¹¹ Consumers of methadone maintenance programs in Australia still have a minor cost associated with the prescription of methadone however this cost is minimal in comparison to the price of street drugs.

The Committee has had complaints that many pharmacists too freely make available hypodermic needles for the use of addicts. . . Experience of members of the Committee suggests that drug addicts are very resourceful in fashioning implements that can be used for hypodermic injections even when needles and syringes are not available. For example, the Drug Squad at Police Headquarters has in its possession many items which had been used as substitutes by drug users.¹¹²

Such an initiative, constituted an early measure by coalface workers (in this case pharmacists) to reduce drug related harm. The consequences of reusing injecting equipment many times, let alone using homemade implements, are potentially very negative due to the risk of bacterial infection and vein damage. Those at the coalface (pharmacy and medical staff), however, knew the risks of using a single syringe for multiple injections and acted accordingly to supply syringes, albeit in an ad hoc fashion.

In sum, principles inherent in harm reduction have existed long before the term was indoctrinated into government policy in the 1980s. Harm reduction as a concept applied to the management of *illicit* drugs gained support and momentum in the 1980s, buoyed partly by the perception that drug use was increasing in line with availability.

The Identification of the ‘Drug Problem’

By the early 1960s there was growing, but still relatively little, reported recreational illicit drug use in Australia. By the end of the decade however, the issue of illicit

¹¹² New South Wales Joint Parliamentary Committee Upon Drugs, *Report into Drug Abuses*, Sydney p95.

drugs was on the political agenda¹¹³ with reports of increasing numbers of organised production and trafficking syndicates.

In the late 1960s, a new dimension of the 'drug problem' namely organized drug trafficking, developed in Sydney with the arrival of US servicemen on leave from the Vietnam War. Local drug markets expanded to meet their requirements, particularly for heroin.¹¹⁴

The perception of increased availability¹¹⁵ and use of illicit drugs along with a new mode of taking drugs (self administered injections) and the reports of increasing sophistication in the production and trafficking of drugs, meant that drug issues quickly gained popular attention through the media.¹¹⁶ This was echoed in several countries around the world with many experts convening to discuss the issue at conferences.¹¹⁷ Consequently, numerous Royal Commissions and Inquiries examining the issue were conducted in the 1970s.

1970s - The Era of the Royal Commission

In the 1970s, six major Inquiries and Royal Commissions ensued in regard to the perception of a growing drug problem.¹¹⁸ These Commissions aimed to provide

¹¹³ Campbell, A., 2001, *The Australian Illicit Drug Guide*, Black Inc, Melbourne, p439.

¹¹⁴ *ibid.*

¹¹⁵ "In particular the sheer vastness of the growth in the availability of all drugs through a multitude of legal and illegal sources has been the most forceful single factor to have struck the Committee during its inquiry. The flood of drugs into the community still taking place must be stemmed and reversed." The New South Wales Joint Parliamentary Committee Upon Drugs, 1978, *Report into Drug Abuse 1978*, p28.

¹¹⁶ "When the Committee embarked on its task in November 1976 . . . drugs were making headline stories almost everyday and certainly as far as many of the media were concerned they would remain high on the list of public excitement", The New South Wales Joint Parliamentary Committee Upon Drugs, 1978, *Report into Drug Abuse 1978*, p17.

¹¹⁷ For example – the 7th International Conference on Alcohol, Drugs and Traffic Safety in Melbourne in 1977.

¹¹⁸ The Senate Standing Committee on Drug Trafficking and Drug Abuse 1971 (Marriot report), The Senate Standing Committee on Social Welfare, 1976, *Drug Problems in Australia: an intoxicated Society*, (Baume Inquiry), The New South Wales Royal Commission into Drug Trafficking 1976 (Woodward Inquiry), Australian Royal Commission of Inquiry into Drugs 1977 (Williams Inquiry),

answers on the nature and problems of drug use in society in the context of very little existing reliable data¹¹⁹, and to dispel myths surrounding drug use while ultimately providing direction to Governments keen to be seen by the electorate as doing something about the ‘problem’. There were several key themes identified by the authors of these Commissions and Inquiries in the 1970s, these are summarised below:

- the recognition that licit substances such as alcohol and tobacco caused more harm than illicit drugs and thus constituted the core of the ‘drug problem’¹²⁰,
- similarly, recognition that pharmaceutical self medication constitutes part of the ‘drug problem’¹²¹,
- distinctions were made between the relative levels of harm and risk of specific drugs (such as cannabis in comparison to heroin)¹²²,
- distinctions were also made between types of drug use (recreational to heavy use)¹²³,
- organised crime and police corruption were identified as being linked with the production and trafficking of illicit drugs¹²⁴, and,
- substantial debate regarding the degree of effectiveness of criminal law in addressing illicit drug use¹²⁵ in this time.

The New South Wales Joint Parliamentary Committee Upon Drugs, 1978, *Report into Drug Abuse 1978*, The South Australian Royal Commission into the Non-Medical Use of Drugs 1979 (The Sackville Inquiry), The Woodward Royal Commission 1980, The Senate Standing Committee on Social Welfare 1981 (Waters Inquiry), The Royal Commission into Drug Trafficking 1982 (Stewart Inquiry).

¹¹⁹ Senate Standing Committee on Social Welfare, 1977, *Drug Problems in Australia: an intoxicated society*, AGPS, Canberra, p13.

¹²⁰ South Australian Government, *Royal Commission into the Non-Medical Use of Drugs*, 1979, p5.

¹²¹ *ibid*, p 43 & p82.

¹²² Senate Standing Committee on Social Welfare, 1977, *Drug Problems in Australia: an intoxicated society*, AGPS, Canberra, p1.

¹²³ Five categories of drug use being: experimental, social/recreational, circumstantial/situational, intensified & compulsive. South Australian Government, 1979, *Royal Commission into the Non-Medical Use of Drugs*, p20.

¹²⁴ The New South Wales Joint Parliamentary Committee Upon Drugs, 1978, *Report into Drug Abuse 1978*, p40-1.

Such comments served to broaden the understanding of the 'drug problem' away from being attributed exclusively to illicit drugs and problematic drug use patterns towards one that incorporated the role of licit and prescribed drugs as well as the link between prohibition and organised crime and police corruption.

Comments in these Royal Commissions echoed key tenets of harm reduction. Authors of the *Senate Standing Committee on Social Welfare 1977*, and the *South Australian Royal Commission into the Non-Medical Use of Drugs* stated that elimination of non-medical drug use entirely from society was an unrealistic goal.¹²⁶ Such a statement essentially challenged the utopian notion of a drug free society (and the efficacy of law enforcement in achieving this) that is an implicit goal of prohibition regimes. As mentioned in Chapter One many writers advocating for harm reduction in drug policy have noted that efforts to enforce a drug free society have the capacity to generate worse harms than from the drugs alone.¹²⁷

Second, in the Sackville Commission it was argued that drug use is *primarily* a social and medical problem¹²⁸ and that "...a coherent, concerted and all embracing

¹²⁵ Campbell, A., 2001, *The Australian Illicit Drug Guide*, Black Inc, Melbourne, p441.

¹²⁶ South Australian Government, 1979, Royal Commission into the Non-Medical Use of Drugs, South Australia, (Sackville Commission), p19; Senate Standing Committee on Social Welfare, 1977, *Drug Problems in Australia: an intoxicated society*, AGPS, Canberra, p1. Moreover, some notions within the harm reduction paradigm suggest that a drug free society is unachievable and as such offers ways of managing, arguably, ongoing and 'normal' human activity.

¹²⁷ Erickson, P., 1992, 'Political Pharmacology: Thinking about drugs', *Daedalus*, Summer, pp239-267; Nadlemann, E., 1993, 'Progressive legalizers, progressive prohibitionists and the reduction of drug related harm', in N Heather et. al (eds), *Psychoactive drugs and harm reduction: from faith to science*, Whurr, London, pp34-35; O'Hare, P., 1992, 'Preface: A note on the concept of harm reduction', in P O'Hare, R., Newcombe, A., Matthews, E., Buning & E Drucker (eds), *The reduction of drug related harm*, Routledge, New York; Riley, D., & Oscapella, E., 1997, 'Canada's new drug law: Some implications for HIV/AIDS prevention in Canada', *International Journal of Drug Policy*, 7:3, pp180-182.

¹²⁸ South Australian Government, 1979, Royal Commission into the non-Medical Use of Drugs, South Australia, (Sackville Commission), p23; Senate Standing Committee on Social Welfare, 1977, *Drug Problems in Australia: an intoxicated society*, AGPS, Canberra, p1.

policy”¹²⁹ be formulated so to reduce drug related harm. Third, the Senate Standing Committee on Social Welfare suggested that a ‘harm audit’ should be conducted on various policies (for example those of law enforcement) in order to determine the correct approach at any one given time. Indeed one author ruminated on the capacity of law enforcement to contribute to drug related harm:

The mechanism for discouragement of use should not be more damaging to the individual than is the drug itself.¹³⁰

In 1972, the *Canadian Government Commission of Inquiry into the Non-Medical Use of Drugs* (the Le Dain Reports) concluded that the notion of ‘harm’ was a robust measure of the relative efficacy of interventions:

In every case the test must be a practical one; we must weigh the potential for harm, individual and social, of the conduct in question against the harm, individual and social, which is caused by the application of the criminal law, and ask ourselves whether, on balance, the intervention is justified. Put another way, the use of criminal law in any particular case should be justified on an evaluation and weighing of its benefits and costs.¹³¹

As mentioned in Chapter One, the notion of ‘harm reduction’ can be conceived of as a yardstick to measure policies. Indeed, in 1977, the Sackville Commission suggested that the reduction of drug related harm be the *major* goal of drug policy:

. . . that the major goal of social policy on drugs should be to minimise the harmful use of mood altering drugs. There too we discussed the relationship between use and misuse and we described those kinds of drug use that might be considered more or less likely to lead to harmful effects,

¹²⁹ *ibid.*

¹³⁰ Senate Standing Committee on Social Welfare, 1977, *Drug Problems in Australia: an intoxicated society*, AGPS, Canberra, p23.

¹³¹ Commission of Inquiry into the Non-Medical Use of Drugs, 1972, *Cannabis*, Information Canada, Ottawa, pp282-3.

either for the individual or society. We pointed out that ... experimental, recreational or circumstantial use did not constitute a great hazard to the public or to the health of most individuals, even if the drugs involved were not obtained through legal sources...¹³²

Such comments, that echoed concepts and principles of the harm reduction approach, from Royal Commissions and Inquiries occurred before harm reduction emerged in the 1980s.

It is important to note however, the apparent limitation of such Royal Commissions and Inquiries as agenda setting instruments for public policy. Such documents represent the views of experts yet often recommendations are ignored. Sackville ruminated:

. . . in Australia and in other countries there has been a record, in modern times, of extensive official inquiries into the regulation of drug use. The reports of these inquiries have often been striking for the similarity of their general approach and sometimes for their recommendations. The unwillingness or inability of governments to implement those recommendations has been equally striking.¹³³

Sackville further commented on the seemingly immovable status of law enforcement in illicit drug policy:

Despite thoughtful and detailed reports from those bodies, governments have found it difficult to depart from entrenched control policies, and public perception of the nature of the problem has been slow to change.¹³⁴

¹³² South Australian Government, 1979, Royal Commission into the non-Medical Use of Drugs South Australia, (Sackville commission), p61.

¹³³ *ibid*, p5.

¹³⁴ *ibid*.

The incapacity of governments to act upon numerous recommendations made by a number of commissions or inquiries points to an irrationality or ‘blockage’ in drug policy making.

In sum, by the end of the 1970s the ‘drug problem’ was a significant political issue with many advocating change in government policy. Royal Commissioners attempted to redefine the ‘drug problem’ to one that included licit substances and also suggested the existence of many different patterns of drug use from recreational to habitual. Moreover, the same authors also suggested that the notion of the reduction of drug related harm should be a major goal of drug policy, or at very least used regularly as a policy yardstick. This period marked the beginning of a change in thinking about illicit drug policy in Australia and indeed in the rest of the world. Berridge¹³⁵, in the United Kingdom, argued that harm reduction was not a new policy objective when adopted by Governments in the 1980s. Previously, there had been a growing belief that harm reduction was a more pragmatic aim than the ideas of ‘treatment’, ‘cure’ and ‘abstinence’.

The concept received its best known public expression in the 1984 ACMD Report on Prevention which abandoned the traditional division into primary, secondary and tertiary prevention in favour of two basic criteria: (1) reducing the risk of an individual engaging in drug misuse; (2) reducing the harm associated with drug misuse.¹³⁶

By the early-to-mid 1980s a distinct policy community was forming in the UK that were sympathetic to these ideas. These ideas were accompanied also by a preference to downplay the medical model of addiction (at both a practical and theoretical level)

¹³⁵ Berridge, V., 1993, ‘Harm minimisation and public health: a historical perspective, in N., Heather, A., Wodak, E., Nadleman & P., O’Hare (eds), *Psychoactive Drugs & Harm Reduction: from faith to science*, Whurr, London, p56.

¹³⁶ *ibid*, p57.

as a disease that required specialist treatment. The 1982 Advisory Council on the Misuse of Drugs (ACMD) report on Treatment and Rehabilitation posited that not all people with drug problems are necessarily suffering from a disease of dependence nor is there any uniform personality trait or type of person that is more likely to be vulnerable to displaying problematic drug behaviour.¹³⁷

The Genesis of a Coalition for ‘Harm Reduction’ in Australia

Other developments in the international arena also helped generate local momentum for a different approach to illicit drug policy. In 1980, the key topic of the first national conference of the Australian Medical Society on Alcohol and Drugs (AMSAD) was the development of a “...broad, long term, health oriented national strategy...”¹³⁸ to address both licit and illicit drug use. The Pan Pacific Conference on Drugs and Alcohol held in the same year called for a regional policy on drugs that was informed by empirical research and reason than by “...inflamed emotion.”¹³⁹ The World Health Organisation (WHO) publication *Memorandum on Nomenclature and Classification of Drug and Alcohol-Related Problems* used the terms “harmful” and “hazardous use” instead of the value laden “abuse” and “misuse”.¹⁴⁰ This shift in terminology reflected a broader move towards formulating a scientific and morally neutral approach to the study of illicit drugs so to allow the refinement of classification and diagnostic systems to allow scientific endeavour into the alcohol

¹³⁷ DHSS, 1982, *Treatment and Rehabilitation: Report of the Advisory Council on the Misuse of Drugs*, London, HMSO.

¹³⁸ MacKellar, M., 1980, *Opening of the First National Conference of the Australian Medical Society on Alcohol and other Drugs Problems*, First National Conference of the Australian Medical Society on Alcohol and other Drugs Problems-Conference Papers, p7.

¹³⁹ Drew, L., 1981, ‘The need for a regional policy on drugs’, *Man, Drugs and Society – current perspectives, proceedings of the First pan Pacific Conference on Drugs and Alcohol*, Canberra, Australia, march 1980, p9.

¹⁴⁰ Edwards, G., Arif, A., & Hadgson, R., 1981, ‘Nomenclature and classification of drug and alcohol related problems: a WHO Memorandum’, *Bulletin of the World Health Organization*, 59:2, pp225-42.

and other drug arena. Such changes in terminology highlighted the bio-medical community's influence in the international alcohol and other drug arena. The terminology from the WHO memorandum was adopted by the newly formed AMSAD, the aim of which was to increase the awareness and knowledge of alcohol and other drug problems in the medical profession.

In an article¹⁴¹ published in the Australian *Alcohol and Drug Review*, Les Drew (a senior bureaucrat with the Federal Health Department) noted the existence of a general consensus that traditional abstinence-oriented and supply reduction policies had not worked and indeed were beginning to lose credibility. This view was endorsed at the 1982 meeting of the WHO Project on the Development of Strategies and Guidelines for the Prevention of Drug Dependence.¹⁴² This further indicated that there was momentum for change and that a 'window of opportunity' had opened for policy makers to suggest new approaches. Les Drew also suggested the need to ensure that people who continue to use illicit drugs do so as safely as possible through targeted programs (for example: the provision of sterile water to drug users so to reduce the instance of injecting tap water and thus depositing bacteria directly into the bloodstream causing infections).¹⁴³

Furthermore, professional journals and associations were initiated in this time. Drew also reiterated the need to instigate and, in some cases, strengthen institutions such as the *Australian Alcohol/Drug Review* (now *Drug and Alcohol Review*), a professional society (Australian Medical Society on Alcohol and Drug Related

¹⁴¹ Drew, L., 1984, 'Strategies for Minimising Drug Related Health Problems', *Australian Alcohol/Drug Review*, 3:1, January.

¹⁴² World Health Organisation, 1982, 'WHO Project on the Development of Strategies and Guidelines for the Prevention of Drug Dependence', *Report of the Advisory Group Meeting*, 20-24 April 1982.

¹⁴³ Drew, L., 1984, Strategies for Minimising Drug Related Health Problems, *Australian Alcohol/Drug Review*, vol3, No. 1, January, p17.

problems), a national organisation (Australian Foundation of Alcoholism and Drug Dependence), national centres of excellence (focusing on applied research) and academic bases (professorships).¹⁴⁴ Therefore, as an individual, Les Drew was a key advocate of harm reduction ideas in the 1980s.

As well as changes in terminology and the formation of professional societies, the contributions of key individuals such as Les Drew and Prime Minister Hawke are central to the development of harm reduction policy in Australia in the 1980s. The first national drug strategy, the *National Campaign Against Drug Abuse* (NCADA) did not mention harm reduction initiatives (except MMT), rather it used the term 'harm minimisation'. In this context such a term had quite a distinct meaning to the term harm reduction. This is discussed in the following section.

The National Campaign Against Drug Abuse (NCADA)

The NCADA was produced by the Department of Health following a Special Premier's Conference held in April 1985. Preceding the conference was consultation between Commonwealth and State/Territory Ministers and Officers.¹⁴⁵ The key points of the NCADA were:

- to encourage cooperation between all levels of Government in managing alcohol and other drug issues;
- a focus on illicit drugs, yet recognition of the widespread health and social problems from use of licit drugs;
- maintenance and enhancement of supply reduction policies;

¹⁴⁴ *ibid.*

¹⁴⁵ Department of Health, 1985, *National Campaign Against Drug Abuse*, AGPS, Canberra, p1.

- supply reduction policies that focussed on traffickers while concurrently offering diversion to treatment for some users;
- enhancement of drug control mechanisms such as Australian Federal Police;
- emphasis on demand reduction to be achieved through education, treatment and rehabilitation programs;
- support for generalist alcohol and other drug workers;
- support for specialist substance use units/committees and policy groups; and,
- introduction of data systems, research and evaluation of existing programs and drug issues.

Previous to the implementation of the NCADA, there was not a national strategy designed to encompass and manage drug use, instead it was largely the realm of law enforcement bodies that implemented policies designed to reduce the supply of drugs in Australia. The medical community did have a role in treatment for dependant persons and had long been involved in programs such as MMT. The NCADA however heralded the beginning of a partnership between health and law enforcement sectors in illicit drug policy. Indeed, the NCADA and subsequent drug strategies generated many opportunities, both formal and informal, whereby law enforcement and health personnel would interact.

The development of the NCADA document reflected the contributions of key individuals such as Prime Minister Hawke and Les Drew. By the time of the 1984 federal election campaign, drug policy was a salient issue, with the 'illicit drug problem' predominantly defined with reference to the link between drugs and organised crime. Les Drew described the initiation of the NCADA:

...when Bob Hawke suddenly decided to have this program I actually wasn't in Canberra at the time, I was directing the Commonwealth's Health Services in Melbourne because there was nothing better to do. . .you know, nothing was happening. . . I came home for Christmas and was in the garden working and the head of the Nutrition section rang up to say could I give her a couple of ideas because she was going to draw up this national drug policy – she'd been told to draw up the program for Bob Hawke's new policy. I said you're kidding – I said I'm not going back to Melbourne. I'll be back in my old job on Monday. So over the Christmas I actually drew up the national program and sent it round to all my mates all round the states so by the time the New Year came round I was able to go back and say look we've got consensus, this is what we want which was totally different to what Bob Hawke wanted.¹⁴⁶

Indeed, Les Drew was a key harm reduction advocate and had published several articles¹⁴⁷ that advocated the use of harm reduction principles in drug policy. In hindsight, Drew could be considered as a key member of the harm reduction coalition who was employed in the senior ranks of the bureaucracy and highly instrumental in the drafting of the NCADA.

The key component of the NCADA was the promotion of the notion of 'harm minimisation' as an overall aim of drug policy. In this context the meaning of harm minimisation encompassed a number of strategies, most of which can be subsumed under the categories of demand reduction (reducing the demand for drugs for actual and potential users through education campaigns and treatment for those existing

¹⁴⁶ Les Drew's recollection of the events around 1985's formulation of the national campaign against drug abuse, cited in Pettingell, J., "Harmspeak: The origins of 'harm reduction' in Australia", Winter School in the Sun, accessed from www.adfq.org/pettinge.html, 24/2/2004.

¹⁴⁷ Drew, L., 1981, 'The need for a regional policy on drugs', *Man, Drugs and Society – current perspectives, proceedings of the First pan Pacific Conference on Drugs and Alcohol*, Canberra, Australia, March 1980; Drew, L., 1984, 'Strategies for Minimising Drug Related Health Problems', *Australian Alcohol/Drug Review*, 3:1, January; Drew, L., 1986, 'Editorial: Cannabis Health issues and Public Policies', *Australian Drug and Alcohol Review*, 5, pp125-126; Drew, L., 1987, 'Beyond the Disease Concept of Addiction: Towards an Integration of the Moral and Scientific Perspectives', *Australian Drug and Alcohol Review*, 6, pp45-48; Drew, L., 1987, 'The Emperor has no Clothes: The Limits of Science in Dealing with Drug Problems', *Australian Drug and Alcohol Review*, 6, pp265-269; Drew, L & Taylor, V., 1988, *Intravenous Drug Use and the AIDS Epidemic: a review*, National Health and Medical Research Council, ACT; Drew, L., 1988, 'Editorial Minimising drug problems: the importance of harm reduction strategies', *Australian Drug and Alcohol Review*, 7, pp139-140.

drug users) and supply reduction (reduction in the amount of drugs available through law enforcement measures). The following excerpt from the NCADA describes the philosophy of demand reduction whereby preventative (and essentially anti-drug) education was regarded as a key way to reduce drug related harm, the aim of which, was to:

...reduce underlying causes of drug abuse by helping people make informed responsible decisions about drug use and promoting self-help and positive alternatives to drug use. Specifically it is aimed to influence attitudes so that drug abuse is less attractive; to increase the ability of individuals to resist the perceived attractiveness of drugs; to promote health through activities such as exercise and community development; to assist individuals to set positive life goals and to increase their self esteem; and to decrease socially irresponsible behaviour.¹⁴⁸

Such a view sought to pre-empt the occurrence of drug-related harm through strategies that aim to limit the desire for drugs by individuals. Thus demand reduction initiatives such as these that aimed to reduce the prevalence of illicit drug use in society reflected the goals inherent in the moral-abstinence approach. In the NCADA, treatment was also subsumed under demand reduction and involved the expansion of MMT, increased support for grassroots health and welfare workers, and further funds for new services for hospitals and community agencies promised. The NCADA noted the aim of MMT was to:

...reduce the risk of harm or death to the individual, to promote contact between treatment programs and opiate dependent persons, to assist these persons to adopt a normal lifestyle, and to reduce crime by removing the need for heroin dependent persons to commit crime to finance their purchase of drugs.¹⁴⁹

¹⁴⁸ Department of Health, 1985, *National Campaign Against Drug Abuse*, AGPS, Canberra, p5.

¹⁴⁹ Department of Health, 1985, *National Campaign Against Drug Abuse*, AGPS, Canberra, p6.

The expansion of MMT was the only initiative in the NCADA that could be classified as harm reduction in nature. Harm reduction was not explicitly mentioned in the NCADA. The NCADA did espouse the reduction of drug related harm as a key strategy, however, the policies and programs designed to reduce harm (predominantly law enforcement and anti-drug education) were nothing new and if anything echoed traditional approaches to drug policy that placed emphasis on abstinence as a key goal. However, implementation of the NCADA resulted in widespread change to the way in which Australian Governments and agencies, such as those from health and law enforcement sectors, responded to drug use.

The Role of HIV/AIDS in the Emergence of Harm Reduction Policy

In 1982 the first case of the human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS) was diagnosed in Australia, with the first death occurring in the following year.¹⁵⁰ By 1985, 49 cases of HIV/AIDS were reported and by 1987, the number had risen to 385.¹⁵¹ Around this time it was identified that, in western countries, HIV/AIDS was primarily transmitted through unprotected anal intercourse between men and the sharing of contaminated injecting equipment.¹⁵² In the early 1980s the virus represented a huge threat to public health in many countries (and still does in many countries, especially those in the third world), as well as an opportunity for the harm reduction advocacy coalition to achieve policy change. In *Aids in Australia: The Primitive Years*¹⁵³ Neal Blewett (Federal Health Minister 1983 to 1990) provided a detailed account of the nature of policy making regarding the

¹⁵⁰ Campbell, A., 2001, *The Australian Illicit Drug Guide*, Black Inc., Melbourne, p444.

¹⁵¹ *ibid*, p445.

¹⁵² Commonwealth Department of Health and Human Services, 1996, *Partnerships in Practice: National HIV/AIDS Strategy 1996-7 to 1998-99*, AGPS, p6.

¹⁵³ Blewett, N., 2003, *Aids in Australia: Reflections on Australia's policy response to the AIDS Epidemic*, Australian Health Policy Institute, University of Sydney.

impact of the HIV/AIDS in Australia in the period 1980 to 1990, the key points of which follow. As will be shown, HIV/AIDS was a critical contributor to the adoption of harm reduction policies and programs later in the decade. According to Blewett, initial HIV/AIDS policy was based on a thin and contested information base with societal mechanisms inadequately prepared. The timing of the identification of HIV/AIDS as a policy issue in Australia was roughly aligned with the arrival of the Hawke Labour Government that was essentially handed a blank slate to make policy to respond to the issue.¹⁵⁴

The combination of blood, sex (and deviant sex at that) and death of course, proved irresistible to the media. There were a sprinkling of sensational stories and lurid headlines – frequently sourced from the United States where of course the epidemic was more advanced.¹⁵⁵

On eve of 1984 federal election, news of the death of four babies in Queensland as result of an HIV/AIDS infected blood transfusion broke. This event propelled HIV/AIDS into the headlines and onto the political agenda¹⁵⁶ and further reinforced the sense of urgency for production of policy. Blewett noted a general reluctance and noticeable absence of policy stakeholders willing to own the problem of HIV/AIDS.¹⁵⁷ Usually the medical profession are the owners of such diseases yet Blewett did not recall the intervention of the Australian Medical Association (AMA)

¹⁵⁴ *ibid.* p4.

¹⁵⁵ *ibid.*

¹⁵⁶ *ibid.* p6.

¹⁵⁷ *ibid.*

into the HIV/AIDS debate until 1989.¹⁵⁸ Similarly, state governments did not claim ownership.¹⁵⁹

Because of the secular and religious passions that seethed around AIDS, the disease added an ideological dimension to a portfolio that was already an administrative nightmare. In such an ideological maelstrom ministers could easily drown.¹⁶⁰

The illegal status of homosexuality in three Australian jurisdictions and the general prohibition of injecting drug use further added to State Government inertia. Homosexuality and injecting drug use were two main routes of HIV/AIDS transmission, and as such, their illegal status (only some states had decriminalised homosexual sex by this time) complicated efforts to address the disease. Blewett argued that exaggerated future estimates of expenditure required to contain HIV/AIDS was the main factor contributing to the "...uncharacteristic readiness to cede health turf to the Commonwealth".¹⁶¹ Further, the already strained health budgets of the states made them open to fiscal involvement and leadership of the Federal Government. Moreover, by 1984 four of the six state Governments were Australian Labor Party (ALP) run and had expectations that the ALP-led Australian Government (formerly known as 'Commonwealth Government') would assist with the burden of HIV/AIDS. Blewett argued that the "...Commonwealth emerged as the chief owner of the disease between the summer of 1984 and the winter of

¹⁵⁸ "The bulk of the medical profession was little touched by AIDS and a significant minority not particularly well informed; indeed governments probably underestimated the need for education within the medical profession. As late as 1989 a survey of [general practitioners] found that 25 per cent did not want to treat AIDS patients; 20 per cent feared infection from giving treatment; and 33 per cent could not provide adequate answers on how to inhibit the spread of the disease", *ibid*, p7.

¹⁵⁹ "...the bureaucratic owners of disease in our society are primarily the state administrators. While the states are usually pugnacious defenders of their constitutional of their constitutional allocations, they were uncharacteristically unpossessive about AIDS." *ibid*.

¹⁶⁰ *ibid*.

¹⁶¹ *ibid*, p8.

1985...”¹⁶² and moreover, that the Queensland baby transfusion cases occurred on the eve of the 1984 federal election further contributed to the Australian Government taking the leadership role.¹⁶³

According to Wodak, that Blewett had a strong civil libertarian background and had some key advisors that were personally affected by HIV/AIDS affected the course taken.¹⁶⁴ Blewett’s personal opinions on HIV/AIDS policy were formed on a visit to the United States whereby he identified two approaches: the California cooperative approach and the New York public health approach.

The [California cooperative approach] was characterised by a partnership between the medical profession and the affected communities, with as great an emphasis placed on education as on medical control, with the integration of the gay community into both public health campaigns and aspects of service delivery. By contrast, the New York model placed greater emphasis on medical control and dominance, and ascribed a lesser role to the affected communities.¹⁶⁵

Blewett recounted that he preferred the former ‘cooperative’ style approach adopted by Californian governments.¹⁶⁶ Ballard argued that by the time HIV/AIDS had reached Australia there was already a mobilised community that had been engaging in health promotion activities to those most affected by HIV/AIDS. Well mobilised homosexual communities were the products of recent legislative battles over decriminalisation. Countries such as France had their HIV/AIDS policy responses inhibited due to not having such organised groups.¹⁶⁷ Ballard argued that both these

¹⁶² *ibid*, p9.

¹⁶³ *ibid*.

¹⁶⁴ Wodak, A, 1992, ‘HIV Infection and injecting drug use in Australia: responding to a crisis’, *The Journal of Drug Issues*, 22:3, p556.

¹⁶⁵ Blewett, N., 2003, *Aids in Australia: Reflections on Australia’s policy response to the AIDS Epidemic*, Australian Health Policy Institute, University of Sydney, p9.

¹⁶⁶ *ibid*, p9.

¹⁶⁷ John Ballard quoted in *ibid*, p37.

factors were essential and prerequisites for the approach Australia took, and which were absent elsewhere.¹⁶⁸ Victoria, South Australia and Western Australia, led by ALP state governments, pursued the cooperative inclusive approach working closely with affected communities.¹⁶⁹ In contrast Queensland (under National Party Premier Joh Bjelke-Peterson) pursued a more conservative approach:

Queensland baulked at everything that the Commonwealth encouraged. There was no cooperation with the gay organisations as they were composed of illegals. There was little state education of at-risk groups on the grounds that it would encourage deviant behaviour. Indeed there was minimal emphasis on education particularly for young people, and what existed was often farcical. When AIDS education was at last permitted in Queensland schools—in April 1987—the Education Minister instructed teachers that the program would not include any sex education. ‘If a student asked what sexual intercourse was the teacher should refer the student to a medical practitioner or health expert’. All best efforts were made to keep condoms out of the hands of the masses so that when Queensland university students—in defiance of a ban—installed condom vending machines the state police ripped them out.¹⁷⁰

Thus the approach taken by Queensland did not include the involvement of affected communities nor frank messages about sexual behaviour in contrast to the approach undertaken in jurisdictions such as the Australian Capital Territory:

Funding was provided for the production of safe-sex materials that drew on the real life experience of gay men and other ‘at risk’ communities and spoke their language. While the new educational programs adopted traditional health promotion techniques such as pamphlets and posters, the materials were shaped in radical and arresting ways. Educational messages were delivered in images, style, language and meaning which communicated directly in the everyday language of the street, of bars, of saunas and backrooms. The clinical phrases of medical practitioners were put aside; so too was the traditional politeness of

¹⁶⁸ John Ballard quoted in *ibid*, p37-8.

¹⁶⁹ *ibid*, p9.

¹⁷⁰ *ibid*, p10.

public discourse. In words and images, posters, booklets, bumper stickers and t-shirts all dealt frankly with, for example, the dimensions of gay sexual experience or the realities of drug use. The language was direct, the meaning unambiguous. As one activist put it, 'an arse was an arse and a fuck was a fuck.'¹⁷¹

Such frankness would be echoed in the types of publications produced by self-help drug user groups since their instigation in the late 1980s and onwards.¹⁷² Indeed, it was evident that such parameters of HIV/AIDS policy were duplicated in illicit drug policy due to the overlap between issues of injecting drug use and HIV/AIDS which would result in affected communities (drug users) becoming involved in policy making.

A key strategy employed by harm reduction advocates was the notion of a 'second aids epidemic' best articulated in a paper entitled *Intravenous Drug Use and the Aids Epidemic* presented to the National Health and Medical Research Council in 1988.

The spread of AIDS in the intravenous drug user (IVDU) population has been described as the second AIDS epidemic, the first being in the homosexual/bisexual population. The critical factors which determine the spread of AIDS in IVDU are the sharing of needles and syringes, and to a lesser extent sexual contact. IVDU come from all classes of society and many continue to function, uninterruptedly as (otherwise) normal community members. Because of this, the most likely pathway by which HIV infection will spread to the general community is by heterosexual intercourse with infected IVDU, with a later secondary spread between non drug users. Although AIDS will cause many deaths amongst IVDU within the next ten years, of even greater importance is the fact that the spread of AIDS among IVDU represents a major threat

¹⁷¹ Thompson, J., 'There isn't room for ambiguity', accessed from Aids Action Council website: http://www.aidsaction.org.au/content/events/reflections/there_isnt_room_for_ambiguity.php, accessed on 2/5/06.

¹⁷² For more information on this type of education see the website of the Australian Illicit Drug Users League at <http://www.aivl.org.au>.

to the health and lives of the general heterosexual community that does not use illicit drugs.¹⁷³

This notion of a 'second aids epidemic' in injecting drug users changed the nature of the illicit drug 'problem' from one that only largely affected drug-using people and their family and friends, to one that had the potential to affect the public health of the mainstream population. Indeed, this was a key development that changed the nature of the problem area. Such a reconfiguration of the drug problem meant that Governments had to change the way their agencies responded to the phenomena of injecting drug use. As well as this change to the problem area was a sense of urgency to enact policy to limit transmission pathways from injecting drug users to the general population. Blewett reinforced the importance of the notion of a 'second AIDS epidemic' as a compelling argument that generated policy change.

In the period 1987-88 virtually every developed nation shifted its public emphasis from the high risk groups to the community more generally. And the reason for this shift was the accumulating and disturbing evidence of heterosexual transmission in sub-Saharan Africa, highlighted internationally by the Second International AIDS Conference in Paris in mid-1986.¹⁷⁴

The threat of mainstream infection was enough to induce rapid policy change in a number of countries around this time. McCallum recalled that this fear of HIV/AIDS affecting the general community was combined with the notion that the optimal way to shape the behaviour of marginalised communities was through their own organisations, lead to increased investment into community organisations.¹⁷⁵

¹⁷³ Drew, L., & Taylor, V., 1988, *Intravenous Drug Use and the Aids Epidemic*, Paper presented to the National Health and Medical Research Council, p1.

¹⁷⁴ Blewett, N., 2003, *Aids in Australia: Reflections on Australia's policy response to the AIDS Epidemic*, Australian Health Policy Institute, University of Sydney, p18.

¹⁷⁵ *ibid*, p33.

If there was single imperative driving government policy it was the determination to resolve this dilemma between community and individual by winning the confidence and the cooperation of the affected individuals for policies that would ensure community monitoring and assessment of the disease.¹⁷⁶

This meant that grassroots workers and affected community members (predominantly gay men and injecting drug users) could have input into policy in the development and implementation stages. This astute positioning of affected community members in policy roundtables generated further legitimacy for harm reduction strategies as such programs were endorsed by these groups as pragmatic and appropriate policy approaches to address HIV/AIDS transmission. Moreover, a focus on gathering sensitive qualitative data (on highly personal sexual and drug using practices) meant that the cooperation of affected communities was seen to be critical to the processes involved in the production of policy evaluation and disease trends. Gathering of such information was regarded as best achieved through involvement of these communities in the policy process. The expansion of self-help user groups meant that some drug users could also participate in policy making. Lou McCallum, a gay community advocate who was present at the time of this partnership between medical and community interests, recalls the positive role of peer involvement in policy:

We could quickly translate complex policy issues into clear information for our communities (not just gay but intravenous drug user, sex worker and people living with HIV groups) and could communicate their views quickly back to government.¹⁷⁷

Another factor that influenced the direction taken by Blewett was a wish to avoid the partisan political debates as had taken place in the USA regarding the more

¹⁷⁶ *ibid*, p16.

¹⁷⁷ Lou McCallum quoted in *ibid*, p31.

controversial dimensions presented by the policy problem of HIV/AIDS. Blewett wished to avoid the anger that Reagan had attracted over his inactivity towards the disease and so subsequently courted key Liberal members to partake in an all party parliamentary liaison committee on HIV/AIDS, instigated in 1985.¹⁷⁸ Further, that the committee was dominated by opposition members including Senator Brian Harradine (a well known conservative moralist) meant that moral concerns about the direction of Government policy were dealt with in this committee rather than in the public arena. The committee was regularly updated by national and international HIV/AIDS experts and acted as a sounding board for policies and concerns.¹⁷⁹ Blewett argues that the consequence of this approach was elite and partisan consensus on policy.¹⁸⁰ Although there were some minor rhetorical flourishes against the direction of HIV/AIDS policy within this committee, consensus at the elite level meant that these flourishes were contained and without influence. Ballard concludes by noting that Blewett created the conditions under which innovation could occur, and also he drew legitimation for his approach from community and state initiatives.¹⁸¹

These changes to both drug and HIV/AIDS policy in the mid 1980s did not automatically lead to swift implementation of harm reduction programs such as NSPs, however. In 1986, the first NSP in Australia began as an unsanctioned program, initiated by grassroots workers and situated in Sydney which at the time was the heartland of the gay community and which also had many injecting drug users:

¹⁷⁸ *ibid*, p9.

¹⁷⁹ *ibid*, p19.

¹⁸⁰ *ibid*.

¹⁸¹ John Ballard quoted in *ibid*, p38.

The opening of a pilot needle syringe scheme in November 1986 by a group of Sydney alcohol and drug workers, frustrated by the slow pace of developments at that time, marked a turning point. Advisory committees had agonised for some time about taking this seemingly momentous first step and how to best monitor and evaluate the effectiveness of such programmes. Although this pilot programme breached recently proclaimed legislation, no police action was taken following decisions taken at a senior level. In December 1986 the New South Wales Department of Health, having only recently opposed a recommendation to increase the availability of sterile needles and syringes, announced the introduction of a needle and syringe distribution scheme through retail pharmacies. Within a few years, all major jurisdictions in Australia had started distribution or exchange of sterile needles and syringes.¹⁸²

Thus the opening of the first NSP in Australia was by workers at Sydney's St Vincent's Hospital who were at the frontline of the HIV/AIDS crisis and refused to wait until the Government had finalised arrangements to open the program.

The link between HIV/AIDS and injecting drug use, encapsulated in the idea of a 'second aids epidemic', was instrumental in securing a number of developments in the period 1985-1990. Wodak¹⁸³ recalls the explosion of harm reduction policy-making to curb HIV/AIDS in Australia in the mid to late 1980s that included:

- a reorientation of the role of alcohol and other drug workers from a focus on obtaining abstinence towards a general focus on prevention of HIV/AIDS infection. This included harm reduction education about virus transmission routes and safe sex practices;
- harm reduction policy options such as NSPs eventually being adopted due to the perceived link between injecting drug use and HIV transmission;

¹⁸² Wodak, A, 1992, 'HIV infection and drug use in Australia', *The Journal of Drug Issues*, 22:3, p552.

¹⁸³ *ibid*, p554.

- funding of self-help user organisations that provided peer education, implemented prevention strategies and advocated for HIV/AIDS infected drug users; and,
- the introduction of HIV prevention measures in sex work environments.

The link between HIV/AIDS and harm reduction policy in Australian drug policy became enshrined in this time with NSPs and self-help groups¹⁸⁴ regarded as effective mechanisms to affect behaviour change in injecting drug users. Moreover, following the NCADA, MMT was expanded¹⁸⁵ to allow for admission of HIV/AIDS infected drug users. Entrance criteria were relaxed so to allow instant inclusion of those injecting drug users with HIV/AIDS.¹⁸⁶ Wodak noted:

Although only a few [injecting drug users] were admitted initially on the grounds of HIV infection alone the change in policy was indicative of a new and pragmatic mood... by 1990 over eight thousand [injecting drug users] were in methadone maintenance treatment programmes in the six most populous of the eight jurisdictions in Australia...[t]he capacity of the methadone programmes throughout the country was expanded more than sixfold in eight years...¹⁸⁷

Ultimately it took the threat of widespread disease in the general community before governments would eventually enshrine harm reduction into illicit drug policy. Such a policy approach was deemed “enlightened pragmatism”¹⁸⁸ and was previously

¹⁸⁴ Self help user groups had evolved in different ways in Victoria, New South Wales and Queensland in the late 1980s. In some cases, some groups had existed before the threat of HIV/AIDS. The Victorian Intravenous AIDS Group (VIVAIDS) formed in 1987, New South Wales Users and AIDS Organisation (NUAA) formed in 1987 and Queensland Intravenous AIDS Association (QuIVAA) formed in 1988. For more information on the evolution of such groups see Crofts, N, 1993, ‘A History of Peer-Based Drug-User Groups in Australia, *Journal of Drug Issues*, 25, pp599-616.

¹⁸⁵ *ibid*, p550.

¹⁸⁶ *ibid*, p553.

¹⁸⁷ *ibid*, p553.

¹⁸⁸ Commonwealth Department of Health and Human Services, 1996, *Partnerships in Practice: National HIV/AIDS Strategy 1996-7 to 1998-99*, AGPS, foreword.

unseen in drug policy (bar MMT). In this sense, the prevention of HIV/AIDS infection was seen as the greater priority than the eradication of drug use.

National HIV/AIDS Strategy 1989

Australia produced its first National HIV/AIDS strategy in 1989. This was the first national strategy that explicitly supported harm reduction programs.

Transmission of HIV is preventable, and behaviour change through education is the principal means of preventing the spread of the virus. Prevention programs, such as the distribution and disposal of sterile needles, have been introduced to complement education campaigns...The major aim of HIV prevention programs for [intravenous] drug users is to eliminate transmission of the virus. Because of the immediate threat of HIV transmission within this group, preventative programs have been introduced which include needle distribution and disposal and information about needle cleaning, safer sex practices and perinatal transmission.¹⁸⁹

Harm reduction policies were regarded as critical to restricting the spread of HIV/AIDS among injecting drug users. Moreover, the policy also reinforced the key role of self-help and peer education programs in stemming HIV transmission through encouragement of safer injecting drug use practices.¹⁹⁰ This document also placed harm reduction strategies in the context of the NCADA:

Promoting abstinence from drug use is the Government's primary aim in initiatives such as the National Campaign Against Drug Abuse. This is a goal which may only be achieved in the long term and must be complemented by other strategies to reduce transmission of HIV amongst [intravenous] drug users.¹⁹¹

¹⁸⁹ Commonwealth of Australia, 1989, *National HIV/AIDS Strategy*, AGPS, Canberra, p10.

¹⁹⁰ *ibid*, p98.

¹⁹¹ *ibid*, p30.

It was clear that harm reduction's place within illicit drug policy was as a mechanism to prevent the spread of HIV/AIDS rather than a strategy to address drug use per se. Safer education was also aimed at those who continued to use about the dangers of sharing equipment and unsafe sexual practices.¹⁹² This document also advocated for instigation of NSPs in every state and territory and in both urban and rural settings.¹⁹³ Moreover, the incorporation of the harm reduction ethos into drug treatment services was also advocated by the 1989 HIV/AIDS policy.

As well as existing drug treatment programs, models will be developed, including the expansion of oral methadone programs, which promote harm reduction rather than abstinence as the cornerstone of treatment.¹⁹⁴

In sum, HIV/AIDS and its link to injecting drug use continued to be the strategy used by the harm reduction coalition in the period following the release of the NCADA to 1990. Indeed, the period 1985 to 1990 was a highly successful period for advocates of harm reduction.

The 1989 NCADA Evaluation

In 1989 an evaluation of the NCADA was published.¹⁹⁵ This document sought to provide future direction for drug policy in Australia and was endorsed by the Ministerial Council on Drug Strategy (MCDS), the peak advisory body to Government. A task force on evaluation of the NCADA was chosen by the MCDS and consisted of representatives from state and territory health authorities, one from

¹⁹² *ibid*, p30.

¹⁹³ *ibid*, p95.

¹⁹⁴ *ibid*, p44.

¹⁹⁵ Commonwealth of Australia, 1989, *The National Campaign Against Drug Abuse 1985-88: Evaluation and future directions*, AGPS, Canberra.

Federal Government, one member from a large scale community based organisation and one with specialist research interests in the field.¹⁹⁶

There were two common themes throughout the document that reflected further incorporation of harm reduction concepts into illicit drug policy. First, there were eight mentions of the link between the transmission of HIV and injecting drug use (the 1985 NCADA did not mention harm reduction nor HIV/AIDS), highlighting how integrated the issue of HIV/AIDS had become in the drug policy subsystem. Moreover, the containment of HIV/AIDS transmission through intravenous drug use was considered a "...high and immediate priority..."¹⁹⁷ through such measures as enhanced treatment options, training of drug workers on HIV/AIDS and safer injection practices, and most notably, the advocacy of increased availability of sterile injecting equipment.¹⁹⁸

Perhaps the single most important change of recent years in the context of drug policy is the emergence of AIDS as a major public health issue in Australia and overseas, and the role of unsafe injecting practice in the spread of the AIDS virus.¹⁹⁹

In addition to alcohol and tobacco consumption, intravenous drug use must be given high priority during the next three years. Evidence on the transmission of the AIDS virus through shared needles and syringes shows that intravenous drug users face serious health risk, and in turn pose a risk to non-using population via perinatal and sexual transmission. A strong and immediate response aimed at minimising the harmful effects of intravenous use of drugs is required.²⁰⁰

¹⁹⁶ *ibid*, p7.

¹⁹⁷ *ibid*, p20.

¹⁹⁸ *ibid*, p21.

¹⁹⁹ *ibid*, p23.

²⁰⁰ *ibid*, p28.

As stated above, the document advocated immediate action to stop the potential spread of HIV into the mainstream population. It further reinforced the notion of a 'second aids epidemic' in injecting drug users and the way that this group could act as a bridge to transmit HIV/AIDS to the mainstream heterosexual population. The document implied the necessity of immediate action to curb transmission pathways, and noted if HIV/AIDS was not quickly addressed, transmission rates would grow exponentially in the future.²⁰¹ Moreover, the document explicitly stated that the nature of the drug debate had changed as the prevention of problems and drug related harm had become a legitimate strategy used in concert with those policies that advocated abstinence.²⁰² Thus, HIV was a major impetus and justification of harm reduction practice through its perceived link with injecting drug use and the potential for transmission to the mainstream.

The second factor in the document that suggested that harm reduction programs had gained legitimacy in public policy was a redefinition of harm minimisation or 'drug related harm' more specifically. In the NCADA, drug related harm was seen to be achieved through reduction in supply of drugs into the community and also through demand reduction initiatives such as anti-drug education as well as MMT and other treatment. In the evaluation report, the minimisation of drug related harm included "...preventive education and preventive health measures, early intervention strategies, the treatment and rehabilitation of drug dependent people and the problem prevention approach to drug issues."²⁰³ Public education measures aimed to delay the uptake of drug use by young people and also to *promote safe levels* and methods of use in relation to all drugs. Early intervention approaches sought to assist those at risk of problematic drug use to *modify* their intake before the entrenchment of use

²⁰¹ *ibid*, p32.

²⁰² *ibid*, p36.

²⁰³ *ibid*, p37.

occurs. Such approaches reflected the incorporation of harm reduction ideas in which users of both licit and illicit drugs are educated about how to reduce harm rather than encouraged to stop using substances. The third and most notable element of minimisation of harm was the ‘problem prevention’ approach:

This approach acknowledges that use of both legal and illegal drugs is entrenched in most societies, and will never be completely eradicated. Reduction of drug use will always be an important component of a comprehensive strategy. However, the problem prevention approach points to a range of strategies which, while not necessarily doing anything to decrease drug use, do decrease the likelihood of harm resulting from that use... Examples in the illegal drug arena would include teaching safer injection practices, encouraging intravenous drug users to adopt safer sexual practices and changing the legal status of relevant drugs.²⁰⁴

By 1989, the impact of the HIV/AIDS virus on drug policy was evident through the change in discourse from a focus on demand and supply reduction to one that also included numerous references to the link between HIV/AIDS and injecting drug use and a reorientation of the definition of harm minimisation as one that also included strategies for people that continued to use drugs. Indeed, in the period between 1980 and 1990, harm reduction ideas became more palatable to Governments due to the threat of HIV/AIDS and the careful stewardship of Blewett of the HIV/AIDS issue.

Explaining Illicit Drug Policy Change Through the Advocacy

Coalition Framework

This final section employs the ACF to explain change in illicit drug policy in Australia in the period 1980-1990. The instigation of Australia’s first national drug

²⁰⁴ *ibid*, p38.

strategy signified a major change in policy as a partnership between health and law enforcement sectors was enshrined in policy under the notion of ‘harm minimisation’. As mentioned earlier the NCADA meant increased interaction between the two sectors in the management of illicit drug policy. Also, the instigation of NSPs and education that included frank safer injecting messages, self-help drug user groups across Australia and the expansion of MMT places were all changes to Government policy. Drawing on Table 1, this section will now address key points of the ACF and assess their utility in explaining change.

ACF Concepts 1 & 2: Advocacy coalitions and policy core beliefs

Sabatier’s description of advocacy coalitions is a useful construct to describe actors in a subsystem who share a set of common and reasonably well-defined policy objectives. In the period 1980 to 1990, a coalition of actors from medical backgrounds, alcohol and other drugs workers, grassroots community workers, the gay community, drug users and key members of the bureaucracy and executive government supported and advocated for policies and programs such as NSPs and safer injecting drug use education, self-help drug user groups and expansion of MMT. Coalition members were united in their belief in the general ethos of harm reduction policies and programs: being a focus on ameliorating adverse health, social and economic consequences associated with use of illicit drugs. Another policy core notion identified was the link between the issue of HIV/AIDS and injecting drug use (in particular the ‘second AIDS epidemic’) and the possibility of a secondary epidemic of HIV/AIDS in the mainstream population. Indeed, there was an identifiable cluster of actors around these ideas that aimed to have their beliefs manifested in policy. The harm reduction coalition’s ‘policy core’ ideas represented

a distinctive departure from traditional approaches that focused on promoting abstinence through supply reduction and anti-drug education. As per Table 1 the second hypothesis of the ACF was supported, namely that there was a group of actors that displayed consensus on issues pertaining to the policy core.

In the ACF, it is proposed that all coalition members would agree on the policies stated above and the general ethos regarding the worth of policies and programs that reduce the harm for those that continue to use. However, given the diverse nature of coalition members perhaps not all would agree on *deep core* beliefs such as:

Harm Reduction accepts that some use of mind altering substances is inevitable, and that some level of drug use is normal in a society.²⁰⁵

It is argued that some in the coalition may indeed see the value of NSPs inextricably linked to the reduction of HIV transmission alone, rather than as a response to drug use per se. It is a matter of conjecture as to how coalition members might have conceptualised harm reduction in the absence of HIV/AIDS. It is entirely possible and quite probable that members of the harm reduction coalition would have different views on such broader questions as: the inevitability of drug use in society; the capacity of law enforcement to curb the activity and the morality of interventions such as safer sex or safer drug using information.

ACF Concept 3: Guidance instruments

The concept of 'guidance instruments' was another useful construct in this analysis. Guidance instruments referred to the ways in which coalitions used changes in rules,

²⁰⁵ Riley, D., & O'Hare, P., 'Harm Reduction: History, Definition and Practice', *Harm Reduction: National and International Perspectives*, Sage, California, p6.

budgets, or information as mechanisms to realise policy objectives.²⁰⁶ The chief guidance instrument employed by the harm reduction coalition was using the notion of a 'second AIDS epidemic' to reinforce the need for harm reduction policies and programs. With regard to Sabatier's taxonomy of guidance instruments the use of the 'second aids epidemic' qualified as using research and information exchange to alter the perceptions of the problem. By broadening the likely impact of a disease from marginalised communities to affecting the mainstream population meant added concern and urgency to policy responses. As mentioned earlier, this occurred concurrently in many states around the world. The work of Stone provides further insight into this technique:

There are several strategies by which groups define issues so as to make a sectional interest appear general... to transform what appear to be narrow interests into broader ones...immediate short term interests are portrayed as long-run interests.²⁰⁷

In other words, the problem was redefined to one that now *required* harm reduction programs to be instituted so to protect the mainstream population. In this sense injecting drug use was now portrayed as an issue that affected many more people than previously thought. This strategic representation of harm reduction, as possessing benefits for the wider community, mobilised support for such programs.

It can also be argued that Blewett's initiation of parliamentary committees consisting of partisan membership and input from health experts around the issue of HIV/AIDS was a type of 'guidance strategy'. The use of these structures facilitated conflict resolution and problem solving in arenas that were away from the media and the

²⁰⁶ Jenkins-Smith, H & Sabatier, P, 1994, 'Evaluating the Advocacy Coalition Framework', *Journal of Public Policy*, 14:2, p104

²⁰⁷ Stone, D., 1988. 'Interests', *Policy, Paradox and Political Reason*, Scott, Foresman and Company, USA, p183.

public more generally. Ultimately, this resulted in an impression of elite partisan consensus on the issue. This was particularly important due to the inherently controversial nature of HIV/AIDS and associated harm reduction measures. Ultimately, the minor rhetorical flourishes of Australian conservative politicians were without influence partly due to the presence of these committees that resolved issues before they reached the public arena. Another way that the coalition used the notion of a 'second aids epidemic' to affect policy was related to the approach Australia took with HIV/AIDS, whereby affected communities were engaged and involved in policy development and implementation so to reduce transmission of HIV/AIDS.

Both these guidance instruments contributed to the adoption of harm reduction programs following the NCADA. Both these instruments can be classified as “trying to gradually alter the perception of a variety of actors through research and information exchange”²⁰⁸ in the current schema of guidance instruments (see Table 1). However it is suggested that Blewett’s parliamentary committee process was an intensive, face-to-face version of information exchange that also acted as a forum in which questions could be answered directly and problems solved collaboratively. Such a process is distinct from other more indirect forms of information exchange such as parliamentary debate, media releases or research published in scholarly journals. The language in the NCADA evaluation report published in 1989 reflected the change to drug policy between 1985 to 1989 and reiterated the link between HIV/AIDS and injecting drug use. Furthermore, the authors of the report also sought to broaden the definition of harm minimisation (beyond supply and demand reduction) to include harm reduction policies and programs.

²⁰⁸ Sabatier, P., & Jenkins Smith, H., 1993, 'The Advocacy Coalition Framework: An Assessment', *Policy Change and Learning: An Advocacy Coalition Approach*, Westview Press, San Francisco, p142.

ACF Concept 4: Policy brokers in strategic positions

In the ACF it is theorised that there is a group of actors that represent the Government called 'policy brokers' who are responsible for receiving conflicting strategies, limiting conflict and reaching compromise between coalitions when making public policy.²⁰⁹ From this analysis it is clear that bureaucrats such as Les Drew and Neal Blewett personally supported harm reduction programs and thus played a significant role in achieving change to illicit drug policy. It seems reasonable to suggest that these two individuals could easily be classified as members of the harm reduction coalition. The positions of both Les Drew in the bureaucracy and Neal Blewett in the political executive were crucial to the outcomes in drug policy in the late 1980s. While the ACF did allow for agency officials to be members of coalitions, and indeed possessing the capacity to hold policy beliefs and engage in a non trivial degree of coordinated activity over time, it also posited that:

Conflicting strategies from various coalitions are normally mediated by a third group of actors, here termed 'policy brokers', whose principal concern is to find some reasonable compromise that will reduce intense conflict.²¹⁰

Les Drew took a key role in the drafting of the NCADA and indeed had written several articles around that time advocating harm reduction strategies. Similarly, Neal Blewett as Federal Health Minister was a key member of the harm reduction coalition and likewise advocated harm reduction type approaches as outlined earlier.

²⁰⁹ Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe', *Journal of European Public Policy*, 5:1, March, p104.

²¹⁰ Jenkins-Smith, H & Sabatier, P, 1994, 'Evaluating the Advocacy Coalition Framework', *Journal of Public Policy*, 14:2, p104.

It would be unwise to classify both as either coalition members or policy brokers exclusively, as both occupied dual roles.

ACF Concept 9: Conditions of ‘major’ policy change?

As described in Chapter Two, under the ACF, major policy change is seen as the result of either an exogenous shock to the subsystem, replacement of one dominant coalition by another, the result of a hierarchically superior unit of government changing policy of a subordinate level and/or a situation whereby all major coalitions agree that perpetuation of the current situation is unacceptable.²¹¹ In the latter a compromise may be sought that is viewed by all coalitions as superior than the status quo.

It was clear that the change to harm minimisation as an overarching goal of illicit drug policy in 1985 qualified as ‘major’. The scope of this change was sector wide with the concept applying to all aspects of drug policy, however the policy mix was still dominated by supply reduction initiatives as it was previous to the instigation of the NCADA. This shift to using the term ‘harm minimisation’ did not signify that the underlying philosophy of Australia’s illicit drug policy had moved away from prohibition. Rather, the concept of ‘harm minimisation’ was seen to *include* supply and demand reduction policies. Thus in this context, the concept of harm minimisation was entirely distinct from that of harm reduction which refers to specific services that reduce harm for those that continue to use. Arguably the greatest change from the instigation of the NCADA came from the amalgam of health and law enforcement sectors in several national drug policy committees and

²¹¹ *ibid*, p119.

groups. Under the NCADA (and subsequent strategies) both sectors would share roles and be represented in such peak groups. HIV/AIDS had left an indelible mark on drug policy, evident by the late 1980s in the HIV/AIDS National Strategy and, moreover, the NCADA evaluation document emphasised this link later in the decade. As such the change to harm minimisation was a 'major' change in drug policy but did not signify a shift to the inclusion of harm reduction ideas (MMT the exception) in illicit drug policy.

'Major' policy change is theorised to be precipitated by some kind of 'external shock' to the policy subsystem. Changes to socio economic conditions, public opinion, system wide governing coalitions or policy outputs from other subsystems are theorised in the ACF as being a *necessary but not sufficient* cause of major change (see Table 1).²¹² Several factors related to those categories contributed to major policy change characterised in the NCADA: a general consensus (from Royal Commission authors, the medical community and reflected in the media more generally) that continuation of the status quo was unacceptable, elections of several ALP state and federal governments and the advent of managerialist practices in Australian bureaucracy.

Firstly in late 1970s, elite (in the numerous Royal Commissions and Inquiries that were established in this period) and mainstream concern that the traditional model of drug policy had proved inadequate, coupled with a perception of rising rates of problematic drug use and organised crime, meant that there was a growing consensus that a new approach to drug policy was required. This provided an opportunity for all stakeholders to advance options to policy brokers.

²¹² Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe' *Journal of European Public Policy*, 5:1, March, p106.

Secondly, and perhaps the most significant of all external shocks to the drug policy subsystem, was the election of the Federal Hawke Labour Government in 1984. This was articulated in the ACF as a 'change in systemic governing coalitions'. This change was further enhanced by the election of state ALP governments that facilitated coordination and cooperation between levels of governments. As drug policy is largely the concern of state governments, the Federal Government worked closely with, and gained agreement from, equivalent ministers from other jurisdictions both in the developmental and implementation stage. Les Drew stated that he was able to approach Prime Minister Hawke with the draft of the NCADA that already had agreement of many of his state counterparts. As stated earlier, Neal Blewett recounted how states with ALP Governments implemented HIV/AIDS policies characterised by cooperation with affected communities. In contrast, the Queensland State Government pursued a different process characterised by a top-down approach that resulted in further stigmatisation of the gay community and injecting drug users. That the Governments of New South Wales, Victoria, Western Australian and South Australia pursued the cooperative model in response to HIV/AIDS meant that ideas associated with harm reduction were able to flourish through closer participation of affected communities in the policy process. Moreover, Neal Blewett was highly instrumental in the content and nature of HIV/AIDS policy that, as the chapter has argued earlier, was a key contributing factor to the implementation of harm reduction policy later in the decade. In sum, Blewett would not have been charged with this role if the ALP were not elected in 1984 and moreover, nor might the cooperative style of policy making have existed across multiple jurisdictions. The overlap between the issues of HIV/AIDS and

problematic injecting drug use lead to the parameters of the former being duplicated in the policy directed toward the latter.

A third external shock to the subsystem was the advent of 'managerialism' in the Australian bureaucracy in the late 1980s.²¹³ Managerialism or 'new public management' (NPM) was a new approach to governance adopted by Australia and many other states including the United Kingdom²¹⁴ and the United States²¹⁵ with the view of reforming the practice of the public sector in the 1980s and 1990s. Key goals in this process were greater efficiency, effectiveness and economy in the production and delivery of publicly provided goods and services as well as greater accountability on public officials to deliver prescribed outcomes.

Hood²¹⁶ identified NPM as comprising of seven main points including: discretionary and active control of organisations by managers ('letting the managers manage'); implementation of performance measurement standards and tools; a greater emphasis on output controls whereby resources are directed to areas according to performance; disaggregation of large departments into corporatised units around specific product areas, funded separately and "dealing with each other on an arm's-length basis"²¹⁷; introducing the concept of competition in the public sector through the employment of contracts and public tendering processes; using private sector styles of management practice through such principles as flexibility in hiring and rewards; and finally engendering greater discipline and parsimony in resource use. Other

²¹³ Hughes, O., 1994, *Public Management and Administration*, Macmillan, Great Britain, p4.

²¹⁴ Horton, S., 1999, 'The Civil Service' in S Horton & D Farnham (eds), *Public Management in Britain*, Macmillan, Basingstoke, p145.

²¹⁵ Osborne, D & Gaebler, T, 1992, *Reinventing Government: How the entrepreneurial Spirit is Transforming the Public Sector*, Addison-Wesley, Reading.

²¹⁶ Hood, C., 1991, 'A public management for all seasons?', *Public Administration*, 69, 1, pp3-19.

²¹⁷ *Ibid*, pp-4-5.

formulations of NPM have been offered,²¹⁸ the key points being similar to the above formulated by Hood.

In the ACF, the advent of NPM qualified as a 'policy decision' or impact from another subsystem. It is argued that propositions inherent in NPM (specifically the performance measurement focus, focus on outcomes and tendering of public services) were compatible with the principles of harm reduction. In contrast to supply reduction, a key principle of harm reduction policy involved the employment of a pragmatic process of identification, measurement and assessment of the relative importance of drug related problems, their associated harms and benefits/costs of intervention so as to focus policy priorities. This then facilitated the production of criteria or targets that could be used for evaluation purposes. The emphasis on demonstration of outputs provided evidence of the level of demand for such services. That harm reduction services were also proven to be highly cost effective in terms of savings on the public health budget, created a rationale for attracting further resources. As harm reduction policies are particularly cost effective,²¹⁹ this focus on evidence-based policy which was evident in the NCADA evaluation document²²⁰ as well as the focus on outcomes only served to strengthen the legitimacy of harm reduction programs then and into the future.

²¹⁸ For example: Holmes, M & Shand, D., 1995, 'Management Reform: Some Practitioner Perspectives on the Past Ten Years', *Governance*, 8:5, p555; Pollit, C, 2001, 'Clarifying convergence: Striking similarities and durable differences in public management reform', *Public Management Review*, 56:2, p473-4; Osborne, D & Gaebler, T, 1992, *Reinventing Government: How the entrepreneurial Spirit is Transforming the Public Sector*, Addison-Wesley, Reading; and Hughes, O., 1994, *Public Management and Administration*, Macmillan, Great Britain.

²¹⁹ Commonwealth Department of Health and Ageing, 2002, Return on investment in needle and syringe programs in Australia, Department of Health and Ageing, Canberra, Available at: <http://www.health.gov.au/pubhlth/publicat/hac.htm> (accessed Jun 2004).

²²⁰ Commonwealth of Australia, 1989, *The National Campaign Against Drug Abuse 1985-88: Evaluation and future directions*, AGPS, Canberra, p35.

Additionally, this new approach emphasised accountability of officials and programs through outcome evaluation processes and such an agenda arguably might have allowed program managers greater ability to drive policy than before the instigation of NPM practices. Finally, tendering of illicit drug services to non government organisations and medical/research agencies also meant a greater employment of harm reduction goals in most instances as such groups constituted part of the core membership of the harm reduction coalition.

ACF Concept 10: How did major policy change occur?

Sabatier hypothesised that changes to policy core of a government program will not be significantly revised while the subsystem advocacy coalition that instigated the program remains in power, except in cases where change is imposed from a hierarchically superior jurisdiction. In the cases of the instigation of the NCADA and also of harm reduction programs such as NSPs, self-help drug user groups and the involvement of affected communities in policy, the latter explanation of hierarchical imposition of policy was accurate as all these changes were instigated by the Federal Government, albeit, in conjunction with largely cooperative State Government authorities.

The Federal Government took the lead in regard to HIV policy. As discussed in this chapter, the states were reluctant to own the issue area of HIV/AIDS, so the Federal Government was endowed with a 'blank slate' accompanied by relative cooperation of four ALP state Governments. Wodak argued that the federal structure of Government in Australia has facilitated change.

When relatively enlightened states introduced controversial policies such as needle and syringe exchange, more conservative states were drawn along, albeit at a slower pace. The number and range of responsible authorities, so often a barrier to progress in Australia, may actually have contributed to the process of change by providing a multitude of opportunities.²²¹

The sense of urgency created by HIV and associated arguments of a 'second AIDS epidemic' meant that most states ceded willingly to the path prescribed by Blewett and the Australian Government. Additionally, fiscal concerns also meant that the states were willing to allow federal leadership on the issue.

How to classify HIV/AIDS in the ACF?

A substantial contributor to both major and minor policy change was the advent of HIV/AIDS which altered the nature of the drug problem. This was best articulated by the notion of a 'second AIDS epidemic' whereby transmission and spread of HIV/AIDS from illicit drug users into the mainstream population was a real fear. Although the disease can be classified as an external system event, it does not easily fit into the categories outlined by Sabatier. The categories noted by Sabatier include changes to socio-economic conditions, public opinion, system-wide governing coalitions or policy outputs from other subsystems (see Table 1 and/or Chapter 2 more generally for more information).

Within the ACF, the advent of HIV/AIDS would be best classified as a change in the 'basic attributes of the problem area'. The emergence of HIV/AIDS as a public health issue had a profound impact upon the nature of the policy problem and generated linkages between the illicit drug policy subsystem with other sectors such

²²¹ Wodak, A, 1992, "HIV Infection and injecting drug use in Australia: responding to a crisis, *The Journal of Drug Issues*, 22:3, p557.

as the Gay community. In the ACF, the category of 'basic attributes of the problem area' is classified under 'relatively stable parameters' (see Figure 1). Such parameters of a subsystem are theorised to be very difficult to change through coalition strategising and there is little theorising in the ACF about how they do affect coalition behaviour if change does occur in these variables. Indeed, changes in these stable parameters are not the subject or mentioned in any of the twelve ACF hypotheses.²²² It is argued that change in the basic attributes of the problem area can indeed produce more profound opportunities for coalition to realise policy objectives than that in dynamic system events.

Conclusion

Change in Australian drug policy was a combination of external (to the subsystem) factors such as the election of the Hawke Labour Government, the strategic location of key harm reduction coalition individuals within that Government and the bureaucracy, and of course the advent of HIV/AIDS. That harm reduction is proven to be a cost effective and pragmatic policy was not a key factor in its adoption by Governments due to its inherent controversial nature. The Advocacy Coalition Framework was a useful policy tool employed to analyse change in the illicit drug policy subsystem from 1980-1990. The framework could explain and describe the majority of factors that contributed to major and minor policy change. It was particularly useful to describe and define a coalition of players that believed in harm reduction ideas, policy and practice as an appropriate and effective tool to address the consequences of problematic drug use (such as HIV/AIDS transmission). Both ACF hypotheses concerning policy change were supported.

²²² Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe' *Journal of European Public Policy*, 5:1, p106.

[T]he policy core attributes of a governmental program are unlikely to be significantly revised as long as the subsystem advocacy coalition which instituted the program remains in power.²²³

The policy core attributes of a governmental action program are unlikely to be changed in the absence of significant perturbations external to the subsystem, i.e. changes in socio economic conditions, system wide governing coalitions or policy outputs from other systems.²²⁴

The major change to drug policy was a result of external system shocks and also the result of imposition of policy from a hierarchically superior jurisdiction. The latter though, was an interesting case as it was imposed without much resistance due to uncertainty felt by the states regarding information and funding in relation to HIV/AIDS. Ownership, and subsequently leadership, of this 'problem' was given automatically to the Federal Government. Thus, the policy was not imposed on reluctant state governments, instead, most of them responded to the agenda of the Federal Health Department, in similar ways (with Queensland as the main exception).

Drug policy did undergo a 'major' change in 1985, yet the law enforcement sector still dominated the illicit drug policy subsystem. Demand reduction and treatment components of the NCADA were a reflection of the strength of health and community interests, yet neither debunked law enforcement as the chief policy of the NCADA. The harm reduction coalition did enjoy success in this period with some policies and programs implemented by the end of the decade due to the confluence of many factors described above. It is clear that without HIV/AIDS, injecting drug

²²³ Jenkins-Smith, H., & Sabatier, P., 1994, 'Evaluating the Advocacy Coalition Framework', *Journal of Public Policy*, 14:2, p184.

²²⁴ *ibid.*

users would not have been regarded as worthy of policy attention as they were, due to the perceived transmission bridge of HIV/AIDS to the mainstream community.

The following chapter examines the continuing efforts of the harm reduction coalition into the following decade from 1990 to 2000. The advent of another virus, namely Hepatitis C, the change to a Liberal Government at the Federal level in 1996, and the intense policy debates in relation to SICs and prescription heroin presented many challenges to, and opportunities for, harm reduction coalition members to realise policy objectives.

Chapter 4: Harm Reduction Policy Stagnation and Police Innovation in Australia between 1990 and 2000

Introduction

In the period 1980 to 1990, illicit drug policy in Australia underwent major policy change with the adoption of 'harm minimisation' as an overarching philosophy and also with the introduction of harm reduction initiatives such as NSPs and self-help drug user groups. The following decade, from 1990 to 2000, is the subject of this chapter. In this period, supporters of harm reduction ideas, buoyed by the success in the previous decade, continued to advocate for further implementation of such policies and programs. The identification of a new BBV, hepatitis C (HCV), and the rise of problematic heroin use in public areas were key issues in this period and also provided further justification for the expansion of harm reduction programs in Australian illicit drug policy. Furthermore, research into the activity of policing as well as operational changes to police practice with regard to illicit drug-related harms was also conducted in this period.

This chapter summarises key events in the Australian illicit drug policy subsystem taken from State and Federal Government reports, policies and evaluations as well as key articles and commentaries. First, key policy documents produced by the Federal Government bureaucracy, including two National Drug Strategies (1993 and 1997), two evaluations of national drug policy strategies (1992 and 1997), and national policies on HIV/AIDS and methadone will be examined in order to understand the wider context of harm reduction policy and the underlying justification for such services. Second, an examination of the policy response to HCV in comparison with that of HIV/AIDS will be used to illustrate harm reduction policy responses in

situations where a threat to public health is limited largely to drug-using populations. Third, the instance of cross-coalition learning between the harm reduction and law enforcement coalitions will be described. Fourth, an analysis of the proposed trial of prescription heroin and SICs will show instances of (largely) failed advocacy attempts. Fifth, the oscillating nature of what the term harm reduction means and the services it encompasses will be discussed. Finally the chapter will conclude with a section applying the ACF to the events that occurred in this period, and will evaluate the usefulness of the model in explaining illicit drug policy-making in this period.

Harm Reduction in the 1990s

This section examines several key national policy documents that were produced in the decade 1990 to 2000 such as:

- *No Quick Fix* – the 1992 evaluation of the 1985 NCADA,
- *National Drug Strategic Plan 1993-97* – the second national drug strategy, released by the Federal ALP Government,
- *Mapping the Future – Evaluation of the 1993 National Drug Strategic Plan*,
- *National HIV/AIDS Strategy 1996-7 to 1998-99*,
- *National Policy on Methadone Treatment* – released in 1997, and,
- *National Drug Strategic Framework 1998-99 to 2002-03* – the third national drug strategy, released by the Federal Liberal Government

Such documents represented the views of various stakeholders ranging from health and law enforcement professionals working in the alcohol and other drug field, as well as Government and community opinion. These were examined for two reasons: firstly

to gauge the support for harm reduction ideas manifested in policies and programs; and secondly, to understand the context in which harm reduction programs were supported.

Two national drug strategies were produced by Federal Governments in this decade. The *National Drug Strategic Plan 1993-97* was produced by the Federal ALP Government and was the second national drug strategy (the first being the NCADA produced in 1985). The *National Drug Strategic Framework 1998-99 to 2002-03* was the third national drug strategy for Australia. This document was produced by a Federal Liberal Government following a change of federal governments from ALP to Liberal in 1996. Indeed, the *National Drug Strategic Framework 1998-99 to 2002-03* was the first national strategy produced by a Federal Liberal Government in Australia as the previous two (produced in 1985 and 1993) had been produced by the ALP Federal Government. National drug strategies provide a framework to coordinate the activities of state and territory Governments of Australia and also the health and law enforcement sectors across Australia. Coordination between states and sectors is facilitated through several structures such as the Ministerial Council on Drug Strategy (MCDS), the Intergovernmental Committee on Drugs (IGCD), the Australian National Council on Drugs (ANCD) and various national expert advisory committees.²²⁵ State Governments have the primary responsibility to enact their own illicit drug policies within this broader framework, however funding is provided from the federal level for some illicit drug programs consistent with national drug strategy priorities. Ergo, such national documents act to represent the views of governments, health and law enforcement sectors and other stakeholders across Australia with regard to the broad illicit drug policy settings.

²²⁵ Commonwealth of Australia, 1998, *National Drug Strategic Framework 1998-9 to 2002-3*, Commonwealth of Australia, p34-5.

As recounted in the previous chapter, in 1985, the NCADA was released. This document outlined Australia's 'harm minimisation' approach to (both licit and illicit) drug policy. The NCADA described the approach as including both supply and demand reduction initiatives. Indeed, it was not until the latter part of the decade when the importance of harm reduction policies were emphasised. This increased emphasis on harm reduction policies was largely due to the policy problem presented by HIV/AIDS. This pressing issue was encapsulated by the phrase 'second aids epidemic', describing the way in which injecting drug use was a major route of HIV/AIDS transmission both between injecting drug users through sharing of injecting equipment, and also between injecting drug users and the mainstream community via transmission through heterosexual sex. Indeed, as outlined in Chapter Three, in the late 1980s and early 1990s, there was an expansion in harm reduction policy as a response to HIV/AIDS, with jurisdictions enacting NSPs²²⁶ and self-help user groups.²²⁷ Therefore, in the period between the release of the 1985 NCADA and the 1993 National Drug Strategic Plan there had been a raft of policy activity directed towards the issue of HIV/AIDS, with harm reduction approaches to illicit drug use (and more specifically injecting drug use) being recognised as key strategies to contain the virus.

The 1993 *National Drug Strategic Plan* (NDS) defined the harm minimisation approach as one that:

²²⁶ "Sterile injecting equipment has been readily available in all major cities and large towns in Australia since 1988-1989." Wodak, A., 1995, 'Needle Exchange and Bleach Distribution Programmes: The Australian Experience', *International Journal of Drug Policy*, 6:1.

²²⁷ Queensland, Australian Capital Territory, South Australia, Northern Territory, Western Australia, New South Wales and Victoria implemented user groups between 1988 and 1992. Tasmania has had user groups on a sporadic basis. Crofts, N., 1995, 'A History of Peer-Based Drug-User Groups in Australia', *The Journal of Drug Issues*, 23:3, pp599-616.

...aims to reduce the adverse health, social and economic consequences of alcohol and other drugs by minimising or limiting the harms and hazards of drug use for both the community and the individual without necessarily eliminating use.²²⁸

Such a definition of harm minimisation resonated with the notion of 'harm reduction' as defined in chapter one. As mentioned, the overarching principle in the harm reduction philosophy is to provide services for existing and continuing drug users, in contrast to policies whereby abstinence is a key goal. Staff in services such as NSPs do not attempt to compel current drug users to reduce or eliminate their use (unless requested for assistance to do so and such a request is initiated by the drug consumer). The following quote from the 1993 National Strategic Plan was indicative of the mark left on Australian illicit drug policy by the advent of HIV/AIDS in the mid to late 1980s.

Harm minimisation demands realistic strategies focused on preventing and reducing harm to individual drug users, their families, their workplaces and the wider community. It accepts that interventions that reduce the risks of harm connected with drug use, without necessarily eliminating use, can also have important benefits for both the individual user and the wider community.²²⁹

Indeed the notion of a 'second aids epidemic'²³⁰ continued to be a driving force in illicit drug policy due to concerns that injecting drug user populations could act as a bridge to transmission of HIV/AIDS to the mainstream population through unprotected heterosexual intercourse.

²²⁸ Commonwealth of Australia, 1993, *National Drug Strategic Plan 1993-97*, Canberra, AGPS, p4
²²⁹ *ibid.*

²³⁰ Drew, L., & Taylor, V., 1988, *Intravenous Drug Use and the Aids Epidemic*, Paper presented to the National Health and Medical Research Council, p1.

Similar to the NCADA, the general approach of the 1993 Drug Strategic Plan was to combine law enforcement and health sectors under one framework to address illicit drug use. However, the 1993 Drug Strategic Plan went further to also include harm reduction programs such as NSPs that had been enacted in the preceding few years. Indeed the framework articulated as a national priority to...

Maintain an environment in which policing activities such as minimising the visible consequences of drug activity, and health activities such as methadone and needle exchange programs, are complementary.²³¹

The potential for counter-production in policy through enacting strategies that aim to reduce the supply of illicit drugs while also providing services for those that use illicit drugs is substantial. Much research²³² has been conducted on the way in which law enforcement interventions can exacerbate or increase the severity and frequency of drug related harms that programs such as NSPs then have to address. The notion of harm reduction and supply reduction measures acting as uneasy bedfellows is outside the scope of this thesis yet is an important variable to consider when thinking about the origins of drug related harms. Indeed, this is explored further throughout this chapter in reference to Hepatitis C and changes to police practices that occurred in this decade from 1990 to 2000. Ultimately, while the 1993 National Drug Strategic Plan articulated the need for harm reduction services such as NSPs, it also reinforced the dominant and pre-existing paradigm of law enforcement as the chief instrument in illicit drug policy.²³³

²³¹ Commonwealth of Australia, 1993, *National Drug Strategic Plan 1993-97*, Canberra, AGPS, p4.

²³² Sutton, A & James, S., 1996, *Evaluation of Australian Drug Anti-Trafficking Law Enforcement*, National Police Research Unit, Adelaide; Green, P & Purnell, I., 1996, *Measuring the success of law enforcement agencies in Australia in targeting major drug offenders relative to minor drug offenders*, National Police Research Unit, Adelaide; Weatherburn, D., & Lind, B., 1995, *Drug Law Enforcement Policy and Its Impact on the Heroin Market*, New South Wales Bureau of Crime Statistics and Research, Sydney.

²³³ Wodak estimated that in 1992, 84% of Federal and State Expenditure towards addressing illicit drugs went to supply reduction initiatives, 6% to treatment, and 10% to prevention and research.

The *National Drug Strategic Framework 1998-99 to 2002-03* was the third national strategy released by federal governments since the NCADA in 1985 and the 1993 National Drug Strategic Plan, and the first released by a Federal Liberal Government. The definition of harm minimisation in the 1993 *National Drug Strategic Plan* was replaced by the following:

Harm minimisation refers to policies and programs designed to reduce drug related harm. Harm minimisation aims to improve the health, social and economic outcomes for both the community and the individual and encompasses a wide range of approaches...²³⁴

The term 'harm reduction' was mentioned several times throughout the document and programs such as NSPs were justified on the basis of their capacity to ameliorate public health problems presented by BBVs such as HIV/AIDS and HCV. The *National Drug Strategic Framework 1998-99 to 2002-03* offered this justification of harm reduction programs:

Governments do not condone illegal risk behaviours such as injecting drug use, but they do acknowledge that these behaviours occur. They have a responsibility to develop and implement public health and law enforcement measures designed to reduce the harm that such behaviours can cause, both to individuals and the community. In these circumstances harm reduction strategies specifically target the individual using drugs and promote initiatives that benefit the wider community. For example, drink driving was identified as a serious drug related harm and changes to legislation and law enforcement practices were introduced. These harm reduction strategies aimed to reduce harm associated with drink driving. Similarly, while the practice of injecting drug use continues, the

Wodak, A., 2000, 'Developing More Effective Responses', in *Drugs and Democracy: in search of new directions*, G., Stokes, P., Chalk & K., Gillen (eds), Melbourne University Press, Carlton South, p184.

²³⁴ Ministerial Council on Drug Strategy, 1998, *National Drug Strategic framework 1998-99 to 2002 - 03*, Commonwealth of Australia, Canberra, p1.

provision of sterile injecting equipment through needle and syringe exchange programs is an important harm reduction strategy for preventing the spread of blood borne viruses such as HIV and hepatitis C.²³⁵

Indeed, by 1998 NSPs were well established in Australia as key mechanisms to reduce transmission of BBVs into the wider community. Such a public health rationale of NSPs was an ongoing justification for such programs. Moreover, the document also emphasised the importance of the involvement of affected communities in the development of drug policy, through providing advice to peak policy groups such as the MCDS.²³⁶ In sum, the document did not herald any clawback to existing harm reduction programs (including NSPs, self-help user groups and MMT) however, it did not signify an expansion of harm reduction services (such as prescription heroin or SICs) either.

In the period between 1990 and 2000, evaluations of the 1985 NCADA (*No Quick Fix*²³⁷) and the 1993 National Drug Strategic Plan (*Mapping the Future*²³⁸) were conducted. The function of the evaluations was to review the direction of national drug policy in accordance with new trends in illicit drug statistics and research and also to examine the overall structure and performance of drug policies. Both evaluations endorsed harm reduction initiatives such as self-help drug user groups, MMT and NSPs, and linked their importance to HIV/AIDS containment.²³⁹ The authors of the 1992 evaluation (*No Quick Fix*) summed up the shift in policy that occurred in the late 1980s:

²³⁵ *ibid*, p16.

²³⁶ *ibid*, p22.

²³⁷ Ministerial Council on Drug Strategy, 1992, *No Quick Fix*, Commonwealth of Australia, p86.

²³⁸ Single, E & Rohl, T., 1997, *The National Drug Strategy: mapping the future*, AGPS, Canberra.

²³⁹ *ibid*, p44, and Ministerial Council on Drug Strategy, 1992, *No Quick Fix*, Commonwealth of Australia, p45-6.

Services to [injecting drug users] have been characterised by a move away from abstinence oriented treatment toward holistic approaches within more general contexts. This shift has been fostered by the advent of AIDS and the recognition of the relationship between HIV infection, unprotected sexual activity and needle sharing, and the acceptance of the harm minimisation approach by the majority of service workers throughout Australia.²⁴⁰

The authors of the 1997 evaluation endorsed self-help drug user groups as important participants in the policy process.

Support for user groups is commended and should be enhanced. Users are in an excellent position to help monitor the emergence of new drugs or patterns of use at the street level. Based on their personal experience, they can anticipate the likely impacts of new policies and programs. The presence of drug users in policy forums helps bring into consideration the likely impacts, intended or unintended, on users themselves. The rights of users are more likely to receive appropriate consideration. When user groups are present, the prevailing concept of an illicit drug user is less likely to be that of a person unable to control his or her actions and prone to criminal behaviour, and more likely to be that of an otherwise normal person who uses drugs and experiences a variety of consequent problems...Programs funded under the NDS would profit by increased consultation with user groups.²⁴¹

As mentioned in chapter three, self-help drug user groups are an important mechanism used in harm reduction policy in the Australian context. Such groups echoed those formed in gay communities that acted as a bridge between medical/research communities, policy makers and the affected communities. Self-help drug user groups translated research findings and public health messages into the language of their communities with the aim of encouraging behavioural change (such as using sterile syringes for every injection) in individuals and improving public health more generally.

²⁴⁰ Ministerial Council on Drug Strategy, 1992, *No Quick Fix*, Commonwealth of Australia, p45-6.

²⁴¹ Single, E & Rohl, T., 1997, *The National Drug Strategy: mapping the future*, AGPS, Canberra, p55.

The strongest affirmation of harm reduction ideas in policy documents in this period was seen in the *National HIV/AIDS Strategy* released in 1996. This document reaffirmed a commitment toward the central principles of the previous HIV/AIDS strategies: partnerships with affected communities, employment of pragmatic strategies and non-partisan political support of HIV/AIDS policy. Further, the strategy championed the incorporation of affected communities at many levels of decision-making and policy formulation:

Australia's success to date in dealing with HIV/AIDS [can be attributed to]: non partisan political support; the partnership between the affected communities, governments at all levels, and medical, scientific and health care professionals' and the active involvement of those communities most affected by HIV in all elements of the response, particularly individuals who are HIV positive.²⁴²

Australia's approach to HIV/AIDS, as described in the previous chapter, combined medical and scientific opinion tempered with "enlightened pragmatism".²⁴³ The symbiosis between HIV/AIDS and illicit drug policy meant that harm reduction approaches were deemed as important strategies to address policy conundrums of both HIV/AIDS and problematic illicit drug use. Indeed, the 1996 *National HIV/AIDS Strategy* reaffirmed this ongoing overlap with drug policies and, more particularly, injecting drug use.²⁴⁴

Many of the behaviours that bear the risk of HIV infection are personal and private, and in some cases illegal. As a result, public health control measures... are not effective.... Sustained and responsible behaviour change is not possible

²⁴² Commonwealth of Australia, 1996, *Partnerships in Practice: National HIV/AIDS Strategy 1996-7 to 1998-99*, AGPS, Canberra, Foreword.

²⁴³ *ibid*, p1.

²⁴⁴ *ibid*, p3

if those who are most at risk are marginalised or fearful of discrimination.²⁴⁵

From the perspective of the authors of HIV/AIDS policy, harm reduction approaches that employed peers/affected communities in education roles were still seen as the principal mechanisms to induce individual behaviour change

The *1997 National Policy on Methadone Treatment* supported the rushed entry of injecting drug users with HIV/AIDS into Methadone Maintenance programs.²⁴⁶ The objectives and rationale that underpinned methadone treatment revolved around the notion of reducing drug related harm for individuals and the community. HCV was also raised as a public health concern in this document and harm reduction services such as education about safer injecting practices were regarded as the main mechanism of prevention of drug related harm (such as BBV prevention) in this document.²⁴⁷ Thus, such harm reduction policies and programs were seen as complementary strategies to the national methadone policy in order to address BBVs.

Throughout the period 1990 – 2000, the worth of harm reduction policies and programs was emphasised by the national policies and documents listed above. The authors of all these documents suggested that harm reduction policies had been critical to the past success of containing viruses (such as HIV/AIDS) within the community, and moreover, that these policies were critical to future containment efforts. Moreover, all these documents emphasised the necessity for harm reduction programs such as NSPs, methadone maintenance treatment and self-help drug user groups as *primary* mechanisms to curb their respective policy problems. While the

²⁴⁵ *ibid*, p6-7.

²⁴⁶ Commonwealth of Australia, 1997, *National Policy on Methadone Treatment*, Canberra, p11.

²⁴⁷ *ibid*, p20.

ideas of harm reduction were clearly articulated within these documents, clear definitions of the approach were not as forthcoming.

In the next section, the Australian policy response to the blood-borne virus HCV is examined. This virus produced another policy problem in which harm reduction ideas form a key solution for the containment of the spread of the virus. The following section examines the *National Hepatitis C Strategy 1999-2000 to 2003-2000* and other commentaries around this issue. Australian policy responses to HCV during the period 1990-2000 are discussed, and contrasted with policy responses to HIV/AIDS.

Hepatitis C: The ‘Poor Cousin’ of HIV

The hepatitis C virus (HCV) was identified in 1988. HCV is predominantly transmitted through blood to blood contact²⁴⁸ and in many western countries is prevalent in people with a history of injecting drug use. Transmission is believed to occur predominantly through the sharing of injecting equipment including not only syringes and also mixing containers, tourniquets and other items used in the injection process.²⁴⁹ HCV infection is a public health concern because of its serious complications, such as cirrhosis of the liver and hepatocellular carcinoma, as well as its high prevalence, long latent period and high probability of long-term carriage and infectiousness.²⁵⁰ In order to understand the place of harm reduction within HCV

²⁴⁸ MacDonald M., Crofts N., Kaldor J., 1996, ‘Transmission of hepatitis C virus: rates, routes and cofactors’ *Epidemiology Review*, 18, pp137-148.

²⁴⁹ Crofts N., Jolley D., Kaldor J., 1997, ‘Epidemiology of hepatitis C virus infection among injecting drug users in Australia’, *Journal of Epidemiology and Community Health*, 51, pp692-697.

²⁵⁰ MacDonald, M., Wodak, A., Dolan, K., van Beek, I., Cunningham, P., & Kaldor, J., 2000, ‘Hepatitis C virus antibody prevalence among injecting drug users at selected needle and syringe programs in Australia, 1995-1997’, *MJA*, 172, pp57-61.

national policy during the period of analysis, this section examines the following documents:

- *Hepatitis C: a review of Australia's response* –Department of Health and Ageing,
- 'Injecting nation: achieving control of hepatitis C in Australia' –article written by key harm reduction advocate Dr. Alex Wodak, St Vincents Hospital in NSW
- *National Hepatitis C Strategy 1999-2000 to 2003-2004*, and,
- *The Road Not Taken: review of the National Hepatitis C Strategy*.

Grassroots organisations that formed to address the issue of HCV started in the early 1990s as affected communities and health professionals formed organisations, while staff from NSPs lobbied for HCV resources. Health care workers, particularly gastroenterologists called for a national response to HCV, partly motivated through a perceived occupational risk of contracting the disease, thus playing a role in the agenda setting process.²⁵¹ In 1993, the Federal Government established a joint task force to address HCV. Members were taken from the National Health and Medical Research Council and the Australian Health Ministers Advisory Council, and this group initiated the first National HCV action plans.²⁵² These documents informed approaches to the diagnosis, treatment and management of HCV-infected people and, to a lesser extent, prevention of further spread. In 1999, the Federal Government released the first national strategy for HCV. The *National Hepatitis C Strategy*

²⁵¹ Department of Health and Aged Care, 1999, *Hepatitis C: a review of Australia's response*, Commonwealth of Australia, Canberra, p99.

²⁵² National Health and Medical Research Council and Australian Health Ministers' Advisory Council, 1994, *Hepatitis C: epidemiology, natural history, control and treatment*, AGPS, Canberra and National Health and Medical Research Council, 1997, *A strategy for the detection and management of hepatitis C in Australia*, AGPS, Canberra, 1997.

1999-2000 to 2003-2004²⁵³ regarded harm reduction approaches as key strategies in the reduction of drug related harm, one component of which was the reduction in rates of transmission of HCV:

There is compelling evidence that harm reduction interventions such as peer support education and needle and syringe programs continue to be highly effective in reducing risk behaviour and the transmission of blood borne viruses such as HIV among people who inject drugs.²⁵⁴

NSPs act to contain HCV through the provision of sterile injecting equipment and also through the provision of information about the virus (especially routes of transmission) to injecting drug users. Such education and equipment provision attempt to increase knowledge and provide the means by which injecting drug users can avoid transmission of the virus. According to some commentators, however, such initiatives that seek to generate behaviour change among injecting drug users are not sufficient to contain the spread of HCV in the injecting drug user population. Indeed, efforts to enact such behavioural change in injecting drug users are impeded by the context of the illegality of the behaviour:

The incidence and prevalence of hepatitis C in Australia are far higher than those of HIV infection. An estimated 130 000 Australians have been infected with hepatitis C virus (HCV) over the last 20 years, with about 6000 new chronic infections a year through injecting drug use alone. In contrast, an estimated 15450 people have been infected with HIV by all routes of transmission, with about 500 new infections a year between 1994 and 1996. Although a smaller proportion of individuals infected with HCV experience serious morbidity and mortality, and only after a longer delay (10%-20% are estimated - conservatively - to develop cirrhosis within 20 years and 5% of these develop hepatocellular carcinoma within five years), the far larger

²⁵³ Commonwealth Department of Health and Ageing, 2000, *National Hepatitis C Strategy 1999-2000 to 2003-2004*, Commonwealth of Australia, Canberra.

²⁵⁴ *ibid*, p14.

pool of infected people and longer duration of illness suggest that the total health and economic burden of hepatitis C in Australia is considerable and may well surpass HIV before too long.²⁵⁵

A 2002 review of the National Hepatitis C Strategy 1999-2004 entitled *The Road Not Taken* alerted Governments to the threat posed by HCV stating that it was the most common notifiable disease in Australia.²⁵⁶ The report noted the limitations of policy to curb the public health impact of HCV (in contrast to that of HIV/AIDS) and attributed it to counterproductive drug laws and policies, a failure to understand the complexity of care of HCV, inadequate governance structures, inadequate research and lack of resources.²⁵⁷ According to Wodak²⁵⁸, a fundamental limitation of Australia's policy response to HCV was the similarity in approach with HIV/AIDS. While the transmission pathways for HCV and HIV/AIDS are similar (sharing syringes being a high risk activity in relation to the transmission of both viruses), the differing disease characteristics meant that policy needed to reflect such distinctiveness in order to contain HCV.

The remarkable infectiousness of hepatitis C by blood to blood spread is illustrated in studies of occupational exposure. Following a needlestick injury with blood from an infected patient, 0.3% of health workers are estimated to have become infected with HIV compared to 3% who become infected with hepatitis C.²⁵⁹

²⁵⁵ Wodak, A, 1997, 'Hepatitis C: waiting for the grim reaper', *MJA*, 166, p283 accessed at <http://www.mja.com.au/public/issues/mar17/wodak/wodak.html> on 28/3/2006.

²⁵⁶ Levy, M., Baum, F., & Thomas, H., 2002, *The Road Not Taken: review of the National Hepatitis C Strategy*, 2002 Reviews of the National HIV/AIDS and Hepatitis C Strategies and Strategic Research, accessed 7/1/04, from Australian Government Department of Health and Ageing website: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-publth-publicat-document-metadata-hivhepc_review.htm/\\$FILE/hivhepc_part3.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-publth-publicat-document-metadata-hivhepc_review.htm/$FILE/hivhepc_part3.pdf) p83.

²⁵⁷ *ibid.*

²⁵⁸ Wodak, A., 1997, Injecting nation: achieving control of hepatitis C in Australia, *Drug and Alcohol Review*, 16.

²⁵⁹ *ibid.*, p277.

Instead of separate structures to address HCV transmission, however, the approach undertaken by Australian Governments mirrored that of HIV/AIDS, and HCV policy/programs were incorporated into existing HIV/AIDS infrastructure. While these approaches proved to be successful in the containment of the HIV/AIDS virus, they were not as effective in addressing the spread of HCV.

In the review of the literature there were three key factors identified as reasons for the failure of these approaches to effectively contain the spread of HCV. First, the HCV-affected communities had not been as effectively engaged as those associated with HIV/AIDS. With HIV/AIDS, the gay community mobilised around the issue buoyed by recent successes in the 1980s with regard to homosexual law reform. While HCV is certainly not confined to injecting drug users and a number of transmissions were linked to blood transfusions previous to 1988, over ninety per cent of *new* HCV infections occurred among people who injected drugs.²⁶⁰ Dr Alex Wodak mused on the political strength of injecting drug users noting that such a group is not traditionally well politically organised (in comparison with HIV/AIDS policy in which gay men successfully formed organisations around a decade before) due to stigma attached to identifying with, and admitting to participation in, an illegal activity. Moreover, few public health practitioners were willing to advocate for injecting drug users.²⁶¹ As such, even though HCV presented a serious threat to public health during the 1990s it did not attract attention as HIV/AIDS had the decade before:

Unlike the situation which prevailed after a few years of knowledge of the existence of HIV/AIDS, there has been

²⁶⁰ Commonwealth Department of Health and Ageing, 2000, *National Hepatitis C Strategy 1999-2000 to 2003-2004*, Commonwealth of Australia, Canberra, p21

²⁶¹ Wodak, A., 1997, 'Injecting nation: achieving control of hepatitis C in Australia', *Drug and Alcohol Review*, 16, p278.

no National Hepatitis C Task Force, no epidemic of hepatitis C pamphlets and posters, no vigorous calls for research and no quilts, ribbons, candlelight vigils, plays, novels, poems or films based on this new public health threat.²⁶²

There are more than five times as many Australians already infected with hepatitis C as HIV and approximately ten times more new cases of hepatitis C every year than HIV...While the burden of HIV is far greater per infected individual, the overall health and economic burden of hepatitis C may be at least comparable with HIV because of the far larger pool of hepatitis C infection... If HIV was the epidemic that Australia did not need to have, hepatitis C is the epidemic that many feared HIV might become.²⁶³

Second, the nature of the problem also impacted upon the policies chosen for HCV. HIV/AIDS containment measures were buoyed by community fear of a widespread epidemic into the heterosexual population. The future spread of HCV, however, most likely will remain largely contained within current and ex-injecting drug user population (because it is only transmitted through blood to blood contact and sexual transmission is thought to be rare) and therefore is perceived as being less of a threat to the mainstream community than HIV/AIDS:

Hepatitis C is a much less dramatic illness than HIV. Predominantly, it threatens marginalized members of the community rather than the talented and creative figures who all too often succumb to HIV. AIDS involves an intriguing combination of sex, drugs, film stars, celebrities and sports stars.²⁶⁴

Existing governance structures have reinforced the position of hepatitis C as the 'poor cousin' of HIV...When hepatitis C began to emerge as a serious public health concern in Australia the HIV/AIDS infrastructure was well established. Hepatitis C was integrated into this infrastructure...Hepatitis C is yet to achieve priority within this infrastructure despite its greater impact in terms of the number of people affected and the projected cost burden relative to HIV/AIDS. Because of the dominance of the

²⁶² *ibid.*

²⁶³ *ibid.*

²⁶⁴ *ibid.*

HIV/AIDS agenda, many opportunities for early, coordinated action to meet the challenges of hepatitis C have not been realised.²⁶⁵

Third, prohibition policy is counterproductive to public health. Wodak suggested that to contain HCV infection, the adoption of traditional responses to reduce HIV transmission were insufficient.²⁶⁶ Indeed, the practice of injecting was at the centre of the problem and Wodak asserted that a change in injecting behaviour, moving from intravenous to non injectable routes of administration (NIROA), was a key way to curb HCV rates of infection.²⁶⁷ The conundrum was, however, the interplay of the individual and the environment: systemic factors such as the prohibition regime around illicit drugs maintains high prices for illicit drugs, which in turn, provides a disincentive to use drugs in any other way than injection, as this is the most cost-effective mode of administration.²⁶⁸ As previously stated, injection practices have accounted for the vast majority of new transmissions of HCV. Authors of the *National Hepatitis C Strategy 1999-2000 to 2003-2004* also agreed that action was required to reduce the stigmatisation and discrimination associated with drug laws, especially in health care settings of those infected with HCV.

Self administration (or 'use') of a prohibited substance remains an offence in New South Wales; that discourages people who inject drugs from attending NSPs and carrying sterile injecting equipment, increasing the likelihood that

²⁶⁵ Levy, M., Baum, F., & Thomas, H., 2002, *The Road Not Taken: review of the National Hepatitis C Strategy*, 2002 Reviews of the National HIV/AIDS and Hepatitis C Strategies and Strategic Research, accessed 7/1/04, from Australian Government Department of Health and Ageing website: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-document-metadata-hivhepc_review.htm/\\$FILE/hivhepc_part3.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-document-metadata-hivhepc_review.htm/$FILE/hivhepc_part3.pdf), pp84-5.

²⁶⁶ Wodak, A., 1997, 'Injecting nation: achieving control of hepatitis C in Australia', *Drug and Alcohol Review*, 16, p279.

²⁶⁷ *ibid.*

²⁶⁸ Commonwealth Department of Health and Ageing, 2000, *National Hepatitis C Strategy 1999-2000 to 2003-2004*, Commonwealth of Australia, Canberra, p50 and Levy, M., Baum, F., & Thomas, H., 2002, *The Road Not Taken: review of the National Hepatitis C Strategy*, 2002 Reviews of the National HIV/AIDS and Hepatitis C Strategies and Strategic Research, accessed 7/1/04, from Australian Government Department of Health and Ageing website: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-document-metadata-hivhepc_review.htm/\\$FILE/hivhepc_part3.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-document-metadata-hivhepc_review.htm/$FILE/hivhepc_part3.pdf), p98

they will share injecting equipment... Fundamental to the success of Australia's approach to HIV was the decriminalisation of homosexuality. Reform of drug laws and policies is now needed to reduce hepatitis C transmission.²⁶⁹

The affected communities are very marginalised, experiencing cultural, social and economic disadvantage. This situation is not unique to hepatitis C: most diseases thrive in such circumstances.²⁷⁰

Other factors such as policing of public injecting can lead to rushed injections which exacerbate unsafe techniques and therefore increase the risk of HCV transmission. Ultimately, harm reduction advocates argue that the criminalisation of injecting drug use compounds the instance of HCV transmission.

In sum, a comparison of the relative impacts of the policy problems presented by HCV and HIV/AIDS on drug policy revealed the way in which the potential benefits of harm reduction programs were thought to be undermined by law enforcement responses to drug use. Containment of HCV required a more systemic view of the environment that engendered HCV transmission. The focus on getting drug users to change drug using behaviours, without addressing contextual factors of use (such as the effect of drug laws on injection practises), was inadequate to contain the virus. That HCV mainly affected injecting drug users with less risk of transmission into the mainstream population than HIV/AIDS meant that policy was not drafted with the urgency or scope that HIV/AIDS was. Around the time HIV/AIDS had become a major public health threat, laws prohibiting homosexual sex had been overturned that had the effect of the removal of stigma and allowance of more effective public health

²⁶⁹ Levy, M., Baum, F., & Thomas, H., 2002, *The Road Not Taken: review of the National Hepatitis C Strategy*, 2002 Reviews of the National HIV/AIDS and Hepatitis C Strategies and Strategic Research, accessed 7/1/04, from Australian Government Department of Health and Ageing website: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-document-metadata-hivhepc_review.htm/\\$FILE/hivhepc_part3.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-document-metadata-hivhepc_review.htm/$FILE/hivhepc_part3.pdf) p98.

²⁷⁰ *ibid*, p100.

interventions however drug laws and attitudes towards injecting drug use are deeply entrenched and act to limit Governments' action toward HCV.

Changes to Law Enforcement: the Softening of Prohibition?

Previous to the NCADA, health and law enforcement worked in relative isolation from each other. Since 1985 however, health and law enforcement agencies have had regular contact through a series of structures formally enacted under the NCADA and successive national drug strategies. The MCDS, the IGDS and the ANCD are three examples of national structures that meet regularly to discuss illicit drug issues and that feature membership drawn from both health and law enforcement sectors as well as other illicit drug stakeholders. Such increased contact between the sectors lead to changes to police practice, however, the ideas of harm reduction in policing have a clear precedent. Concepts such as random breath testing and police assistance in the development of such concepts as responsible service of alcohol are two examples of the capacity of law enforcement to affect areas previously thought only applicable to the domain of health.²⁷¹ Moreover, the wider structure of successive national drug strategies has meant new perspectives on law enforcement practice. Indeed the authors of *The National Drug Strategy: mapping the future* stated that successive national drug strategies had engendered a collaborative relationship between health and law enforcement agencies that has had an impact on both sectors.

With the NDS has come a research philosophy which has been instrumental in encouraging police at all levels to consider options which would not have been examined in a

²⁷¹ Single, E & Rohl, T., 1997, *The National Drug Strategy: mapping the future*, AGPS, Canberra, p67.

traditional law enforcement paradigm. Police are starting to recognise the intrinsic value of harm minimisation within a community policing context. Similarly, health agencies are starting to appreciate the police role in contributing to the effectiveness of harm minimisation.²⁷²

The earliest example of harm reduction ideas in policing was encapsulated in the 'Merseyside Model' from the early 1980s in the UK. In this model, there were three factors that constituted this particular approach to illicit drug use. First, psychiatrists at a Merseyside drug dependency clinic prescribed injectable opiates on a take-home basis.²⁷³ Second, the area implemented one of the first NSPs in the UK.²⁷⁴ Both these initiatives were supported by the third element of the Merseyside Model - namely the support and cooperation of the local police who agreed not to observe drug services and also referred drug users who had been arrested to local drug services.²⁷⁵

The police role in the administration of drug policy towards drug dependent people in Rotterdam is completely integrated with other agencies. The 'harm reduction' principle in the police context means that trafficking is pursued whilst the drug user is left alone as much as possible. This applies to both 'hard' and 'soft' users and low level dealers. Only if they cause 'unacceptable annoyance' to other citizens, especially in residential areas, do the police take action.²⁷⁶

In this model the police were a critical element that contributed to the overall success of the both drug treatment agencies and services such as NSPs. In many areas, where harm reduction and law enforcement activities co-exist, police were initially reluctant to support NSPs as they were seen to be counterproductive to their

²⁷² *ibid*, p68.

²⁷³ Riley, D., O'Hare, P., 2000, 'Harm Reduction: History, definition and Practice', in J. Inciardi & L. Harrison (eds) *Harm Reduction: national and international perspectives*, Sage, California, p3-4.

²⁷⁴ *ibid*.

²⁷⁵ *ibid*.

²⁷⁶ Chappell, D., Reitsma, T., O'Connell, D., & Strang, H., 1993, 'Law Enforcement as a harm reduction strategy in Rotterdam and Merseyside', in N. Heather, A. Wodak, E. Nadlemann & P. O'Hare (eds) *Psychoactive drugs & Harm Reduction*, Whurr, London, p120.

work and also as condoning drug use. Authors of the *Australian Illicit Drug Report* suggested that the adoption of harm minimisation as the key goal of illicit drug policy created “conceptual difficulties for law enforcement”.²⁷⁷ Understandably such difficulties stemmed from the traditionally disparate roles of both law and health agencies in relation to drug use. Changes to police practice, especially the incorporation of harm minimisation, have not been without operational challenges. These have included: the tension between the application of operational discretion and fair and consistent enforcement of the law, secondly, recognition that drug busts could increase crime in an area or displace crime to another area, and, a lack of adequate treatment facilities or places to refer offenders.²⁷⁸

Law enforcement’s adoption of the harm minimisation approach to drug laws has, however, been problematic. Most senior law enforcement officers have embraced the approach, but many junior officers have found it difficult to reconcile the concept with their traditional role...some police still believe that in relation to illicit drugs, their role is to simply identify drug criminals, [with] other agencies being responsible for prevention, treatment and harm minimisation.²⁷⁹

Since implementation of harm reduction services in many countries however, there is now a wider understanding and support for such schemes.²⁸⁰ In Australia, the ways in which law enforcement agencies supported harm reduction initiatives included better integration with harm reduction programs such as NSPs and treatment agencies. Indeed, it is now recognised that the support of law enforcement for harm

²⁷⁷ Australian Bureau of Criminal Intelligence, 1997, *Australian Illicit Drug Report 1996-7*, Commonwealth of Australia, p8.

²⁷⁸ Single, E & Rohl, T., 1997, *The National Drug Strategy: mapping the future*, AGPS, Canberra, p68.

²⁷⁹ Australian Bureau of Criminal Intelligence, 1997, *Australian Illicit Drug Report 1996-7*, Commonwealth of Australia, p7.

²⁸⁰ Hellowell, K., 1995, ‘The Role of Law Enforcement in Minimising the Harm Resulting from Illicit Drugs’, *Drug and Alcohol Review* 14, pp317-22.

reduction programs is a critical element in the success of such programs.²⁸¹ In one example of the impact of police activity on harm reduction activities, in July 1994, police activity around an NSP in Victoria resulted in a significant reduction in the number of service users (particularly Vietnamese clients) and amount of returned syringes.²⁸² This example of zealous law enforcement activity and the effect it can have on the operation of harm reduction programs occurred despite stipulations in policy that police were to support measures designed to reduce HIV/AIDS and HCV transmission.²⁸³ The liberalisation and standardisation of laws relating to the possession of injecting equipment that occurred as a result of the implementation of NSPs was also another example of how changes in law enforcement practice can engender responsible disposal of injecting equipment, protect public health and generally enhance the operation of harm reduction programs.²⁸⁴

The second example of changes to law enforcement in this period is regarding the introduction of cannabis cautioning programs and diversion schemes in Australia in this period was another change to the role of law enforcement. Reviews of cannabis laws were undertaken by the Australian Capital Territory (ACT) Legislative Assembly Select Committee on HIV, Illegal Drugs and Prostitution and the Queensland Criminal Justice Commission.²⁸⁵ The *(ACT) Drugs of Dependence (Amendment) Act 1992* resulted in the issuing of 'cannabis offence notices' for

²⁸¹ Griffin, M., 1995, 'Building on Common Ground', *Connexions*, 15:4, pp8-14 and Hellawell, K., 1996, 'The Role of Law Enforcement in Minimizing the Harm resulting from Illicit Drugs', *Drug and Alcohol Review*, 14, pp317-22.

²⁸² Kutin, J., 1998, 'Law Enforcement and Harm Minimisation', M. Hamilton, A. Kellehear & G Rumbold (eds) *Drug use in Australia: a harm minimisation approach*, Oxford University Press, Melbourne, p163.

²⁸³ Victoria Police, 1997, 'Needle Exchange Program', section 5.1.6 of the *Operating Procedures, Victoria Police Manual*, Victoria Police, Melbourne quoted in *ibid*, p163.

²⁸⁴ The illegality of carrying injecting equipment means that some users might choose to dispose of the equipment in public areas soon after injecting rather than carry syringes back to the NSP and risk an infringement. Kutin, J., 1998, 'Law Enforcement and Harm Minimisation', M. Hamilton, A. Kellehear & G Rumbold (eds) *Drug use in Australia: a harm minimisation approach*, Oxford University Press, Melbourne, p163.

²⁸⁵ Campbell, A., 2001, *The Australian Illicit Drug Guide*, Black Inc, Melbourne, p447

possession of small amounts of cannabis that meant that users could pay within a period of sixty days without a conviction recorded.²⁸⁶ In 1998, Tasmanian and Victorian Police introduced the Cannabis Cautioning Policy²⁸⁷ whereby offenders in possession of small amounts could receive a caution notice that included information on health and legal issues.²⁸⁸

In 1994, the Alcohol and Other Drugs Council of Australia conducted a study of the diversion of drug users in Australia. The term 'diversion' was defined to include a large and varied range of approaches and policies aiming to reduce the number of offenders entering the criminal justice system. The authors, Collins and Lapsey²⁸⁹ estimated the costs of law enforcement activity related to illicit drugs to be in excess of \$450.6 million. Of this, \$230.5 million was for the prison system, \$64.1 million was for court funding, with \$156 million left for state and territory police, the National Crime Authority, the Australian Federal Police and Customs Service. Thus, it was apparent that over half of the law enforcement costs dedicated to illicit drugs was allocated to prison and court systems.

Diversion programs and cannabis cautioning schemes not only reduced the harm associated with illicit drugs for some drug users through the removal of criminal

²⁸⁶ *ibid.*

²⁸⁷ "Formal cautioning, the newest approach to minor cannabis offences in Australia, is being embraced by governments who see problems with the total prohibition approach but do not want to change the cannabis law in a way which could be construed as 'soft on drugs'. In 1998 VIC and TAS introduced cautioning systems for cannabis use, and WA began a trial of a limited cannabis-cautioning scheme in two police districts. The Victorian scheme aims to provide an alternative to court proceedings and associated stigma, reduce the lag between offending and punishment, provide support, assistance and encouragement, and optimise informal communication between police and offender. In [Victoria], police can issue a caution for possession use of less than 50 [grams] of cannabis. The scheme applies to those 17 years and over, but not to people with prior drug offences. The person has to admit the offence and a caution cannot be issued to the same person on more than two occasions." Lenton, S., MacDonald, D., Ali, R., & Moore, T., 1999, 'Laws applying to minor cannabis offences in Australia and their evaluation', *International Journal of Drug Policy*, 10:4, pp299-303.

²⁸⁸ *ibid.*

²⁸⁹ Collins, D., & Lapsey, 1996, *The Social Costs of Drug Abuse in Australia in 1988 and 1992*, AGPS, Canberra.

penalties and convictions (that can often affect a person's chance of employment as well as other opportunities reliant on minimal or no criminal convictions) but also through the reduction in court time and police work involved in the prosecution of drug users with possession-type offences. The Australian Bureau of Criminal Intelligence (now the Australian Crime Commission) supported the notion of diversion for "...appropriately classified offenders..."²⁹⁰ and suggested that this practice would "...allow police to rationalise their role consistent with the harm minimisation philosophy."²⁹¹ In 1999, the NSW Government experimented with the notion of a drug court as an alternative to existing judicial processes.²⁹² The purpose of the drug court was to deal with people who were dependent on illegal drugs and had committed a non violent crime, with an overall aim of helping people progress on from their drug dependencies (albeit through being compelled to attend drug treatment) and move away from criminal networks. Such changes in approaches and penalties directed toward drug users was indicative of the overall trend towards lessening penalties (and drug related harms) for drug users and increasing penalties toward drug manufacturers, traffickers and suppliers in this period.

Amendments to drug laws and implementation of, for example, diversion programs reflected a change in thinking about the nature of drug use as being a health problem rather than a criminal problem. Another benefit of diversion programs was a redirection of resources dedicated to the penalisation of drug use towards trafficking offences. Sutton and James²⁹³, Green and Purnell²⁹⁴ and Weatherburn and Lind²⁹⁵ in

²⁹⁰ Australian Bureau of Criminal Intelligence, 1997, *Australian Illicit Drug Report 1996-7*, Commonwealth of Australia p10.

²⁹¹ *ibid.*

²⁹² *ibid.*, p126.

²⁹³ Sutton, A & James, S., 1996, *Evaluation of Australian Drug Anti-Trafficking Law Enforcement*, National Police Research Unit, Adelaide.

²⁹⁴ Green, P & Purnell, I., 1996, *Measuring the success of law enforcement agencies in Australia in targeting major drug offenders relative to minor drug offenders*, National Police Research Unit, Adelaide.

their studies of law enforcement practice all presented arguments for a distinction between manufacturers/traffickers and drug users in policy. To an extent economic imperatives (for example the reduction of court costs allocated to processing possession offences) provided a further rationale for this change while the health sector seen as best placed to address issues of drug use.

Third, there has also been research and focus on the counter-productive and unintended effects of policing and, specifically, how such activities can exacerbate and/or generate drug-related harms. In the 1990s, research²⁹⁶ into the connection between law enforcement and the effect on drug-related harms occurred. Previously the notion of unintended harm that resulted from law enforcement efforts to police illicit drugs had been regarded as a necessary evil. For example, while street level policing of illicit drug use and dealing in public areas has the overall aim of reducing the prevalence of drug use and associated criminal activity, it may also however, lead to displacement of the problem into neighbouring areas. Moreover, zealous street level policing of drug use in public places can also impact on the way in which drug consumers administer drugs (for example: rushed injection practices leading to increased risk on contracting BBVs) and dramatically increase harms well beyond those associated with the drug itself. Indeed, by the 1990s such a dynamic was recognised by law enforcement agencies, with a report from the Australian Bureau of Criminal Intelligence reporting that:

²⁹⁵ Weatherburn, D., & Lind, B., 1995, *Drug Law Enforcement Policy and Its Impact on the Heroin Market*, New South Wales Bureau of Crime Statistics and Research, Sydney.

²⁹⁶ Sutton, A & James, S., 1996, *Evaluation of Australian Drug Anti-Trafficking Law Enforcement*, National Police Research Unit, Adelaide; Green, P & Purnell, I., 1996, *Measuring the success of law enforcement agencies in Australia in targeting major drug offenders relative to minor drug offenders*, National Police Research Unit, Adelaide; Weatherburn, D., & Lind, B., 1995, *Drug Law Enforcement Policy and Its Impact on the Heroin Market*, New South Wales Bureau of Crime Statistics and Research, Sydney.

Drug users react in various ways to street level policing in order to avoid detection. They often go 'underground' to avoid scrutiny and in some cases they even fail to seek out treatment opportunities because they fear police involvement. Under a strict law enforcement approach heroin users found injecting in public places should be arrested. Consequently, some users inject drugs in less than ideal situations, often quickly, soon after purchase, without sterile needles, and under constant pressure of detection. It would appear that street level policing is leading to an unintended, but potentially serious, harm for users. In the long run this will harm society as a whole...Law enforcement thus must strike a balance between the need to deter drug use and the need to avoid harming consumers.²⁹⁷

In *Drug law enforcement policy and its impact on the heroin market*, Weatherburn and Lind noted the way in which law enforcement can drive up heroin prices which then creates a need for drug users to commit crime to fund higher costs of the drug.

It is the effect of prohibition on the price of heroin, after all, not the effect of the drug on heroin users, which causes them to commit property crime at very high rates.²⁹⁸

Weatherburn and Lind's research found that variations on the average amount of heroin seized exerted no impact on the price, purity or availability of heroin at street level, and, rate of arrest for heroin users similarly exerted no effect on the street price or the rate at which users seek treatment.²⁹⁹ Moreover this research also examined whether street level policing impacted upon the rate of admission into MMT. Examples of such research examined not only the effect of policing interventions on crime outcomes but also on health outcomes. Such research into the effect of law enforcement on drug related harm and the interplay between policing efforts and the price and purity of illicit drugs is indicative of the development of a greater

²⁹⁷ Australian Bureau of Criminal Intelligence, 1997, *Australian Illicit Drug Report 1996-7*, Commonwealth of Australia, p7.

²⁹⁸ Weatherburn, D., & Lind, B., 1995, *Drug law enforcement policy and its impact on the heroin market*, New South Wales Bureau of Crime Statistics and Research, Sydney, piii.

²⁹⁹ *ibid.*

understanding by law enforcement bodies of the impact of their activities on drug related harm and the ways in which such agencies can work to minimise such impacts.

Ultimately, in the period between 1990 and 2000, there was a focus on improving the performance of police in relation to the overall goal of reducing harm. In this period, several groups advocated for changes to police practice. The Victorian Drug Expert Committee³⁰⁰ suggested changes to the role of police such as: greater cooperation and links with health agencies, especially treatment providers (for example MMT); initiation of drug courts; monitoring of the counterproductive impacts of law enforcement across jurisdictions; commitment for further training in harm minimisation for police officers; and relaxation of laws regarding medicinal use of cannabis. Indeed the majority of the recommendations for law enforcement in this document advocated further entrenchment of harm minimisation ideas in illicit drug policing. Additionally, the *1996-7 Australian Illicit Drug Report*³⁰¹ suggested that training in harm minimisation for Police be enhanced and continued.

In 1996, the Victorian Premier's Drug Advisory Council also suggested that the Police should ensure that harm minimisation strategies govern operational practice at all levels of the force.³⁰² The 1997 Single and Rohl evaluation of the *1993 National Drug Strategic Plan* made recommendations in regard to enhancing the cooperation between health and law enforcement that included: rescheduling MCDS meetings so to allow greater law enforcement personnel attendance as well as more law

³⁰⁰ Drug Policy Expert Committee, 2000, *Drugs: meeting the Challenge*, Stage Two Report, Victorian Government, accessed at <http://www.health.vic.gov.au/drugservices/pubs/polcomm.htm>, on 12/12/04, p182

³⁰¹ Australian Bureau of Criminal Intelligence, 1997, *Australian Illicit Drug Report 1996-7*, Commonwealth of Australia, p8.

³⁰² State Government of Victoria, 1996, *Turning the Tide: Victorian Government Response to the Report of the Premier's Drug Advisory Council and Implementation Strategy*, State Government of Victoria, Melbourne.

enforcement involvement in secretariat functions and agenda setting.³⁰³ Finally, in the period 1990-2000, elites from the law enforcement sector have advocated such initiatives as supervised injecting centres and prescription heroin. This is discussed in greater detail in the following section and in chapter five.

Up until the NCADA in 1985, law enforcement and health agencies worked in relative isolation from each other to address particular illicit drug issues. In the period 1990 to 2000, it was evident that police practice had undergone some change in relation to the way law enforcement agencies addressed the issue of illicit drugs. Changes to police practice, implementation of cannabis cautioning and diversion programs and research into the role and effects of policing can be at least partly attributed to the increased collaboration between law enforcement and health sectors generated by the successive NDS' that created ongoing opportunities for increased collaboration and cooperation. Moreover, it is clear that policy-makers seemed willing to change the policy 'status quo' toward regarding personal use as a health issue while promoting the enhancement of the role of law enforcement in addressing trafficking and manufacturing.

³⁰³ Single, E & Rohl, T., 1997, *The National Drug Strategy: mapping the future*, AGPS, Canberra, p67.

Advocating Prescription Heroin and Supervised Injecting Centres

A substantial increase in opioid overdose and associated rise in public nuisance associated with heroin use in cities such as Melbourne and Sydney in the 1990s meant that options such as supervised injecting centres (SICs) and trials of prescription heroin were considered by some state governments. While harm reduction advocacy attempts in relation to prescription heroin and SICs are the subject of the following chapter, a brief outline is provided here as such efforts are relevant in the period of analysis of this chapter. The proposed ‘heroin trial’ involved the provision of injectable heroin as a form of treatment for opioid dependent people which had either not sought treatment or who had failed at other forms of treatment, including MMT.³⁰⁴ SICs are premises designed to provide a safe environment for the injection of illicit drugs and also called ‘drug consumption facilities’, ‘injecting rooms’ or ‘medically supervised injecting centres’ (in New South Wales), ‘supervised injecting place’ (ACT) and ‘off street injecting facilities’ (Victoria). Both SICs and prescription heroin are easily classified as harm reduction interventions due to their focus on the reduction of drug related harm for people that continue to use illicit drugs. Around the time when the issue of problematic heroin use was identified as an issue in metropolitan cities such as Sydney and Melbourne, a change of federal government occurred. In March 1996, the Howard-led Liberal Coalition Government was elected by voters, succeeding the Keating-led ALP Government. The ALP Government had been instrumental in the establishment of harm reduction measures such as NSPs and self-help drug user groups in the 1990s.

³⁰⁴ Hall, W., Kimber, J & Mattick, P., 2002, Breaking the deadlock over an Australian trial of injectable opioid maintenance, *MJA*, 176:2, pp72-3.

Heroin trial

Advocates for a trial of prescription heroin in Australia suggested that the initiative would increase the proportion of people with opiate dependencies in treatment, reduce street heroin use, drug-related crime, and deaths due to overdose. In 1997, the MCDS voted in favour of a heroin trial.³⁰⁵ After only a year in Government, the Howard Cabinet intervened to stop the trial occurring, with the justification that the Australian Government would require special legislation to enable the importation of heroin.³⁰⁶ Prime Minister Howard suggested that the trial was contingent on this legislation and also that such an initiative “would send the wrong message” to the community in regard to drug use.³⁰⁷ The trial was to be conducted in the ACT, which is under Australian Government rule. Consequently the Government refused to amend legislation to allow heroin to be imported for the trial or allocate funds to monitor the use of heroin in accordance with international treaties.³⁰⁸ Dramatic rises in the number of deaths caused by opioid overdose in subsequent years prompted further calls for a heroin trial.³⁰⁹ The Australian Government, by refusing to countenance a trial, created a policy deadlock that prevented the evaluation of a program that proponents claimed was a potentially valuable policy option for both health and law enforcement sectors.

Supervised Injecting Centres

SICs have been operating in Europe since the 1970s as a public health intervention and as a response to public nuisance problems associated with injection of drugs in public places. Facilities were located mainly within other health services that were

³⁰⁵ *ibid.*

³⁰⁶ Campbell, A., 2001, *The Australian Illicit Drug Guide*, Black Inc, Melbourne, p450.

³⁰⁷ *ibid.*

³⁰⁸ Hall, W., Kimber, J & Mattick, P., 2002, Breaking the deadlock over an Australian trial of injectable opioid maintenance, *MJA*, 176:2, pp72-3.

³⁰⁹ *ibid.*

directed both at those that continued to use and those who wished to stop their use. In 1997, the report from the Wood Royal Commission into the NSW Police Service advocated for SICs, which generated widespread debate in Australia.³¹⁰ A diverse group participated in the debate that included: members of all tiers of Government; community organisations; the clergy; researchers; alcohol and other drug agencies; professional bodies; and advocacy groups.³¹¹ Following the Royal Commission, a NSW Parliamentary Group was established in 1997 to consider trialling the centres.³¹² Recommendations in the *Report on the Establishment or Trial of Safe Injecting Rooms* from this group suggested that the trial should not take place.

Subsequently, in 1998 frustrated workers decided to open an unofficial supervised injecting room called the 'Tolerance Room' located at the Wayside Chapel, Uniting Church in Kings Cross. The room attracted much controversy and was open for several weeks.³¹³ In 1999 the Vatican instructed the Sisters of Charity³¹⁴, to abandon plans to open a SIC in Sydney.³¹⁵ Such grassroots resistance in the form of civil disobedience was reminiscent of the instigation of NSPs in the previous decade whereby drug and alcohol workers at St Vincent's Hospital in Sydney started Australia's first NSP. A detailed discussion on the policy debates surrounding prescription heroin and SICs occurs in the following chapter.

³¹⁰ Campbell, A., 2001, *The Australian Illicit Drug Guide*, Black Inc, Melbourne, p450.

³¹¹ Dolan, K., Kimber, J., Fry, C., Fitzgerald, J., McDonald, D & Trautmann, F., 2000, 'Drug consumption facilities in Europe and the establishment of supervised injecting centers in Australia', *Drug and Alcohol Review*, 19, p342.

³¹² Joint Select Committee into safe injecting rooms, 1998, *Report on the establishment or trial of safe injecting rooms*, Parliament of New South Wales.

³¹³ Dolan, K., Kimber, J., Fry, C., Fitzgerald, J., McDonald, D & Trautmann, F., 2000, 'Drug consumption facilities in Europe and the establishment of supervised injecting centers in Australia', *Drug and Alcohol Review*, 19, p342.

³¹⁴ The Sisters of Charity are a religious catholic order and operate from St Vincent's Hospital in Sydney, whereby another harm reduction advocate Dr Alex Wodak works and also the facility opened the first NSP in Australia as mentioned in chapter three.

³¹⁵ Campbell, A., 2001, *The Australian Illicit Drug Guide*, Black Inc, Melbourne, p451.

It is important to note in this chapter, however, that the prescription heroin trial came very close to being implemented and was supported by the peak illicit drug body, the MCDS yet was thwarted by the Howard Government. Chapter five provides a detailed examination of the arguments used for and against, and the advocacy methods, employed by both harm reduction and moral-abstinence coalitions with regard to prescription heroin trial and SICs undertaken by stakeholders.

The Softening of Harm Reduction?

Another phenomenon that occurred into the 1990s was a focus on the meanings of the terms ‘harm minimisation’ and ‘harm reduction’, and more specifically, what types of interventions/policies/programs such terms encompassed. The central issues in debates were whether the term ‘harm reduction’ could encompass abstinence-oriented approaches and moreover, whether the term harm minimisation could describe initiatives such as supply reduction. As stated in the first chapter, the original meaning of harm minimisation/reduction (both were used originally used interchangeably), coined in the early 1980s, was to describe policies and programs designed to reduce drug related *harm* without requiring a reduction in drug *use* among individuals that accessed such programs. This kind of philosophy toward drug use accepted that people may continue to use illicit drugs, in contrast to abstinence-oriented approaches that aim to have a drug user become drug free. With the adoption of ‘harm minimisation’ as the key notion of Australia’s drug policy in 1985, the meaning of the term was widened (in the Australian context) to include supply reduction initiatives as well as abstinence-oriented approaches. Indeed, definitions of ‘harm minimisation’ in Australia’s national drug strategies since 1985 have stated that the very *combination* of supply, demand and harm reduction act in

concert to result in the reduction of drug related harm. Therefore since 1985 in the Australian context, the term harm minimisation has an entirely distinct meaning to 'harm reduction'.

In 1998, Single and Lenton³¹⁶ identified 'narrow' and 'broad' definitions of harm reduction. Narrow definitions included those that referred *only* to the reduction of harm among people that continued to use. Thus, within this definition, interventions could only be called harm reduction if they were aimed at people that wished to continue to take drugs, therefore excluding abstinence-oriented strategies. The broad definition of harm reduction, however, encompassed *any* program or policy that was theorised to reduce drug-related harm. Such a definition could include abstinence-oriented approaches such as those seen in some drug treatment interventions (for example, Narcotics Anonymous). In 1995, Wodak and Saunders noted "...to some harm reduction means the employment of any means to reduce the harm resulting from illicit drugs"³¹⁷ thus reflecting the way in which the term had been co-opted since the original meaning was coined in the early 1980s. Essentially, for some the broad definition was *too* inclusive, whereby any policy or program could claim to reduce drug related harm. In this vein then, '12 step' (for example: narcotics anonymous) programs could be classified as harm reduction programs. Wodak and Saunders suggested that the logical extension of these broad definitions could include drug-free states or the indefinite incarceration of drug users to prevent them doing harm to themselves or others.³¹⁸

³¹⁶ Lenton, S., & Single, E., 1998, 'The definition of harm reduction', *Drug and Alcohol Review*, 17.

³¹⁷ Wodak, A., & Saunders, B., 1995, 'Special issue on harm reduction', *Drug and Alcohol Review*, 14, p269.

³¹⁸ *ibid.*

The *National Drug Strategic Framework 1998-99 to 2002-03* (released by Federal Liberal Government) was the third instalment of national strategies released by federal governments since the NCADA in 1985 (the two latter strategies were released by Federal Labor Governments). The document offered this justification of harm reduction:

Governments do not condone illegal risk behaviours such as injecting drug use, but they do acknowledge that these behaviours occur. They have a responsibility to develop and implement public health and law enforcement measures designed to reduce the harm that such behaviours can cause, both to individuals and the community. In these circumstances harm reduction strategies specifically target the individual using drugs and promote initiatives that benefit the wider community. For example, drink driving was identified as a serious drug related harm and changes to legislation and law enforcement practices were introduced. These harm reduction strategies aimed to reduce harm associated with drink driving. Similarly, while the practice of injecting drug use continues, the provision of sterile injecting equipment through needle and syringe exchange programs is an important harm reduction strategy for preventing the spread of blood borne viruses such as HIV and hepatitis C.³¹⁹

The quote reflects the politically sensitive nature of harm reduction programs, as the rationale for such approaches are often accompanied by a caveat suggesting that governments do not really wish to implement such programs but are compelled to do so in the interests of public health. The 1996 National HIV/AIDS strategy echoed the importance of harm minimisation as a broad approach and the utility of harm reduction strategies within this broader framework. This document, however, saw the term 'harm reduction' as including both approaches aimed at those who

³¹⁹ Ministerial Council on Drug Strategy, 1998, *National Drug Strategic framework 1998-99 to 2002 – 03*, Canberra, Commonwealth of Australia, p16.

continued to use and also abstinence-oriented approaches.³²⁰ The following quote was drawn from the 1998 NDS, written before the quote above:

Governments do not support or encourage illegal risk behaviours such as injecting drug use, but they do acknowledge that these behaviours occur. They recognise their responsibility to develop and implement public health measures designed to minimise the harm that such behaviours can cause, both to individuals and to the community. Harm minimisation seeks to balance the cost to the community and to individuals of illegal behaviours ...This approach acknowledges the fact that some individuals will continue to participate in illegal behaviours.³²¹

Lenton and Single critiqued the narrow definition and suggested that it may have excluded some interventions such as abstinence-oriented detoxification programmes, court diversion and cautions for first offenders that clearly have the capacity to reduce drug related harm. They insisted that abstinence-oriented strategies can result in reduction of drug related harm and thus to omit these might exclude what could be an effective alternative. Moreover, sometimes a contained period of abstinence can be negotiated with a user who wishes to work towards a long term goal of self regulated use. Lastly they argue that this narrow definition did not reinforce communication between different sections of the drug treatment sector that is conceptually divided between abstinence and non abstinence-oriented services and similarly created divisions between supply reduction versus law reform.³²² The authors argue that this last point is the main reason that Australian and Canadian drug strategies have used the broader definition of harm reduction. It was also noted that the narrow definition is of little use when applied to tobacco smokers that

³²⁰ Commonwealth of Australia, 1996, *Partnerships in Practice: National HIV/AIDS Strategy 1996-7 to 1998-99*, AGPS, Canberra, p16.

³²¹ *ibid*, p16-7.

³²² Lenton, S., & Single, E., 1998, 'The definition of harm reduction', *Drug and Alcohol Review*, 17, p214.

usually aim for cessation. Moreover, some harm reduction measures involved affecting the amount or frequency of drug use, for example: trying half of one's supply first in order to test for quality so to avoid overdose or taking a break from use. Further, some research has described a situation whereby peers exert pressure on fellow users in order to stymie excessive or inappropriate drug use.³²³

In 1998, Single and Lenton defined three criteria that characterised harm reduction:

A policy, programme or intervention should be called harm reduction if, and only if: (1) the primary goal is the reduction of drug related harm rather than drug use per se; (2) where abstinence-oriented strategies are included strategies are also included to reduce the harm for those who continue to use drugs; and (3) strategies are included which aim to demonstrate that, on the balance of probabilities, it is likely to result in a net reduction in drug related harm.³²⁴

Successive national drug strategies from the NCADA in 1985 to the *National Drug Strategic Framework 1998-99 to 2002-03* used the broader definition of harm minimisation that included supply reduction and demand reduction and sometimes mentioned harm reduction (indicated by problem prevention and/or use of the phrase “without necessarily eliminating use”). Single and Lenton argued that the broader definition of harm minimisation as encompassing many different types of approaches adopted in all national drug strategies has provided common ground for all drug policy stakeholders to collaborate, and “...to a greater or lesser extent, to reduce drug related harm”.³²⁵ The broader definition reflected the interaction between health and

³²³ Gamble, L., & George, M., 1997, ‘Really useful knowledge’: the boundaries, customs and folk laws governing recreational drug use in a sample of young people’, in Erickson, P, Riley, D., Cheung, Y, O’Hare, P., (eds) *Harm Reduction: a new direction for drug policies and programs*, Toronto, University of Toronto Press, pp340-62.

³²⁴ Lenton, S., & Single, E., 1998, The definition of harm reduction, *Drug and Alcohol Review*, 17, pp213-220.

³²⁵ *ibid*, p215.

law enforcement sectors under the framework of successive national drug strategies. That supply reduction was classified as a strategy that reduced drug related harm was dubious for some commentators as the policy mix of supply reduction and harm reduction could be construed as counterproductive:

It has been claimed that attempts to legislate and enforce abstinence are counterproductive, and that there are harms due to these measures that are far worse than the effects of the drugs themselves.³²⁶

Indeed, supply reduction has the capacity to create a new suite of drug related harms (for example, displacement of heroin users and vendors to other areas and rushed preparation and injection can lead to unsafe injecting techniques and associated harms such as BBV transmission and poor vein health) and in some cases exacerbate existing harms (for example, the fluctuating purity of opiates purchased on the illicit market can lead to overdoses). The measurement of the extent to which law enforcement activity actually manufactures drug related harms that harm reduction programs must then respond to is beyond the scope of this research, however it must be mentioned here that this dynamic in illicit drug policy has the capacity to be somewhat ironically counterproductive.

Ultimately, the original meaning of harm reduction encompassed a set of ideas which challenged dominant approaches to illicit drug use, moreover many writers that advocated for harm reduction critiqued existing models of drug policy such as prohibition. Since the implementation of harm reduction programs however, such

³²⁶ Erickson, P, 1992, 'Political pharmacology: Thinking about drugs', *Daedalus*, Summer, pp239 – 267; Nadelmann, E., 'Progressive legalizers, progressive prohibitionists and the reduction of drug-related harm', *Psychoactive drugs and harm reduction: from faith to science*, N, Heather, A, Wodak, E, Nadelmann & P, O'Hare (eds), London, Whurr; O'Hare, P., 1992, 'Preface: A note on the concept of harm reduction', in P., O'Hare, R., Newcombe, A., Matthews, E., Bunning & E., Drucker (eds), *The reduction of drug related harm*, New York, Routledge; Riley, D., & O'capella, E., 1997, 'Canada's new drug law: Some implications for HIV/AIDS prevention in Canada', *International Journal of Drug Policy*, 7:3, p180-182.

policies and programs have had to work within the dominant framework and as such confront underlying tensions between traditional abstinence-based and alternative approaches. A reluctance to be more inclusive of abstinence oriented programs, exemplified in the debate regarding the definition of harm reduction, may be a result of a fear held by harm reduction supporters that such a move might constitute a first step to co-option of their policies and programs. Indeed the underlying politics of harm reduction (which were more evident before the approach was enshrined in mainstream policy) were in direct opposition to traditional abstinence-oriented models.

Explaining Policy Change through the Advocacy Coalition

Framework

In this period there were several changes to policy such as the instigation of HCV organisations and changes to police practice in relation to illicit drugs. Support for those harm reduction services implemented in the previous decade (NSPs, self-help drug user groups and expansion of MMT) remained fairly stable in their period yet attempts to implement further harm reduction such as prescription heroin and SICs were stymied. The stronger relationship and greater interaction between health and law enforcement agencies under the framework of NCADA and successive national drug strategies was evident in this period and resulted in policy change. Indeed, the main type of policy change between 1990 and 2000 was changes to law enforcement practice and also the types of questions that research into policing posed. Drawing on Table 1, this section will examine key points of the ACF and their utility in explaining policy change.

ACF Concept 1 & 2: Advocacy Coalitions & Policy Core Beliefs

The notion of advocacy coalitions adequately describes the variety of policy actors united by their belief in the utility of harm reduction ideas. Such individuals and organisations supported phenomena as NSPs, safer injecting education, self-help drug user groups, expansion of MMT as well as SICs and prescription heroin. In the period 1990 to 2000, the harm reduction coalition consisted of individuals and groups from medical and research fields, workers in the alcohol and other drugs sector, grassroots community workers, some members of the Gay community, affected communities represented in self-help drug user groups, key members of the bureaucracy and representatives from law enforcement fields. The inclusion of law enforcement among the coalition advocating for harm reduction ideas in policy was a relatively new phenomenon. Although certain judges and experts with a law enforcement background had advocated in previous decades for incorporation of some harm reduction ideas to government policy (most notably in the Royal Commissions in the 1970s), in this decade there was systemic support for harm reduction policies and programs from law enforcement personnel. This occurred most notably in debates regarding SICs which will be expanded upon in the following chapter. In this period harm reduction ideas were increasingly integrated into policing policies and practices reflecting the extent of policy oriented learning. Research into the counterproductive effects of policing, specifically the capacity of law enforcement activities to manufacture drug related harm also reflected policy oriented learning and the increasing importance of the concept of drug related harm being used as a policy barometer. Thus in this period there was a noticeable expansion of the harm reduction coalition to include law enforcement personnel. This expansion of the support base for harm reduction may be attributed to the

increased interaction between health and law enforcement sectors since the instigation of the NCADA in 1985. Indeed, the extent of policy-oriented learning between sectors is discussed further in this chapter.

That coalition actors' displayed consensus on such 'policy core' ideas, such as the reduction of drug-related harm as a primary policy goal in health services (rather than abstinence), was clear from policy documents surveyed in this chapter. Central to advocacy efforts throughout this decade was the public health utility of harm reduction programs, especially in regard to the prevention of the transmission of BBVs both within the drug using community, and between drug users and the mainstream populations. The link between harm reduction programs and their capacity to curb HIV/AIDS transmission, (established in the previous decade) continued and influenced the way that harm reduction policies and programs were justified. HCV presented a new threat to public health in this period and galvanised advocacy efforts. Indeed, critical support for harm reduction programs and policies were also drawn from such arenas as gay and public health communities (for example, public health departments in the bureaucracy). The considerable overlap between both HIV/AIDS and HCV prevention efforts and harm reduction programs for illicit drugs highlighted the importance of such approaches in terms of their potential impacts on public health.

ACF Concept 3: Guidance Instruments

The identification in 1988 of a second BBV, namely HCV, that may be spread among injecting drug users and into the general community presented the harm reduction coalition with further opportunities to affect policy in the 1990s. In the

late 1980s and early 1990s, coalition actors mobilised and instigated peak national groups and state organisations to respond to this public health issue. As noted earlier, the link between the HCV virus and injecting drug use was well recognised with the majority of new transmissions linked to the phenomenon of injecting drug use.³²⁷ Harm reduction approaches that focused on safer injecting techniques to encourage behaviour change among those that injected were deemed critical to limiting the spread of the virus. In contrast to HIV/AIDS in the previous decade, however, the disease characteristics of HCV (being a slow acting virus with less aggressive symptoms than HIV/AIDS - at least in the short to medium term - and transmitted exclusively through blood to blood contact, in contrast to HIV/AIDS whereby saliva and other bodily fluids contain the virus) meant that the virus presented less of a threat to the mainstream population as HIV/AIDS and consequently advocacy efforts were not as successful with HCV policy mirroring that of HIV/AIDS.

The upsurge in problematic heroin use during the 1990s also presented the harm reduction coalition with opportunities to affect policy. Feasibility studies and community development regarding the implementation of a trial of prescription heroin were conducted in the early to mid 1990s. Moreover, SICs were also offered as possible responses to address the visibility of problematic heroin use. Ultimately when the issue of problematic heroin use was raised in the 1990s, the harm reduction coalition were prepared to present possible solutions having conducted the necessary community development and research. Both prescription heroin and SICs are the subject of the following chapter and as such are not discussed at length here.

³²⁷ Crofts N., Jolley D., Kaldor J., 1997, 'Epidemiology of hepatitis C virus infection among injecting drug users in Australia', *Journal of Epidemiology and Community Health*, 51, pp692-697.

While both the identification of HCV as a virus transmissible through the sharing of injection equipment and the increase in drug related harm from heroin use occurred in this period, the election of the Federal Howard Government in 1996 had a major limiting effect on the advocacy efforts of the harm reduction coalition. Coalition efforts to implement a trial of prescription heroin and SICs were largely unsuccessful due to direct intervention from the Federal Liberal Government. The prescription heroin trial was abandoned in 1997 following an intervention and accompanying decree from Prime Minister Howard that such an approach would not be implemented. While one SIC was implemented in this period, it was an isolated victory for the harm reduction coalition.

ACF Concept 7 & 8: Policy oriented learning and policy change

A key part of the theorising on policy change in the ACF revolved around the notion of cross-coalition learning. The authors of the ACF contended that policy change might be the result of policy oriented learning within and between coalitions. The assumptions in the ACF regarding the cross pollination of ideas in professional environments includes hypotheses on the way in which information is disseminated and moderated and the nature of the forums. Sabatier developed two hypotheses about cross coalition learning and one schema that outlined the qualities of “successful forums”.

ACF Hypothesis: policy oriented learning across belief systems is most likely when there is an intermediate level of informed conflict between the two coalitions. This requires that:

- a) each has the technical resources to engage in such a debate.

Sabatier's hypotheses regarding cross-coalition learning and consequent policy change holds in this analysis of Australian drug policy developments during 1990-2000. Both the health and law enforcement sectors were funded through successive national drug strategies and had to interact with each other when debating drug policy as part of the national framework. Sabatier's hypothesis regarding the conduct and nature of such professional norms is as follows:

ACF Hypothesis: policy oriented learning across belief systems is most likely when there is a forum which is:

- a) prestigious enough to force professionals from different coalitions to participate; and
- b) dominated by professional norms³²⁸

This hypothesis is also supported in this analysis with these forums (discussed below) conducted at a national level and constituting the apex of decision making in Australian drug policy. Such forums are necessarily dominated by professional norms. Personnel drawn from the elite level of both health and law enforcement sectors regularly engaged in high level committees and meetings in such forums as:

- the *Ministerial Council on Drugs* (MCDS), the peak policy and decision-making body in relation to licit and illicit drugs in Australia. The council membership included representatives of Australian and state and territory Ministers from health and law enforcement, including the Minister responsible for Education. The role of the council was to determine national policies and programs within the Australian community. The MCDS met biannually since inception.³²⁹

³²⁸ Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe, *Journal of European Public Policy*, 5:1, p106.

³²⁹ For details about the membership of the MCDS, see the Australian Government National Drug Strategy website: <http://www.nationaldrugstrategy.gov.au/councils/mclds.htm>, accessed 15/3/05.

- the *Intergovernmental Committee on Drugs*³³⁰ (IGCD) (and its predecessor, the National Drug Strategy Committee) which provided policy advice to Ministers on the full range of drug-related matters and was responsible for implementing the National Drug Strategic Framework. This Committee membership was comprised of senior officers representing health and law enforcement in each Australian jurisdiction as well as people with expertise in identified priority areas, including representatives of the Australian Customs Service, the Ministerial Council on Aboriginal and Torres Strait Islander Affairs and the Department of Education, Science and Training.³³¹
- the *Australian National Council on Drugs* (ANCD), which was established in March 1998 as a vehicle to exact the voice of the non-government sector into drug policy. The ANCD represented a cross-section of interests and expertise ranging through academia, medicine, education, law enforcement, treatment services, families who have suffered loss, those who have been affected by drugs, the Indigenous community and government. This forum met quarterly since its 1998 inception.

Professional forums such as these were conducted regularly throughout the period of analysis and were pivotal in the development of illicit drug policy.

A key factor articulated in the ACF related to the process of policy change is the nature of the professional forums that facilitate exchanges of ideas, and consequently learning, between coalitions. In order to be defined as a successful forum under the

³³⁰ For details about the membership of the Intergovernmental Committee on Drugs, see the Australian Government National Drug Strategy website. This lists the current membership of the committee, it is clear that it is equally shared between both health and law enforcement sectors with relevant members from other jurisdictions such as education, aboriginal affairs and state representatives. http://www.nationaldrugstrategy.gov.au/councils/igcd_members.htm, accessed 15/3/05.

³³¹ For details about the membership of the Australian National Council on Drugs, see the Australian Government National Drug Strategy website <http://www.nationaldrugstrategy.gov.au/councils/igcd.htm>, accessed 15/3/05.

ACF, consensus must be reached among previously disagreeing members, and secondly the decisions of the forum must have been accepted by the major coalitions involved.³³² Further characteristics of successful forms are described in the ACF as such:

- 1) *Composition*: forums must be composed of officials associated with each of the coalitions and chaired by a neutral official.
- 2) *Funding*: Funding must come from a source not dominated by a specific coalition.
- 3) *Duration*: the forum should meet at least half a dozen times “over a year or so”.
- 4) *Context of a mutually unacceptable policy stalemate*: a successful forum is one in which coalitions view a continuation of the status quo are unacceptable. Meaningful compromise is only attained when coalitions are willing to alter their perceptions in aspects, such as the seriousness of various causes of the problem.

When related to the above groups, Sabatier’s schema on ‘successful’ forums holds in this analysis, and these are considered in turn below:

- 1) *Composition*: all of the committees described above had shared membership from health and law enforcement sectors, and while the chair was not always a neutral player, this role was often shared between both sectors on a rotational basis.

³³² Sabatier, P., et. al. 1993, *The Advocacy Coalition Framework, Policy Change and Learning*, Westview Press, San Francisco, p148.

- 2) *Funding*: committees were funded from Government sources under the NDS and thus not dominated by either health or law enforcement.
- 3) *Duration*: some forums met more, or less, regularly than the frequency described in the ACF, however due to the complex web of committees and official groups it is clear that both sectors have countless opportunities (in many types of committees and groups) to meet in this period.
- 4) *Context of a mutually unacceptable stalemate*: both health and law enforcement sectors, and Government more generally, were clearly frustrated with the status quo of drug policy during the period of analysis and had been so since the late 1970s. Reform efforts conducted prior to 1990 were not considered to have produced satisfactory results and the issue of the ‘drug problem’ as a challenge for policy had been recurrent since the late 1970s.

Another minor change involved research into the counterproductive effects of law enforcement on drug related harm. Where previously the role of law enforcement went largely unchallenged, research in this area in Australia started to be conducted in the 1990s with the results articulated by law enforcement bodies. Such changes signified that, to an extent, the aim of drug policy had started to change from protection of morality to protection of the public health. Another minor change within the law enforcement sector were cannabis cautioning policies and diversion schemes as a way of reducing legal harms to those that consumed illicit drugs. However, at the same time, penalties remained significant for those who manufactured and/or sold illicit drugs.

These changes to law enforcement in this period are classified as ‘minor changes’ in the *drug policy* subsystem but classified under the ACF as ‘major’ in the *law*

enforcement subsystem. These minor changes can, at least, be partly attributed to the policy oriented learning which had taken place as a result of the increased interaction between the health and law enforcement sectors during the period of analysis, that was in turn, generated by the broad framework of the NDS.

Coalition strategising

The advent of HCV presented simultaneous opportunities and challenges for those that advocated for harm reduction programs and policies. The virus had the potential to cause both significant physical harm in some individuals and substantial economic cost to the public health budget in the long term. Harm reduction approaches were widely endorsed as a sound public intervention to the spread of HCV with organisation around the issue mimicking that of HIV/AIDS. Indeed, similar to the public health threat of HIV/AIDS half a decade before, the advent of HCV further strengthened the utility of harm reduction policies and programs as sound interventions to engender the containment of BBV transmission.

Australia's response to the management of HCV, described earlier, highlighted contemporary challenges to harm reduction policy and practice. First, and in contrast to HIV/AIDS, policy responses to contain HCV were impeded by drug laws and law enforcement activity that inhibited behaviour change of injecting drug users. For example and as described earlier, increased surveillance and policing of an area deemed to be a drug using 'hotspot' can result in increased drug related harm as injecting drug users attempt to inject quickly to avoid scrutiny, potentially leading to careless injecting practices and consequently HCV transmission. Indeed, harm reduction strategies that encourage behaviour change of injecting drug users (such as

safer using education that suggest the optimal way to inject so to avoid BBV transmission) will always be contingent upon such contextual factors such as drug laws and policing. In the case of HIV/AIDS, legislation in regard to homosexual sex was repealed in most states and territories in the 1980s, thus beginning the process of removing the stigma attached to such activity which enabled safe sex education. In contrast, laws prohibiting possession and self administration of drugs remained in states and territories around Australia to varying degrees in this period. In sum, the illegality of injecting drug use continued to limit the potential of the public health benefits from harm reduction approaches in reducing the transmission of BBVs, and drug related harm more generally.

The second challenge to harm reduction advocates was the differing disease characteristics of HCV in comparison to HIV/AIDS. That the virus would largely be contained within the injecting drug user community (a largely diverse and marginalised group) and thus not present the same threat to the mainstream population as did HIV/AIDS meant that acceptance and support of the issue was difficult to broker in the political marketplace. Organisation in response to the virus mimicked that in response to HIV/AIDS however, given the particular characteristics of HCV, the annual rate of new transmissions far outnumbered that of HIV/AIDS.

Hepatitis C is the most commonly diagnosed notifiable communicable infection in Australia. There have been more than 165 000 notifications of hepatitis C infection since 1990, when antibody testing became available in Australia. The number of notifications remained very stable, at 18 000–20 000 a year, between 1994 and 2000. It is estimated that there were approximately 210 000 people living with hepatitis C infection in Australia in 2001 and that around 16 000 new infections are occurring each year. The total number of notified cases represents approximately 60 per cent of the estimated number of people living with the virus. This is probably one of the

highest rates of diagnosis in the world. The actual rate of undiagnosed people may be lower, depending on the extent of multiple notifications.³³³

Curbing transmission rates of HCV continues to be a challenge to advocates of harm reduction policies and programs. The problem of how to garner support for programs to curb transmission rates of HCV among injecting drug users from a polity hostile and dismissive to the health problems of such populations remains one of the most salient public health issues in relation to injecting drug use in Australia today. As such, self-help drug user groups remain critical to these efforts as well as the long term goal of changing drug laws.

Conclusion

In this period harm reduction ideas, policies and programs were supported by key national policies, however toward the end of the decade it was clear that the coalition had experienced an 'identity crisis'. This identity crisis was in regard to the lack of a consensus regarding the correct definition of harm reduction, specifically questioning whether abstinence-oriented approaches could be classified as harm reduction approaches. Concurrently in this period, law enforcement had amended its approach toward some drug users with penalties being reduced or substituted with compulsory treatment programs (albeit some treatment programs being very short in duration). Finally an examination of the issue of HCV showed how supply reduction and harm reduction approaches coexist in an essentially counterproductive relationship as the former essentially generates a degree of drug related harm that the latter are then charged with the responsibility of ameliorating.

³³³ Australian National Council on AIDS, Hepatitis and Related Diseases, 2003, *National Hepatitis C Testing Policy*, p3-4.

Another important factor in the period 1990 to 2000 was the extent of policy oriented learning conducted as a result of successive NDS'. As described above, research into the counterproductive effects of policing and resulting changes to operational practices of law enforcement resulted in greater awareness of the way in which law enforcement is a contributor of drug related harm. Thus, to an extent the harm reduction project has benefited from the federal arrangements generated by NDS' through the propagation of harm reduction ideas in other arenas such as law enforcement.

The following chapter examines the attempts to implement a trial of prescription heroin in the ACT and several SICs in metropolitan areas in Australia in the mid to late 1990s. In contrast to the previous two chapters, chapter five centres on the arguments, both supporting and opposing, such initiatives. Indeed, the essence of such arguments for harm reduction programs is explored and evaluated. Both prescription heroin and SICs are highly controversial policy options implemented sporadically in the European context, in comparison to NSPs and MMT which have been more widely accepted and implemented in many more contexts around the world.

Chapter 5: Moral entrepreneurs and the undeserving: advocating prescription heroin and supervised injecting rooms in Australia in the 1990s

Introduction

For many people, the implementation of harm reduction initiatives such as supervised injecting centres (SICs) and prescription heroin signifies that the values of society have taken a step towards increasing permissiveness in relation to illicit drugs. That argument follows that an implicit 'message' is sent to the polity that illicit drug use is now condoned and by extension, encouraged, and, that this leads to an increase in the prevalence of injecting drug use. To date, this position is regarded as common sense by those who espouse it regardless of the fact that there is little to no evidence to support the link between such facilities or programs to an increase in intravenous drug use. For other sections of the community, such facilities and programs represent a pragmatic response to a public health and order problem. The capacity to ameliorate such drug related harms as BBV transmission (especially HCV), rates of overdose and moreover, to reduce the visibility and problems associated with public injecting of heroin are seen as necessary trade offs.

Chapters three and four of this manuscript examined advocacy of harm reduction policy in response to drug use over a 20 year period, commenting on the emergence of a coalition in the 1980s and the stagnation of harm reduction policy in the 1990s. This chapter focuses on a particular issue within that 20 years: namely the dramatic rise in problems associated with heroin use in the mid-to-late 1990s in Australia. This rise in problems meant an opportunity for stakeholders to suggest policy responses. Two potential policy panaceas advocated by the harm reduction coalition

were prescription heroin and SICs. This chapter examines the advocacy efforts of the harm reduction and moral-abstinence coalition regarding these proposed initiatives.

Two groups of actors were identified around this issue, the ‘harm reduction’ and the ‘moral abstinence’ coalition. Both groups were unified by their distinct approaches to the policy problem presented by increased problematic heroin use. These two groups and their associated ideologies have consistently been at the forefront of illicit drug policy debates since the early 1980s. Both groups used distinct strategies to influence policy: the harm reduction coalition largely employed an evidence based, scientific approach to support their policy positions whereas the moral abstinence coalition appealed to ‘moral truths’ while also drawing legitimacy for their position from general socio-cultural values whereby heroin is external to the boundaries of societal mores, often demonised and the practice of intravenous drug use is seen as ‘evil’.

Government policy papers (for example: the Commonwealth National Heroin Strategy), Parliamentary Committee reports (such as Joint Select Committee into Safe Injecting Rooms), proceedings from Hansard and key meetings (such as the NSW Drug Summit), key actors’ commentary from proceedings, websites from advocacy groups, National surveys, newspaper reports, reports from law enforcement and health institutes and journal articles were used. Largely the harm reduction coalition was unsuccessful in attempts to affect policy change regarding these particular initiatives. Only one trial of a SIC was approved in NSW while both a trial of prescription heroin in the ACT and the attempt to implement several SICs in Victoria were unsuccessful.

Finally, the chapter will reveal that the moral abstinence coalition did not have a monopoly on ‘moral’ arguments’. The discussions regarding SICs in NSW showed that harm reduction coalition members attempted to use moral arguments to both support their advocacy efforts and also to distance themselves from the usual comments applied to harm reduction programs, namely that such approaches normalise, condone and encourage illicit drug use.

The Heroin ‘Problem’

During the 1990s heroin use and associated problems escalated in large metropolitan cities in Australia. Problematic heroin use increasingly became visible in this period. In NSW the price of heroin reached a historic low, with purity around 60% and heroin being the most commonly used drug among regular injecting drug users.³³⁴ In the late 1990s there were increased numbers of: people that commenced treatment for heroin dependence; HCV infections; arrests related to heroin and heroin related overdoses.³³⁵ Indeed, all these variables had steadily escalated in the first half of the decade.

During the 1990s deaths from heroin use had nearly quadrupled in a decade...

Over the last decade there has been a steady increase in the number of heroin related deaths. The Australian Illicit Drug Report (AIDR) 1999-00 indicates that in 1991, there were approximately 250 overdose deaths in Australia. In 1997, there were 600 overdose deaths in Australia... In 1998, 737 people died in Australia as a result of heroin related overdose... While in 1999, there were a total of 958 deaths

³³⁴ Degenhardt, L., Conroy, E., Gilmour, S., & Hall, W., 2005, ‘The effect of a reduction in heroin supply on fatal and non-fatal drug overdoses in New South Wales’, Australia, *MJA* 182:1, pp20-23.

³³⁵ *ibid.*

attributable to opioid overdose among those aged 15 to 44 years.³³⁶

Law enforcement studies also reiterated the increased supply and availability of heroin in Australia in the late 1990s.

The increasing availability of heroin at street level is of growing concern to law enforcement and health agencies in Australia. The increase is evident in all States and Territories but New South Wales continues to experience the highest level of availability and of trafficking in bulk high-grade heroin, from Sydney to other centres and jurisdictions.³³⁷

Data taken from the 2004 National Drug Strategy Household survey also indicated an increase in recent (within last 12 months) heroin use around 1998.

Table 2: Recent use of heroin: proportion of the population aged 14 years and over³³⁸

Males				Females			
1995	1998	2001	2004	1995	1998	2001	2004
0.5	1.0	0.3	0.2	0.2	0.5	0.2	0.1

Source: 2004 National Drug Strategy Household Survey

Other problems with an increase in heroin use in the 1990s also were identified. It was estimated³³⁹ that between 12,000–21,000 non-fatal overdoses occurred in Australia annually in the late 1990s. Such non-fatal opioid overdose can result in significant permanent morbidity such as brain damage. Furthermore, up to 60% of

³³⁶ Commonwealth of Australia, 2001, *National Heroin Overdose Strategy*, Commonwealth Department of Health and Aged Care, p4.

³³⁷ Australian Bureau of Criminal Intelligence, 1999, *Australian Illicit Drug Report 1998-1999*, accessed online at: http://www.crimecommission.gov.au/content/publications/aidr_2000/03_Heroin.pdf on 10/7/05.

³³⁸ Commonwealth of Australia, 2001, *National Heroin Overdose Strategy*, Commonwealth Department of Health and Aged Care, p4.

³³⁹ Warner-Smith M., Lynskey M., Darke S., Hall W., 2000, *Heroin overdose: prevalence, correlates, consequences and interventions Monograph No. 46*, National Drug and Alcohol Research Centre, University of New South Wales.

heroin users reported having experienced at least one overdose while up to 70% had witnessed an overdose.³⁴⁰ Health care costs associated with heroin related overdose also impacted upon health budgets³⁴¹ (for example spending on ambulance attendances), the public health system, upon family and friends and broader community were further compelling reasons toward gaining changes in policy.

There was also evidence that prohibition responses to escalating heroin use further exacerbated drug related harms. Changes in the concealment methods applied by heroin providers due to increased vigilance by police further exacerbated the harms associated with heroin use.

Oral and nasal storage and transfer of heroin between dealers and users has become commonplace. At the time of purchase, the dealer simply spits the cap, which is contained within a small balloon, into their hand and passes it to the customer in exchange for cash. Such transfers happen so quickly that they are very difficult to detect. In some circumstances the cap may be passed directly from mouth to mouth. As police have become more alert to these concealment and transfer methods dealers have begun storing caps in their noses before passing them to users, who may then place the caps in their own nose or mouth. As well as risking disease, people involved in transactions of this kind are at greater risk of overdose because they may swallow the heroin in order to avoid detection.³⁴²

This was a further example of the way in which prohibition policies had created further drug related harm for consumers of drugs. As the quote suggested, oral and

³⁴⁰ Gossop M., Griffiths P., Powis B., Williamson S., Strang J., 1996 'Frequency of non-fatal heroin overdose: survey of heroin users in non clinical settings', *British Medical Journal*, pp 313:402; Darke S., Ross J., Zador D., Sunjic S., 2000 'Heroin-related deaths in New South Wales, Australia 1992-1996', *Drug and Alcohol Dependence* 60, pp141-150; McGregor C., Darke S., Ali R, Christie P., 1998 'Experience of non-fatal overdose among heroin users in Adelaide, Australia' *Addiction* 93:5, pp701-711; Loxley W., & Davidson P., 1998, *Forgetting to Breathe: opioid overdose and injecting drug users in Perth*, National Centre for Research into the Prevention of Drug Abuse, Perth; Strang J., Powis B., Best D., Vingoe L., Griffiths P., Taylor C., Welch, M., Gossop M., 1999, 'Preventing opiate overdose fatalities with take-home naloxone: pre-launch study of possible impact and acceptability' *Addiction* 94:2, pp199-204.

³⁴¹ Zook C., and Moore F., 1980 'High-cost users of medical care' *The New England Journal of Medicine* 302: pp996-1002.

³⁴² Australian Bureau of Criminal Intelligence, 1999, *Australian Illicit Drug Report 1998-1999*, accessed online at: http://www.crimecommission.gov.au/content/publications/aidr_2000/03_Heroin.pdf on 10/7/05.

nasal storage was preferred by some so to avoid random searches by street level police. This, however, had meant that there was an increased degree of risk of overdose if the carrier felt they had to swallow the drugs to avoid detection. Further risks in this scenario included bacteria from the mouth contaminating the drug mixture and subsequently leading to infections when administered intravenously.

Research conducted on the consequences of concentrated police activity targeting heroin use and dealing in public places had unintended negative effects.

The University of New South Wales recently completed a detailed three-year study of the impact of street-level law enforcement of heroin use and distribution. It was concluded that crackdowns by uniformed police resulted in counter-productive effects, among them public health risks, threats to community safety (as a result of geographical, social and substance displacement) and harm to the relationship between the police and the community—in turn resulting in lowered police efficiency. Increasing attention by law enforcement authorities has forced users to leave public business areas and go to private and semi-private areas such as cars and abandoned houses. This dispersal of users and locations over a wider geographical area is spreading the problem further into the community. More members of the public are being exposed to discarded syringes, while emergency services are having greater difficulty getting to and dealing with overdose situations in isolated areas. Heroin is now available in neighbourhoods where it was previously hard to obtain and drug-related property offences have increased in those neighbourhoods.³⁴³

The quote also describes to the ‘public nuisance’ aspects of the problem. Syringe litter, crime, increased availability of heroin and rates of overdoses all created visible reminders of the ‘problem’ of heroin use. Other research has found an increased unwillingness of consumers to carry sterile injecting equipment due to a fear of detection meaning that drug consumers are less likely to have access to sterile

³⁴³ *ibid.*

equipment and more likely to engage in high risk practices such as picking up used needles from the street.³⁴⁴

Such increases in rates of overdose and public nuisance issues prompted increased attention in the media³⁴⁵ in the late 1990s. These reports in the media were mainly focused on the extent of the increase in overdose and public nuisance problems associated with heroin injection. Also in the media was a discussion regarding suggested solutions to this issue such as the instigation of SICs and/or dedicating more street level police. Headlines included: 'Heroin Toll soars to record level', 'Injecting room – saving lives or foolish compassion', 'Injecting room appeals to users', 'Moralising while the body count rises' among many others.

By the mid to late 1990s problematic heroin use had become a visible issue for all illicit drug policy stakeholders due to the escalation of rates of overdose and associated public nuisance problems. Kingdon³⁴⁶ argued that many changes in public policy result from 'policy windows' that open sporadically. These 'windows' are the result of the convergence of problems, policies and politics³⁴⁷ and rarely stay open for long and present opportunities for policy actors to act on policy initiatives. The increase in problems around heroin use in Australia in the mid 1990s created a window of opportunity for policy actors in the harm reduction coalition to propose solutions. Two such solutions were the instigation of prescription heroin and

³⁴⁴ Dixon, D. 1999, *Law Enforcement, Harm Minimisation and Risk Management in a Street-level Market*, University of New South Wales, Sydney.

³⁴⁵ National Drug and Alcohol Research Centre, 1999, 'Heroin Overdoses Up Over 20%: New Figures Released Today', *Media Release*, Sydney; 'Moralising while the body count rises', *The Sunday Age*, 7/3/99; 'Push for civil disobedience campaign', *The Age*, 29/5/99; 'Injecting rooms appeal to users', *The Age*, 14/12/98; 'Opening injecting room the right thing to do' *The Sydney Morning Herald*, 10/5/99; 'Injecting room: saving lives or foolish compassion?', *The Sydney Morning Herald*, 7/5/99; 'Why more police won't stop heroin dealers', *The Sydney Morning Herald*, 10/3/99; 'Heroin hot-spots pray for church as lifesaver', *The Australian*, 19/7/99; 'Heroin toll soars to record level', *The Age*, 15/12/98; 'Shooting galleries the politics of heroin', *The Sydney Morning Herald*, 5/6/99.

³⁴⁶ Kingdon, J., 1984, *Agendas, Alternatives and Public Policies*, Little, Brown and Company, Boston.

³⁴⁷ "The separate streams of problems, policies and politics come together at certain critical times. Solutions become joined to problems, and both of them are joined to favourable political forces". *ibid*, p21.

supervised injecting rooms. What follows is a description of the way in which the harm reduction coalition advocated for these proposals.

Prescription Heroin

Prescription of drugs to dependent people is a key type of harm reduction strategy as such approaches place an emphasis on the reduction of drug related harms such as BBVs, crime and other consequences of drug use. Heroin on prescription is a similar approach to MMT that is currently available on a controlled basis to eligible opiate dependent people. MMT seeks to ameliorate the consequences of being addicted to 'street' opiates and allow the consumer to get on with a 'normal' life away from criminal networks while reducing doses of opiates in a controlled environment. Obtaining funds, often through criminal or other means, in order to ward off the physical discomfort of withdrawal often becomes time consuming. Moreover, engaging in criminal networks to procure the drug is also another unavoidable side effect of being dependent on illicit opiates. Thus, much the same as MMT, the function of prescription heroin is to stabilise the lives of people dependent on drugs through the medically controlled provision of opiates.

Not all entrenched heroin users respond to MMT, thus the purpose of a scientific trial was to examine further treatment options for this group, such as prescription heroin. Getting this group off street heroin and on treatment could benefit not only the drug users but also their families and the mainstream population through reductions in crime and health care costs. The prescription of heroin is seen as another treatment option for chronic heroin dependent people who have repeatedly failed in other available treatments such as MMT. Indeed, some research from Switzerland has

shown that prescription heroin treatment retained drug users in treatment as well as affecting reductions in crime and improvements in health.³⁴⁸

Britain began using prescription heroin as treatment in the 1920s.³⁴⁹ This initiative was born from recommendations of the Rolleston Committee that consisted of a group of physicians experienced in the treatment of people dependent on drugs. The committee reported in 1924:

When ... every effort possible in the circumstances has been made, and made unsuccessfully, to bring the patient to a condition in which he is independent of the drug, it may ... become justifiable in certain cases to order regularly the minimum dose which has been found necessary, either in order to avoid serious withdrawal symptoms, or to keep the patient in a condition in which he can lead a useful life.³⁵⁰

In 1912 'maintenance clinics' began to open in the United States, yet by 1921 these clinics were closed. To date, Britain is the only country to use prescription heroin for many years. Since 1965, however the number of prescribing doctors in the UK, and subsequently the number of opiate addicted people treated with heroin, had diminished due to limitations imposed by Government.

In the 1980s and 1990s the idea of using prescription heroin as treatment was debated in several countries such as Australia, Switzerland, Germany, the

³⁴⁸ Uchtenhagen A. Summary of the synthesis report. In: Uchtenhagen A, Gutzwiller F, Dobler-Mikola A, editors, 1997, *Programme for a medical prescription of narcotics: final report of the research representatives*, Institute for Social and Preventive Medicine, University of Zurich, Zurich, quoted in Metrebian, N., Shanahan, W., Wells, B & Stimson, G., 1998, 'Feasibility of prescribing injectable heroin and methadone to opiate dependent drug users: associated health gains and harm reductions', *MJA*, 168, pp596-600.

³⁴⁹ Canrwath, T., 2004, 'Heroin prescription for heroin addiction - an English view', *Acta Neuropsychiatrica*, 16:5, p275, from 'Prescription of Opiates and Controlled Stimulants' accessed on 27/4/05, from <http://www.aidslaw.ca/Maincontent/issues/druglaws/e-iduback/Paper3/prescription-3.htm>

³⁵⁰ *ibid.*

Netherlands, Spain, and Canada.³⁵¹ In the Netherlands in 1983, experiments were conducted whereby the physician prescribed intravenous morphine and amphetamine to five patients. Following positive results published in the *Dutch Monthly Journal of Mental Health*³⁵² the physician negotiated with local health facilities to extend the program. After much debate a morphine dispensation program for 37 patients was approved and ran for two years.³⁵³ Around the same time the city council of Amsterdam announced plans for heroin prescription for 300 drug users, however this was rejected by the Dutch Government.³⁵⁴ Swiss authorities conducted experimental trials of prescription heroin from 1994 to 1996 with evaluations indicating positive results. Follow-up consultations with patients showed that they were more likely to succeed in social integration into the community, stop illicit drug use, decrease cocaine use and decrease contact with drugs more generally.³⁵⁵ Furthermore, the project attracted considerable popular support with 71 percent of all voters supporting it in a national referendum. Consequently the medical prescription of heroin remains an important treatment option in Switzerland.³⁵⁶

The debate surrounding prescription heroin in Australia began in 1989, with the medical research community spearheading the advocacy process. While the project attracted wide support within and external to the harm reduction community, the debate was polarised along familiar lines, with the ideas of harm reduction in opposition to those from moral-abstinence groups.

³⁵¹ *The International Heroin Trials Debates: To Prescribe or not Prescribe: the State of Heroin Trials Around the World*, Report from 10th International Conference on the reduction of drug related harm 21-25 March 1999, accessed from <http://cfdp.ca/heroin.htm> on 20/4/2005.

³⁵² van den Brink, W., Hendricks, V, van ree, J., 1999, 'Medical co-prescription of heroin to chronic, treatment resistant methadone patients in the Netherlands', *Journal of Drug Issues*, Summer, accessed: http://www.findarticles.com/p/articles/mi_qa3733/is_199907/ai_n8841987/pg_8

³⁵³ *ibid.*

³⁵⁴ *ibid.*

³⁵⁵ *The International Heroin Trials Debates: To Prescribe or not Prescribe: the State of Heroin Trials Around the World*, Report from 10th International Conference on the reduction of drug related harm 21-25 March 1999, accessed from <http://cfdp.ca/heroin.htm> on 20/4/2005.

³⁵⁶ *ibid.*

Advocating prescription heroin in Australia

The idea of a prescription heroin trial was initiated in 1989 by members of the Select Committee on HIV, Illegal Drugs and Prostitution formed from the ACT Legislative Assembly. Members of this committee were derived from both political parties and resident groups (for example: groups such as the 'Resident Rally'). This committee approached key experts in the science/medical community who endorsed the idea and by 1991 had attracted a grant to investigate it. A four year feasibility study was enacted, resulting in proposals for a medical trial of prescription heroin. The proposed medical trial was to involve two pilot studies and a full-scale clinical trial.³⁵⁷ The trial attracted overwhelming support from research/medical interests involved in drug treatment³⁵⁸ and was to take place in the ACT. Box 1 – 'A Brief history of the prescription heroin feasibility study' describes the process undertaken by Gabrielle Bammer (chief researcher) and her team to initiate a heroin trial in the ACT.

³⁵⁷ Bammer, G & Douglas, R., 1996, The ACT heroin trial proposal: an overview, *MJA*, 164, pp690-692.

³⁵⁸ *ibid.*

Box 1: A brief history of the prescription heroin feasibility study

A BRIEF HISTORY OF THE FEASIBILITY STUDY - *Gabriele Bammer, The National Centre for Epidemiology and Population Health, The Australian National University, Canberra.*

In 1989, the newly formed ACT Legislative Assembly established a Select Committee on HIV, Illegal Drugs and Prostitution. It had representatives from both major political parties and was presided over by Mr Michael Moore, then a member of the Residents' Rally, a minor party, and later an independent member. ...In March 1991, the Presiding Member approached the Director of the National Centre for Epidemiology and Population Health (NCEPH), Professor Bob Douglas, to discuss the possibility of a trial of controlled heroin availability. In April a group of Australian experts in drug treatment and drug policy assembled at NCEPH, endorsed the need for a study into the feasibility of controlled heroin availability and suggested a four-stage process. Each stage was to be self-contained, ending with a decision about whether or not to proceed further. The first stage was to consider the issue of feasibility in principle, the second to consider logistic feasibility, the third to pilot procedures and the fourth to be the trial itself.

In April 1992, the then Minister for Health, Mr Wayne Berry, took the issue of the feasibility study to the Ministerial Council on Drug Strategy (MCDS)... In subsequent years progress reports about the study were noted and in 1994 a subcommittee of the National Drug Strategy Committee (NDSC) was established to consider the stage 2 report when it was released. NDSC is a similarly representative committee of senior officers (public servants and police), which supports MCDS.

NCEPH and [Australian Institute of Crime] decided to proceed with the stage 2 feasibility research after strong support at a one-day national seminar 'Heroin Treatment -New Alternatives' in November 1991. The decision was made possible by a peer reviewed competitive grant of \$A445000 over 5 years.... A further \$A15000 was raised through other competitive peer-reviewed grants to fund a number of specific sub-projects.

...The process was guided by a 19-member Advisory Committee which met three times in 1992 and annually thereafter. The Committee had Australia-wide representation from academics, advocates for illicit drug users, judiciary, police, policy makers and treatment service providers. In order to ensure that a balance of views was represented on the Advisory Committee, it was agreed at the outset that the Committee would not be asked to formulate or endorse the final recommendations.

As discussed in more detail below, there was emphasis on an open, consultative process...ACT community surveys were conducted in 1991 and 1994; Sydney and Queanbeyan residents were surveyed in 1991; and a national survey was conducted in 1995. There were also informal discussions with individuals and particular community interest groups...The police were surveyed in 1991, were involved in a workshop about drug markets in 1992 and in a workshop specifically on policing issues for a trial in 1994. There were regular discussions with the ACT Drug Squad and the Australian Bureau of Criminal Intelligence. There were also discussions with the Australian Federal Police Association (the police union) and individual ACT and interstate police...Illicit drug users in and out of treatment were surveyed in 1991 and 1993. A reference group of people who are advocates for illicit drug user interests (without necessarily being users or ex-users themselves) was also consulted regularly and there were many informal discussions with individuals and advocacy groups, locally and interstate. There was also participation in public meetings organised by the ACT Intravenous Drug Users League (ACTIV) and the Dependency Care Foundation... There were a number of discussions with staff from the ACT Health Drug and Alcohol Service and staff from non-government organisations, particularly Assisting Drug Dependents Inc. and the Alcohol and Drug Foundation of the ACT. There were also discussions with the Australian Medical Association, the Australian Salaried Medical Officers Federation and individual doctors, pharmacists and other health professionals.

Source: Bammer, G, 1996, 'When science meets politics: the Australian heroin trial feasibility study', *The International Journal of Drug policy*, 7:1.

As described in Box 1, many key groups were contacted and surveyed in order to gauge public acceptance of the trial. Further, representatives from the drug treatment and law enforcement sectors were briefed regularly through MCDS meetings. The research team also were subject to a steering group that comprised a mixture of stakeholders such as academics, advocates for illicit drug users, judiciary, police, policy makers and treatment service providers. Ultimately, while the process was driven by medical interests, the research team also engaged comprehensively with other sectors, groups and individuals throughout the process. See Box 1 for any further detail on the process.

The architects of the trial posed a central question:

If maintenance treatment for opioid dependence is expanded, so that both injectable diacetylmorphine (heroin) and oral methadone are available, is this more effective than current maintenance treatment with oral methadone alone?³⁵⁹

Thus the rationale was to determine if there would be improved outcomes *if* prescription heroin was included in the armamentarium of treatment options. Such outcomes included the:

- Ability to attract dependent heroin users into treatment;
- Ability to prevent premature drop-out from treatment;
- Ability to improve health and well-being of people with opiate dependencies, including reducing drug use and criminal behaviour and improving social functioning;
- Analysis of cost-effectiveness of prescription heroin.³⁶⁰

The architects of the trial had also evaluated potential risks arising from a prescription heroin trial such as: displacement of more dependent heroin users to the

³⁵⁹ *ibid.*

³⁶⁰ *ibid.*

ACT; an increase in 'permissive' attitudes to illicit drug use; increase in road accidents related to heroin use; diversion of heroin to the black market; the site of the trial might act as a 'honeypot', attracting those who use heroin to congregate at the site; increase in diacetylmorphine-affected babies and further institutionalisation and marginalisation of a trial-dependent heroin users.³⁶¹ Ultimately, the authors of the study concluded that the benefits (reduction in drug related crime, BBVs and general drug related harm) of testing prescription heroin as a new treatment option outweighed potential risks.

The proposal for a trial of heroin on prescription attracted a great deal of media attention in 1996 and 1997. On April 9th 1996, the then Commonwealth Minister for Health, Michael Wooldridge (only a month after the Liberal Party assumed Government at the federal level) stated that he was unsure if a trial would proceed.³⁶² As debate intensified, it was evident that the coalition supporting the trial consisted of a wide variety of individuals and organisations predominantly from health, medical and research and law enforcement interests. Religious organisations were split on the idea of a trial. Indeed the main opposition to the trial arose from individuals such as the Prime Minister John Howard and others who campaigned against it on moral grounds. The following quotes are taken from an article entitled 'Heroin hell their own making: construction of heroin users in the Australian press 1992-97',³⁶³ that analysed the perception of drug users within the press debate about the heroin trial.

Child abuse, sexual assault and stealing also could, with some justification, be seen as sicknesses, but no one would

³⁶¹ *ibid.*

³⁶² Campbell, A., 2001, *The Australian Illicit Drug Guide*, Black Inc, Melbourne, p450

³⁶³ Elliot, A., Chapman, S., 2000, 'Heroin hell their own making: construction of heroin users in the Australian press 1992-97', *Drug and Alcohol Review*, 19, pp191-201.

seriously suggest that society supply the ingredients to make these activities possible (Salvation Army leader).³⁶⁴

For some heroin addicts death is better than the degrading lives they lead, a Sydney religious leader said yesterday. — There are worse things than death when it comes to heroin addiction. Heroin users become very degraded by things they have to do to support their addiction. (Salvation Army leader).³⁶⁵

It is often claimed that heroin addiction is a victimless crime. Tell that to those whose lives have been ruined by the addicts — the parents, husbands and wives of the junkies, or the decent citizens who have had their homes ransacked and their possessions ripped off (columnist).³⁶⁶

Such comments were used to oppose the trial. Indeed, the identification of heroin as an agent of destruction on familial relationships meant that efforts to prescribe the drug were regarded as having the potential to cause further harm in the community.

Supporters of the trial included a wide range of organisations and individuals. In terms of political parties both the Democrats³⁶⁷ and the ALP³⁶⁸ released statements that suggested they would consider proposals for a trial of heroin prescription. Federal Greens leader Bob Brown and several Liberal Members of Parliament (including Brendan Nelson and Jeff Kennett) also supported the trial. Public support, measured in three polls conducted between 1997 and 1999, concluded that around 45–50% of those polled supported the trial.

³⁶⁴ *ibid*, p195.

³⁶⁵ *ibid*, p196.

³⁶⁶ *ibid*, p198.

³⁶⁷ Family and Friends for Drug Law Reform, Supporters of a heroin trial in Australia, accessed at www.ffdlr.org.au/factfile/WhoSupports on 12/12/04.

³⁶⁸ *ibid*.

Table 3: Public support of prescription heroin

	Supported	Against	Undecided
Neilsen-McNair 19/8/97 (Australia-wide)	45%		
Canberra Times 17/10/97	50%	40%	10%
Herald AC- Neilson 4/3/99	45%	48%	

Source: Data accessed from Friends and Families of Drug Law Reform website:
www.ffdlr.org.au/factfile/WhoSupports.

Justice James Wood, in the *Royal Commission into the New South Wales Police Service* published in 1997 also supported a 'cautious move' towards a heroin trial.³⁶⁹

Other supporters included: the Australian Medical Association (AMA); Royal Australasian College of Physicians; Royal Australian College of General Practitioners; Society of Hospital Pharmacists; Australasian Faculty of Public Health Medicine; Law Council of Australia; Law Society of NSW; Directors of Public Prosecutions of NSW, South Australia and the ACT; all capital city mayors; Australian Lions Drug Awareness Foundation; Australian Federation of AIDS Organisations; Former Australian Federal Police Commissioner Mr Mick Palmer; NSW Commissioner for Police Peter Ryan; South Australia Police Commissioner Mal Hyde; Former Police Commissioner for Tasmania, Jack Johnston; Former Victoria Police Commissioner, Neil Comrie; Head of National Crime Authority, Gary Cooke; Former Bishop Richard Randerson; Anglican Diocese of Canberra and Goulburn; Victorian Uniting Church Community Services Director Colleen Pearce; Reverend Gregor Henderson; National General Secretary, Uniting Church; Salvation Army Southern Command; Family and Friends for drug law reform; The Damien

³⁶⁹ Wood, J, 1997, *Royal Commission into the New South Wales Police Service*, The Government of the State of New South Wales, Volume 2, p228.

Trimingham Foundation; Australian Drug Foundation and DrugAid.³⁷⁰ Indeed, in the coalition that supported prescription heroin were many individuals from health and law enforcement and religious organisations that grouped together to support the medical/research interests to examine new options for drug treatment.

In publicly supporting a trial of prescription heroin, the National Crime Authority has joined along list of distinguished individuals and organisations from health professional and law enforcement backgrounds which have concluded that this research is a fundamental step before we can make sustained progress on illicit drugs.³⁷¹

The MCDS issued a communiqué on 31st of July 1997 announcing the start of a trial in the ACT:

If a number of preconditions can be met, the ACT Government will undertake a small trial of controlled availability of heroin involving 40 people.³⁷²

Federal Cabinet, however, on 19th of August 1997, put an end to the trial through an application of federal powers to override the ACT government's decision. Two reasons were stated as rationales to oppose the trial. Firstly, that legislation to allow the provision of heroin for the trial would need to be amended, and secondly, a moral imperative to block the trial as it 'sends the wrong message'. Prime Minister John Howard was particularly vocal on the latter issue:

I have had parents of children who have died through drug overdoses plead with me, plead with me not to weaken the law, not to experiment with trials, not to do anything that could send an adverse signal... I am a human being, I am a

³⁷⁰ Family and Friends for Drug Law Reform, *Supporters of a heroin trial in Australia*, accessed at www.ffdlr.org.au/factfile/WhoSupports on 12/12/04

³⁷¹ Wodak, A., 2001, 'Overseas heroin trials point the way ahead', *Sydney Morning Herald*, 10/8.01. Also available at : <http://www.forensics.edu.au/article.php?sid=41>

³⁷² Quoted in Wodak, A., 1997, 'Public health and politics: the demise of the ACT heroin trial', *MJA*, 167, p348.

father, I am the Prime Minister and I am trying to bring the best judgment I can.³⁷³

Despite much interest and determination by members involved in the planning stages of this process, the Minister of Health overturned the decision to go ahead and did not support the heroin trials. Even though Victoria's peak Drug Advisory group expressed support for the notion of a trial in the 'Pennington report'³⁷⁴, the Victorian Government announced that it would not support a clinical trial of heroin in Victoria and instead injected around \$2 million into a feasibility study of alternative drug therapies such as slow release oral morphine, buprenorphine and naltrexone.³⁷⁵

On the subject of morality and illicit drug policy, Nick Crofts, a prominent member of the harm reduction coalition, ruminated:

The issue of morality often underlies the arguments [against harm reduction approaches]. Moral arguments have their place, but are meaningful only when based on accurate information. The morality that rejects a place for opiates in this society because they are dangerous, when the danger demonstrably comes more from their illegality than from the drugs themselves, is flawed. I have often pondered why it is heroin that we have demonised and suspect that such violent reactions must be extremely attractive to those waging the War on Drugs. The obverse of approaches considered to "condone" heroin use are those which make it as dangerous as possible. It is a strange morality which argues for so many deaths to prevent the use of a substance that is relatively harmless under controlled conditions - a morality that has given us enormous epidemics of HIV infection among children of heroin users in the United States and elsewhere. This is a morality which I suspect most people would not support without the intense social conditioning of the War on Drugs.³⁷⁶

³⁷³ John Howard quoted in 'Heroin trials not on, says Howard', *The Australian*, 20/8/97.

³⁷⁴ Premier's Drug Advisory Council report, 1996, *Drugs and our Community: Report of the Premier's Drug Advisory Council (Pennington Report)*, Melbourne, pp93-4.

³⁷⁵ Campbell, A., 2001, *The Australian Illicit Drug Guide*, Black Inc, Melbourne, p450

³⁷⁶ Crofts, N, 1996, 'The heroin trial we had to have', *MJA*, 164, p695.

The role of morality-based arguments in drug policy leads to an impasse between stakeholders as evidenced in the approval and then rejection of the prescription heroin trial. Prime Minister John Howard's personal conviction that such an initiative was 'the wrong thing to do' and decision to stop the trial contrasted with the rational-scientific approach of Bammer and her team. The competition between morality based and rational-scientific approaches is an ongoing characteristic of illicit drug policy since the inception of harm reduction approaches (and of course medical approaches more generally) and points to the importance of examining the intersection between established cultural and social values and policy making. Moreover, such values also mean that some harm reduction policies can be discredited or misrepresented automatically (for example: harm reduction policies as condoning or encouraging drug use) without any requirement of evidence. As described in the first chapter the foundations of most of these values towards illicit drugs are based on historically arbitrary decisions, and according to some, fallacies. Thus the way in which this knowledge has been created and reinforced is a key systemic factor that has affected the perception and consequently the political palatability of harm reduction policies.

In parallel to the prescription heroin debate was the debate regarding supervised injecting centres. As noted earlier, both initiatives were advocated by the harm reduction coalition as responses to the problem of heroin use in Australia in the 1990s.

Supervised Injecting Centres

As noted earlier, heroin use and associated problems had escalated in the 1990s in major capital cities. One of the proposed solutions advanced by a coalition of health

workers, law enforcement personnel, research bodies and other key stakeholders was the notion of instigating medically supervised injecting centres in appropriate metropolitan areas. SICs are premises designed to provide a safer environment away from public areas for the injection of illicit drugs. Such premises have also been referred to as 'drug consumption facilities', 'injecting rooms' or 'medically supervised injecting centres' (in New South Wales), 'supervised injecting place' (ACT) and 'off street injecting facilities' (Victoria). For clarity, the term supervised injecting centre (SIC) will be used to refer to those injecting rooms that have been sanctioned by Governments. It is acknowledged that there are illegal injecting rooms operating yet these differ from legally sanctioned rooms that provide not only sterile equipment but also qualified professionals who provide information and referrals to mainstream services. Below are two definitions of SICs:

...legally sanctioned and supervised facilities designed to reduce the health and public order problems associated with illegal injection drug use.³⁷⁷

...a legally sanctioned indoor facility where injecting drug use would occur under the supervision of appropriately trained personnel, who could provide access to medical equipment in the event of an overdose.³⁷⁸

SICs are premises, sanctioned by Government, in which people are able to inject illicit drugs under supervision from health professionals with the rationale that such facilities both reduce the problems associated with injecting (such as overdose and transmission of BBVs), and, public nuisance issues associated with injecting in public places (such as syringe litter and public order problems). Many European countries, such as Switzerland, the Netherlands and Germany, have had SICs since

³⁷⁷ Dolan, K., Kimber, J., Fry, C., Fitzgerald, J., McDonald, D & Trautmann, F., 2000, *Drug consumption facilities in Europe and the establishment of supervised injecting centers in Australia*, *Drug and Alcohol Review*, 19, p337.

³⁷⁸ Joint Select Committee into safe injecting rooms, 1998, *Report on the establishment or trial of safe injecting rooms*, Parliament of New South Wales, p5.

the 1990s with some as early as the 1980s. In most cases, the facilities were located within primary care services where qualified staff provided a holistic approach to the issue of injecting drug use with mainstream health and welfare services accessible in the centres as well as NSPs. The first Swiss SIC opened in 1986 and by 2000, there were seventeen operating.³⁷⁹ In most cases, these Swiss facilities contained cafes, counselling rooms, and primary care clinics with discrete injecting rooms within the centre. Moreover, such facilities were tolerated by Swiss community.³⁸⁰ The Netherlands established their first SIC in the 1970s and by 2000 there were sixteen operating.³⁸¹

In the Netherlands, SICs have been regarded as measures to reduce public nuisance and harms associated with injecting in public places.³⁸² Most Dutch SICs are run by regional drug services and incorporate harm reduction measures as well as abstinence-oriented treatment and are integrated within other services that offer medical care, counselling, food and wider health services.³⁸³ The first SIC opened in Germany in 1994, and in 2000 there were thirteen in operation³⁸⁴. Similar to other European countries, these SICs were seen as a measure to address and minimise injecting in public areas and centres were located within professionally staffed services.³⁸⁵ In February 2000, laws were amended in Germany allowing for their legal operation.³⁸⁶ Indeed, such research from the European experience suggested that SICs had the capacity to address those problems associated with heroin use in

³⁷⁹ Centres were in Basel, Bern, Olten, Schaffhausen, Wattil, Wil, Solothurn, St Gallen, Winterthur, Chur and Zurich. Dolan, K., Kimber, J., Fry, C., Fitzgerald, J., McDonald, D & Trautmann, F., 2000, *Drug consumption facilities in Europe and the establishment of supervised injecting centers in Australia*, *Drug and Alcohol Review*, 19, p337.

³⁸⁰ *ibid*, p339.

³⁸¹ Centres were in Amsterdam, Apeldoorn, Arnhem, Den Bosch, Eindhoven, Heerlen, Maastricht, Rotterdam and Venlo. *ibid*, p 338.

³⁸² *ibid*, p339.

³⁸³ *ibid*.

³⁸⁴ Hamburg, Frankfurt, Hannover and Saarbrücken, *ibid*, p339.

³⁸⁵ *ibid*, p340.

³⁸⁶ *ibid*.

Australia, especially overdose rates and public nuisance problems as such facilities had addressed those problems in the European context.

Groups in New South Wales (NSW) and Victoria initiated the idea of SICs in the late 1990s. An inquiry into the relative costs and benefits of establishing SICs in NSW began in 1997 by the Joint Select Committee into Safe Injecting Rooms. This was borne from a recommendation made at the Wood Royal Commission into the New South Wales Police Service. Commissioner James Wood concluded that the Commission was supportive of the establishment of SICs and stated:

At present, publicly funded programs operate to provide syringes and needles to injecting drug users with the clear understanding they will be used to administer prohibited drugs. In these circumstances to shrink from the provision of safe, sanitary premises where users can safely inject is somewhat short sighted. The health and public safety benefits outweigh the policy considerations against condoning otherwise unlawful behaviour... For these reasons, the Commission favours the establishment of premises approved for this purpose and invites consideration of an amendment of the Drug Misuse and Trafficking Act to provide for the same.³⁸⁷

Thus Commissioner Wood regarded SICs as a logical extension of harm reduction services, such as NSPs, that had been operational in Australia since the mid 1980s.

In 1999, the state ALP government in Victoria announced it would introduce SICs “in five locations on a controlled trial basis.”³⁸⁸ The five proposed SIC locations were announced in September 1999: Melbourne central business district (CBD), Collingwood, St. Kilda, Footscray and Dandenong/Springvale and nominated \$1.5

³⁸⁷ Joint Select Committee into safe injecting rooms, 1998, *Report on the establishment or trial of safe injecting rooms*, Parliament of New South Wales, pxvi.

³⁸⁸ Paras, R., 2000, *Medically Supervised Injecting Service: A Primary Health Care Facility*, City of Greater Dandenong, p7.

million specifically for their establishment.³⁸⁹ In December 1999, Victoria's state Labor Government released *Labour's Health Policy on Tackling Drug and Alcohol Abuse* that stated:

Labor will take immediate action to prevent the tragic deaths occurring amongst our young people, particularly from heroin overdose. This will include a focus on drug safety education, mobile overdose response services, a medically supervised heroin trial, safe injecting facilities and the development of alternatives to methadone.³⁹⁰

One group that mobilised to support the instigation of SICs in Victoria was 'Footscray Cares'. This group was constituted by concerned residents of Footscray and surrounding suburbs³⁹¹ and was mainly concerned with issues to do with heroin use and as such organised 'heroin reform rallies' and public meetings. Included in these meetings were public figures such as well known performers and religious figures that culminated in a wide mix of people that supported such a facility. Thus by the late 1990s Victorian and NSW state governments were confronted with proposals for SICs. The types of arguments used by harm reduction and moral abstinence coalition arguing for and against SICs respectively are detailed below.

Not just for the 'undeserving': advocating SICs in Australia

According to the NSW *Report on the establishment or trial of safe injecting rooms*, arguments in relation to SICs in Australia can be ordered into four categories: 'health', 'social', 'economic' and 'legal' rationales. It is evident however, that another category can be added as 'moral' rationales for SICs became apparent when

³⁸⁹ *ibid*, p8.

³⁹⁰ Paras, R., 2000, *Medically Supervised Injecting Service: A Primary Health Care Facility*, City of Greater Dandenong, Attachment 1.

³⁹¹ Footscray cares web page: accessed at www.paradigm4.com.au/footscraycares/ on 6/12/2004.

studying proceedings from the 1999 NSW Drug Summit. Each type of argument is discussed in turn below. The harm reduction coalition that advocated for SICs drew upon the European experience and research into the positive outcomes of such facilities. Moreover, this group also repetitively framed their arguments in support of SICs as having benefits beyond the drug policy arena to police service, local residents and the public health of society more generally. The objectors to SICs resonated with similar arguments to those in the debate around prescription heroin. Largely ‘moral’ reasons against SICs that such facilities ‘send the wrong message’ and thus, by extension, have the function of entrenching or encouraging drug use was a recurring theme. Furthermore, the dichotomy of ‘deserving’ and ‘undeserving’ recipients of Government aid also peppered moral objections.

‘Health’ arguments for SICs

The harm reduction coalition argued the health benefits of SICs as producing:

- Reductions in fatal and non fatal overdoses,
- Reductions in transmission of BBVs (benefiting both injecting drug users and the wider community),
- Reductions in health risk behaviours such as sharing or reusing injecting equipment,
- Increased access to mainstream health providers for injecting drug users, and,
- Improvement of occupational health and safety for health workers regarding needlestick injuries.

The coalition supporting SICs suggested that the implementation of SICs had the potential to benefit not only injecting drug users but also health workers and the

wider community. The coalition drew upon research that indicated that SICs may be linked to a reduction in the number of fatal and non fatal overdoses. In particular it was argued that, the provision of increased access to resuscitation and dissemination of information on safer using practices and overdose prevention had the capacity to reduce the amount of overdoses.³⁹² The coalition reported that cities with SICs such as Frankfurt in Germany had experienced more reductions in fatal overdoses than the rest of Germany as a whole.³⁹³

Further, it was argued that SICs could affect a reduction in the transmission of BBV infections such as HIV and HCV through provision of free sterile injecting equipment as well as information on how to use drugs without contracting such viruses. A study by Buerki examined HIV risk behaviour among injecting drug users that attended SICs in Berne, Switzerland found that over time there was a decrease in such behaviour.³⁹⁴ Another study pointed to a stabilisation, and in some cases an improvement in, the general health of injecting drug users attending SICs in Basel, Switzerland. This included a stabilisation of HIV prevalence and abscesses.³⁹⁵

There were further arguments that SICs may provide injecting drug users with better access to primary medical care and drug treatment programs through on site referrals made by qualified staff with the consent of the service consumer.³⁹⁶ Finally, the harm reduction coalition argued that SICs may improve the occupational health and safety conditions for health workers, police officers and ambulances, as such groups

³⁹² Joint Select Committee into safe injecting rooms, 1998, *Report on the establishment or trial of safe injecting rooms*, Parliament of New South Wales, p81.

³⁹³ *ibid.*

³⁹⁴ Buerki, C., 1996, 'HIV risk Behaviour Among Street IVDUs attending a shooting room in Berne, Switzerland, 1990 and 1995', University Psychiatric Services.

³⁹⁵ Ronce, C., Coda, P., & Schopfer, R., 1994, *Evaluation der Gassenzimmer I, II und III in Basel*, Institut für Sozial und Präventivmedizin der Universität Basel.

³⁹⁶ Joint Select Committee into safe injecting rooms, 1998, *Report on the establishment or trial of safe injecting rooms*, Parliament of New South Wales, p88.

are often at most risk of needlestick injury when engaged with drug consumers such as when conducting searches or attending an overdose.³⁹⁷ The argument followed that the lower the number of overdoses officials had to attend in uncontrolled environments such as public places like streets and parks or in private homes, the less the risk of contracting a needlestick injury.

'Social' arguments for SICs

The harm reduction coalition argued that SICs had the potential to provide social benefits in terms of:

- a capacity to address public nuisance problems through provision of a place to inject,
- clarification of the role of police around existing illegal injecting rooms,
- entrenching access for drug consumers to mainstream health services such as drug treatment services,
- reintegrating marginalised populations into the wider community through greater access to activities and services provided on SIC premises, and,
- an ability for SIC staff to interact with drug consumers and to encourage behaviour change such as reductions in drug driving.

The increased incidence of injecting in public places aggravated local communities and was a major problem in the 1990s in large metropolitan areas in Australia.³⁹⁸ Inappropriately discarded injecting equipment, witnessing people injecting drugs and encountering drug-affected people were also of concern. Moreover, the use of public spaces such as parks and public toilets as regular injection venues meant that some in

³⁹⁷ *ibid*, p89.

³⁹⁸ *ibid*, p93.

the broader community regarded these areas as hazardous to use. The NSW *Report on the establishment of or trial of safe injecting rooms* stated that SICs had the capacity to reduce public injecting through provision of a place to inject and subsequently reduce the amount of inappropriately discarded needles in public places.³⁹⁹ Other proponents reiterated that SICs are a logical extension of the service provided through NSPs:

...[community members] would prefer it if the needle exchange outlet had an injecting room so that users would not have to inject in front of their house.⁴⁰⁰

Another argument links the SIC and reduction of police corruption:

Based on evidence given at the Wood Royal Commission into the NSW Police Service that a corrupt relationship existed between some members of the police and distributors of narcotics and that this relationship extended to the protection of those operating illegal injecting rooms...⁴⁰¹

Police had wrestled with the idea of illegal injecting rooms as officers had to weigh up the possible health and social benefits associated with injecting rooms against their illegal status when considering whether to close them down.⁴⁰² Alex Wodak summarised the dilemma police faced:

The third type of benefit after public nuisance and public health would be reducing the opportunities for corruption in the police service. This is not an area I can claim any expertise as a medical practitioner, but I have certainly been able to observe what has been happening in Kings Cross over the last few years. I think the community put the police in a dreadful position, of being forced to choose

³⁹⁹ *ibid*, p94.

⁴⁰⁰ *Ibid*, p96.

⁴⁰¹ *ibid*, p98.

⁴⁰² *ibid*, p99.

either between acting in a way that was contrary to public health or enforcing the laws. The police, I think, very bravely, chose to do the right thing by public health. They allowed a number of injecting rooms that were run by illegal operators, they allowed these to continue, and I am sure that this reduced the number of overdose deaths and reduced the number of people who got terrible infections. But by the same token the police were doing something that no one can really feel comfortable with and where there is a great opportunity for corruption. I think the police deserve better treatment from the community than that, and I think the police deserve to be put in a position where it is very clear that they are acting both to enforce the laws and to preserve public health. I think the best way of doing this is by having injecting rooms run by legal operators run officially out in the open. If the community is not ready to have legal injecting rooms I am sure that we will continue to have illegal injecting rooms with all the problems that that ensues.⁴⁰³

Another argument was that SICs, through offering assistance with access to drug treatment might mean that users commit less crime. Results from surveys of attendees at Swiss and German SICs suggested an increase in the number of their service consumers that had shifted to relying on welfare benefits for income possibly meaning that users had moved away from crime to support themselves.⁴⁰⁴

Furthermore, some concerned residents had reported many users driving straight after using drugs:

I live on the first floor of my building and I have witnessed many times people injecting in their cars who then drive off. You notice when you look down a car with a cigarette lighter lit in the car. It is perfectly obvious what they are doing. It is lit for quite some time while they are heating the heroin in the spoon ready to inject. We see this happen day in and day out.

⁴⁰³ Alex Wodak's submission to the Committee, 9 October 1997 quoted in Joint Select Committee into safe injecting rooms, 1998, *Report on the establishment or trial of safe injecting rooms*, Parliament of New South Wales, p99.

⁴⁰⁴ Buerki, C, 1996, 'HIV risk Behaviour Among Street IVDUs attending a shooting room in Berne, Switzerland, 1990 and 1995', Department of University Psychiatric Services.

Attendees at an SIC would be encouraged to remain on the premises after using drugs and moreover be encouraged not to drive while intoxicated.⁴⁰⁵

Lastly, SICs would enable contact with this extremely marginalised group of people. Currently NSPs are the main point of contact for injecting drug consumers yet most of the time transactions at an NSP are fleeting. Staff at SICs would have the time to develop rapport and thus be better able to provide injecting drug users with information on other drug treatment programs and services.⁴⁰⁶

Injecting rooms would be of benefit not only to the wider community but to individual drug users themselves by providing a means by which they could reintegrate into mainstream society.⁴⁰⁷

The harm reduction coalition argued that provision of activities and job schemes through SICs (as is the case in the Rotterdam and Frankfurt SICs) may further contribute to such reintegration. Evidence from the European SICs indicated that development of vocational activities and life skills enabled some drug users to control and reduce their drug use. Moreover it is widely recognised that for many, problematic drug use lasts a few years until the person has enough information to modify their behaviour or makes the decision to reduce their use to a level that is not problematic.⁴⁰⁸ Thus, it was argued that SICs had the capacity to keep people safer during this experimental time and decrease the likelihood of contracting a lifelong viral infection such as HIV/AIDS or HCV. Such 'social' arguments ostensibly broadened the theoretical impact of SICs from having benefits for the drug consumer to the wider community.

⁴⁰⁵ Joint Select Committee into safe injecting rooms, 1998, *Report on the establishment or trial of safe injecting rooms*, Parliament of New South Wales, p101.

⁴⁰⁶ *ibid*, p103.

⁴⁰⁷ *ibid*, p104.

⁴⁰⁸ *ibid*, p102-3.

The harm reduction coalition argued also that SICs have the capacity to affect economic savings through:

- prevention of fatal and non fatal overdoses and associated problems,
- reduction in BBV transmission both within the drug using community and broader society and, and,
- more drug consumers opting for treatment.

Supporters of SICs in the *Report on the establishment or trial of safe injecting rooms* stated that such facilities have the capacity to reduce costs to the community through prevention of overdose or at least a reduction in the number of ambulance responses to overdose as well as treatments in hospital emergency departments, intensive care units, general hospital wards and the cost of rehabilitation if the person is disabled following the overdose.⁴⁰⁹ Further, the harm reduction coalition argued that SICs, through provision of sterile equipment and also safer injecting information (generally staff can engage injecting drug users longer in this context than NSPs) might impact on transmission rates of BBVs such as HIV or HCV. Moreover, it was stated that medical costs of treating these infections are considerable:

One HIV infection in terms of medical and health cares costs represents about \$100,000 to the Australian health budget.⁴¹⁰

We assume that there are about 88,000 or 90 000 people in New South Wales with hepatitis C and it is going to cost the health system \$1.258 billion for the current pool. For

⁴⁰⁹ *ibid*, p110.

⁴¹⁰ *ibid*, p111.

new infections which are taking place, it is adding \$71 million per year to the already high number.⁴¹¹

Results from European studies⁴¹² were drawn upon to support the claim that SICs reduce rates of transmission for infections and subsequently the financial burden on the community of supporting people living with such illnesses would also be lessened.

As it was argued that SICs have the capacity to improve the health of injecting drug users through acting as a gateway to mainstream services, therefore such facilities were claimed to also have the capacity to affect savings on the health budget.

Health costs of a drug dependant person are estimated to be some 80% higher than those of an average citizen in the same age group. If injecting rooms provided information to injecting drug users on issues such as primary health care, how to avoid needle-site infections and overdoses and how to access drug treatment and rehabilitation programs, economic and social costs to the community related to injecting drug use may be reduced.⁴¹³

Moreover, the harm reduction coalition continued, if the information provided to drug consumers meant that more access drug treatment, the costs associated with problematic illicit drug use would be lessened (for example, reduction in BBVs and overdose). SICs also have the capacity to reduce the number of discarded syringes in public areas through provision of and public place to inject along with appropriate disposal facilities, consequently reducing the amount of money spent by councils on retrieval.

⁴¹¹ *ibid.*

⁴¹² In Frankfurt, the ratio of HIV positive people that had overdoses declined from 21% in 1986 to 8% in 1995, this was attributed in part to the establishment of SICs. *ibid.*

⁴¹³ *ibid.*, p112.

'Legal' arguments for SICs

One 'legal' rationale mentioned by the harm reduction coalition to support implementation of SICs was that such programs would clarify the role of police around existing illegal injecting rooms. As illegal injecting rooms already existed in Australia, it was argued that the implementation of a legal SIC would clarify the role of police in relation to both drug consumers and those running such establishments.⁴¹⁴ Police have a difficult task when balancing public health needs versus upholding the law. Self administration, possession, possession of drug paraphernalia (other than sterile needles and syringes), aiding and abetting or involving another person in the administration of drugs are all offences yet police are expected to tolerate some practices from a harm reduction perspective.⁴¹⁵ Commissioner Wood noted:

Tension exists between law enforcement and the recognition that addiction to prohibited drugs is also a medical and social problem. Criminal sanctions do not and can not address the latter. The National Drugs Strategy objective is harm minimisation... there remains a substantial area of potential conflict between the traditional law enforcement methods and the harm minimisation mode.⁴¹⁶

Legalising injecting rooms and exempting certain activities in the relevant state acts would resolve this problem for police.

Moral arguments for SICs

In the 1999 NSW Drug Summit proceedings, it was clear that some of the language and arguments used in advocacy for SICs had a moral undercurrent. What follows

⁴¹⁴ *ibid*, p119.

⁴¹⁵ *ibid*.

⁴¹⁶ *ibid*.

are excerpts from the working group. Advocates of SICs suggested that the existing approach to the 'heroin problem' was more unacceptable than the implementation of SICs.

I feel it is also necessary to say that the only thing I have found more confronting and repugnant in my career on a day to day basis is when young people whom I have been managing over a period – sometimes years – have died. One of their friends would come into Kirketon Road and say that they heard that a particular person died over the weekend. Nobody tells us this information officially: as I say, it comes via the grapevine. We ring the morgue to find out whether or not it is true, and it is not unusual for us to be asked to identify the body because a lot of these young people have been well and truly out of contact with their families for a long time. When their parents have been contacted, on more than one occasion they have asked if they could take the young person's medical file home because that is the only tangible thing that they have to prove that their child was ever alive. That is a lot more repugnant than safe injecting rooms... I urge this Summit forward to consider what can possibly be best described as a necessary evil. Safe injecting rooms are not something that should be in every suburb, but certainly where there is street injecting and a public order issue, I think this recommendation is well worth considering on a trial basis.⁴¹⁷

One of the key rationales advanced for SICs was the capacity to provide medical assistance to overdoses that occur on site and thus save more lives than if the overdoses occurred in an unsupervised setting.

Moreover many of the advocates also felt the need to express moral objections to the practice of intravenous drug use. NSW Premier Carr stated at the Summit Working group:

There is no one more repelled by the whole business of injecting heroin than I. But the proposition is one that will

⁴¹⁷ Dr van Beek speaking at NSW Drug Summit 1999 – 'Summit Outcomes, Consideration of Resolutions', Working Group, Health Maintenance and Treatment Services, Extract from report of proceedings of 20/05/99, accessed online at www.sydneymsic.com/PF/Pfdsummitoutcome1.htm

be given the most careful and painstaking consideration by the Government... I speak as someone whose repugnance for the whole business of injecting additive poisons into people's bodies is as repulsive as anything I can contemplate, but we will give the fairest consideration to this as fashioned by this conference, to see that all the concerns and aspects of dealing with this horrendous problem are dealt with as fairly and critically as possible.⁴¹⁸

By taking such a moral position, Premier Carr distanced himself from the claims that advocates of such programs are necessarily pro-drug use by announcing that he was in fact anti-injecting drug use. Traditionally harm reduction advocates display a value neutral attitude toward drug use. Moreover, the coalition also directly addressed a criticism that is often levelled at harm reduction namely that the logical consequence of implementation of harm reduction programs such as NSPs and SICs is normalisation or entrenchment of injecting drug use. Another participant at the working group rejected notions (most famously suggested by Prime Minister John Howard) that such facilities 'send the wrong message' and indeed suggested to the contrary:

If people are sincerely concerned about the sorts of messages that injecting rooms might send to young people, I can only say that, if anything, these rooms are so far from glamorous environments that I would go so far to say this it might be almost worth considering having young people attend the facilities to prevent them from taking up drug use. I feel very strongly that not only do these rooms not send the wrong message, but also that they may well send the right message as to where drug use ends up or where it can end up.⁴¹⁹

Lastly, one participant noted the similarities between the philosophies of Christianity and harm minimisation:

...I would like to recount to you again that after four days and a long conversation with Brian Watters and Ingrid van Beek earlier today, the three of us come from different parts of this debate. Our conversation was about how much

⁴¹⁸ NSW Premier Bob Carr speaking at NSW Drug Summit 1999 – *ibid.*

⁴¹⁹ Dr van Beek speaking at NSW Drug Summit 1999 – *ibid.*

we agreed on, whether it was 90 per cent or 95 per cent. There is an increment of difference and whether we call it Christian compassion or harm minimisation, the words are potent. I stress that what we have is actually a description of an increment of growth on mechanisms that we have all supported with good intent. I appreciated that dialogue.⁴²⁰

From this brief survey of the ideas and types of arguments used by the harm reduction coalition, several strategies are apparent. Firstly, a number of the arguments presented aimed to broaden the benefits of SICs beyond injecting drug users to having benefits to the whole of society. For example the reduction in transmission of BBVs, economic savings through reduction of health problems and lessening of the prevalence of drug use and most critically, reduction of the incidence of public nuisance problems were key benefits cited. This type of argument meant that even those people that objected to public funds being dedicated to so called ‘undeserving’ populations such as drug users, that implementation of SICs would benefit those ‘deserving’ of taxpayer funding. Secondly, the claims that SICs would lead to economic savings was a key point. Expansion of health budgets and the increasing focus upon responsible economic management and managerialist practice within bureaucracy and those contracted to provide services means that this type of argument is politically shrewd. Indeed the insistence on an evidence base for harm reduction services is entirely compatible with the focus on outcome evaluation that has been a key approach by Government departments in Australia since the shift to new public management techniques⁴²¹ in the 1980s and 1990s. Thirdly, the harm reduction coalition appealed to the sensibilities of the moral coalition through claims

⁴²⁰ Mr P Woods speaking at NSW Drug Summit 1999 – *ibid.*

⁴²¹ ‘New public management’ or ‘managerialism’ are terms that reflect the type of reform undertaken by bureaucracies in Australia and some other countries in the 1980s and 1990s. In this model Government services are evaluated according to the outcomes achieved by the programs rather than by a focus on the process by which such services deliver services. Indeed, Di Francesco suggested that new public management “...is framed around control for the achievement of outcomes (what is achieved) rather than the management process (how things are done)”. Di Francesco, M., 2001, ‘Process not outcomes in New Public Management?: ‘Policy Coherence’ in Australian Government’, *The Drawing Board: An Australian Review of Public Affairs*, 1:3, March, p106.

that SICs would lower the prevalence of drug use through increasing access to mainstream services for drug consumers and reintegration of this group into mainstream society. Finally, advocates in NSW used moral arguments to advocate for an SIC. There were two types of moral arguments used: objections to the current situation (that it was immoral to allow the escalating rate of overdose to continue) while concurrently expressing moral objections to the practice of injecting drug use in general. The latter meant that harm reduction advocates distanced themselves from any possibility of being portrayed as pro-drug advocates.

Helping the undeserving leads to more of them: advocating against SICs

The recurring criticisms of harm reduction programs more generally were also directed towards the implementation of SICs. Indeed, there is a recycling of arguments against harm reduction programs that has occurred in the period of analysis. The main objection to SICs was underwritten by ‘moral’ concerns largely that providing services for people that continue to use drugs will entrench or promote the activity. Consequently, so the argument follows, the prevalence of illicit drug use would either remain stable (an unacceptable outcome) or likely increase. Thus, harm reduction programs are regarded as essentially normalising the ‘evil’ and dangerous ‘nature’ of illicit drug use. Moreover, the labelling of injecting drug users as ‘undeserving’ recipients of scarce public money was also a key theme of arguments applied by moral agents. The following section outlines the health, social/moral, economic and legal arguments against the implementation of SICs in Australia as applied by the moral abstinence coalition.

'Health' arguments against SICs

In the *Report on the establishment or trial of safe injecting rooms*, there was concern about the health and safety implications for service consumers and staff of SICs. Some of those that made submissions suggested that some drug consumers might react violently to staff as a result of using drugs such as amphetamines.⁴²² Others suggested that SICs would lead to an increase of injecting drug use (through normalisation of such an activity) and also might delay drug consumers from entering rehabilitation (through entrenching drug use).⁴²³ These last points are key criticisms of harm reduction ideas and programs more generally and are related to 'moral' arguments against SICs. These are discussed below.

'Moral and Social' arguments against SICs

Several submissions put to the *Joint Select Committee into Safe Injecting Rooms* suggested that there were some concerns about the social impact of SICs. Firstly, moral concerns that that such a facility may send the 'wrong signal' to the community that injecting drug use is condoned is a common argument often directed toward harm reduction programs. This was the argument that the Howard Government produced in response to the trial of heroin prescription. Professor Pennington, Chair of the Premier's Drug Advisory Council in Victoria described these types of 'moral' arguments to harm reduction programs in a presentation at the New South Wales Parliament House in July 1996:

I went into it knowing that it would be controversial, I went into it knowing that we would be dealing with a situation where a number of people in the community have

⁴²² Joint Select Committee into safe injecting rooms, 1998, *Report on the establishment or trial of safe injecting rooms*, Parliament of New South Wales, p92.

⁴²³ *ibid*, p90.

very strongly held views, that use of illicit drugs is to them an immoral act, open and shut, that anything to do with illicit drugs is something wicked, something that is very closely aligned to peoples' religious views or peoples' set of moral values. That is one problem and many of those people are not willing even to have questions raised to analyse the situation to see whether or not arrangements, as they now stand, are working, whether they are productive or counter-productive.⁴²⁴

One example of such an argument can be seen in the following submission to the Joint Select Committee into safe injecting rooms:

The use of addictive drugs is a voluntary action and if the person becomes addicted to heroin, morphine etc it is for the want of a better word 'a self inflicted wound' and the law abiding citizens and society owes the addict nothing... safe injecting rooms for drug addicts is revolting, vulgar and an insult to all law abiding citizens who face everyday problems without turning to drugs. Safe injecting rooms would be a reward for illegal actions and would encourage weak willed persons to follow the same road.⁴²⁵

The argument that implementation of SICs in Australia would lead to normalisation and entrenchment of drug use, was a real concern for those that advocated against SICs. This is also a common argument against harm reduction programs yet this claim does not have the support of evidence.

The second theme or arguments applied by the moral coalition against the implementation of SICs reason was the effect of such a facility on the local area. It was suggested that the opening and presence of an SIC may lead to a congregation of drug users around the site (the 'honey pot' effect) that might lead to further problems (such as drug dealing and an increase in opportunistic street and property crime around the site) and labelling of an area as a drug centre.

The public image of Cabramatta or the City of Fairfield has been somewhat that is far less than desirable and the public

⁴²⁴ Professor Pennington quoted in Joint Select Committee into safe injecting rooms, *ibid*, p108-9.

⁴²⁵ Submission to Joint Select Committee into safe injecting rooms, *ibid*, p109.

perception of the place, I must say, has been very very damaging to the local community who live there... no doubt we would send a very wrong signal to the local community that: 'Oh well, because of that particular region of Sydney has such a large concentration of Indo-Chinese or Asian communities, if we cannot have it elsewhere in Sydney we will just dump it in that area of Cabramatta because those Indo-Chinese would not know how to react, would not know how to object, let them have it if nobody else wants it.'⁴²⁶

We believe that the provision of a 'safe house' in Nimbin will serve to further identify our town as 'the drug capital of Australia' and as such will attract more itinerant, untidy, unlawful, indolent and unemployed youth of the type we already have an excess of.'⁴²⁷

Thus, some local councillors were concerned that the public image of their localities may be tainted by the centres.

'Economic' reasons against SICs

Several submissions to the NSW Joint Select Committee into safe injecting rooms expressed resentment that scarce public funds were being spent on consumers of illicit drugs. For some, the medical problem of drug dependencies was regarded as a matter of an individual lacking willpower. In this line of argument dependencies were conceptualised as self-inflicted problems and thus those with them considered as 'undeserving' of public funds. Others were apprehensive and fearful of injecting drug use.

Why should we make their lives comfortable? Why should we pay for their habit? Why should we feel uncomfortable walking down the main street of our own town? Why are their problems in life any worse than ours? We have suffered all the grief and despair but we know if you hang in there and plug on you can get on top of it. Letting yourself slide down and hide behind a veil of unreality is not the answer and expecting to be picked up at society's expense is unrealistic and grossly unfair to those who do

⁴²⁶ Submission to the Joint Select Committee into safe injecting rooms, *ibid*, p107.

⁴²⁷ Submission to the Joint Select Committee into safe injecting rooms, *ibid*.

play on and climb out. Society is already feeding them, housing them, clothing them... How much further do we have to go? Ask them what they give back to society.⁴²⁸

Another theme to financial arguments levelled against SICs was concern regarding the impact SICs would have local business and property values nearby.⁴²⁹ Other costs estimated as linked to the implementation of SICs included: due to the congregation of drug users means that councils and businesses would require upgrades to security systems due an increase in drug related crime such as shoplifting; tourism and custom to local businesses might be affected and insurance premiums might be rise.⁴³⁰ Other arguments raised against SICs were that money would be better spent on law enforcement and/or treatment programs that encourage people to become abstinent.⁴³¹ This last point is related to the claim that a drug free country is both an achievable and desired aim. These words resonate with the key tenets of the moral-abstinence coalition's approach toward illicit drug policy as described in chapter one.

'Legal' arguments against SICs

A further theme of arguments raised against the SIC revolved around legal concerns and inconsistencies that might be encountered following the implementation of SICs. It was argued that to legalise some behaviour, such as self administration of drugs, in the context of a SIC while such an act remains illegal in all other arenas, would generate problems for law enforcement. Director of the Criminal Law Review Division stated:

⁴²⁸ Gregory Soward, president of the Nimbin Agricultural Industrial Society quoted in Joint Select Committee into safe injecting rooms, *ibid*, p115.

⁴²⁹ *ibid*, p116.

⁴³⁰ *ibid*.

⁴³¹ *ibid*, p117.

...one cannot get away from the fact that there are going to be arbitrary cut off points and there are going to be undoubted anomalies and all of those things simply arise from... seeking to say that something is legal in one part of New South Wales and illegal in another part.⁴³²

A second argument levelled against SICs from a legal perspective revolved around potential legal liability of incidents that occur. Civil liability issues for the operators if a consumer dies or if a staff member is injured could be considerable.⁴³³

From a survey of those arguments and testimonials presented in the Report on the establishment or trial of safe injecting rooms, several factors are evident. Firstly, the nature of the 'moral' argument against SICs is based on 'faith' rather than evidence. In contrast to the harm reduction coalition, that drew upon research from implementation in the European setting, criticisms of SICs are necessarily based upon anecdotal incidents or concerns of what *might* happen. Research around harm reduction programs more generally that refuted these claims was ignored or treated with scepticism. For example, studies have shown that harm reduction programs do not result in an increase in illicit drug use and moreover studies from the European experience have pointed to positive outcomes for both drug consumers and the public more generally.⁴³⁴ The moral-abstinence coalition's submission did not include evidence based analysis, nor did it draw upon research more generally, rather there was faith that their arguments were correct. This is due to the convergence or reflection of the values of the moral-abstinence coalition with those traditional values

⁴³² *ibid*, p123.

⁴³³ *ibid*.

⁴³⁴ Dolan, K., Kimber, J., Fry, C., Fitzgerald, J., McDonald, D & Trautmann, F., 2000, *Drug consumption facilities in Europe and the establishment of supervised injecting centers in Australia*, *Drug and Alcohol Review*, 19; Buerki, C, 1996, HIV risk Behaviour Among Street IVDUs attending a shooting room in Berne, Switzerland, 1990 and 1995, University Psychiatric Services.

of states such as Australia. Put simply, evidence was not needed, as this point of view was regarded as “common sense”.

Secondly, the moral-abstinence coalition implied that such harm reduction programs are not deserving of public money, arguing that money should not be spent on immoral programs that have the effect of entrenching and encouraging drug use. Moreover that injecting drug users have themselves to blame for their own dependencies/drug related harms means that these people are labelled as ‘undeserving’ of public money. The moral abstinence coalition in submissions to the Joint Select Committee into Safe Injecting Rooms did not provide strategies on how to ameliorate the public health dimensions of drug use such as the impact of BBVs and economic costs associated with illicit drug use.

Debates and Outcomes: a trial of a medically supervised injecting centre in Kings Cross

Both Victorian and New South Wales Parliaments debated bills to instigate SICs. In June 2000 in Victoria, retailers such as Myer and David Jones echoed moral abstinence coalition members in calling for greater law enforcement to address drug problems in the CBD and advocated for the area to become ‘a drug free zone’.⁴³⁵ Both Melbourne City Council and the City of Greater Dandenong Council voted against SICs in their area in June 2000.⁴³⁶ In September 2000 the Victorian Parliament voted against the *Drugs, Poisons and Controlled Substances (Injecting*

⁴³⁵ Gunaratnam, P., 2005, *Drug policy in Australia: The supervised injecting facilities debate*, Asia Pacific School of Economics and Government, ANU, accessed online: www.apseg.anu.edu.au, 7/9/2005.

⁴³⁶ *ibid.*

Facilities Trial) Bill 2000.⁴³⁷ Those opposing the bill cited financial and legal problems with the trial and also expressed scepticism of the science that underpinned the evidence that pointed to the benefits of SICs in the European context.

The Joint Select Committee into Safe Injecting Rooms voted against the establishment of a trial of SICs in NSW.⁴³⁸ Subsequent to this decision a group of clergymen, former MPs, doctors, drug users and parents of drug users established an unsanctioned SIC in early 1999 at the Wayside Chapel in Kings Cross, Sydney. Such a facility was intended by its founders to act as a "...symbol of civil disobedience".⁴³⁹ The facility was closed by police soon after it had opened and the issue was on the agenda for the 1999 NSW Drug Summit.

SICs were debated at the 1999 Drug Summit in NSW. A long time advocate of harm reduction programs and policies, and participant at the Summit, Dr Alex Wodak, described the Summit as "...marking a watershed"⁴⁴⁰ for illicit drug policy and recalled that these talks were remarkable in comparison to other such events.

Another major outcome of the Summit was the astonishing discovery that drug users are, after all, also human beings. The need for a more compassionate approach to drug users was widely endorsed, although only grudgingly for some.⁴⁴¹

⁴³⁷ Drugs Poisons and Controlled Substances (Injecting Facilities Trial) Bill, Victorian Hansard, 7/9/2000.

⁴³⁸ Joint Select Committee into safe injecting rooms, 1998, *Report on the establishment or trial of safe injecting rooms*, Parliament of New South Wales, p188.

⁴³⁹ Wodak, A., Symonds, A., & Richman, R., (2003), 'The role of civil disobedience in drug policy reform: how an illegal safe injection room led to a sanctioned medically supervised injecting centre', *Journal of Drug Issues*, 33:3, p609.

⁴⁴⁰ Wodak, A, 1999, 'That was the Summit that was', posted on www.onlineopinion.com.au, accessed on 16/11/05.

⁴⁴¹ *ibid*.

The way in which the issue of SICs was debated at the NSW Drug Summit was also a politically shrewd measure. SICs were linked to treatment⁴⁴² rather than programs such as NSPs which are primarily focussed on disseminating equipment to drug consumers. Similar to SICs, one of the core functions of NSPs however is in providing a link or gateway to treatment services for marginalised consumers. This categorisation of SICs as treatment or health maintenance programs was evident as the discussion about the facilities at the NSW Drug Summit was conducted at sessions entitled 'Health Maintenance and Treatment Services'.⁴⁴³

Further, as discussed earlier those advocating for harm reduction provided 'moral reasons' (specifically that the existing situation and number of deaths was unacceptable and an abhorrence of the practice of injecting) to support the implementation of SICs. Expression of a moral repugnance for injecting drug use is not a tactic commonly employed by advocates of harm reduction programs.

Wodak also noted the different approaches of harm reduction and moral-abstinence advocates:

It is hard not to comment on the very different performance of the Government and the Opposition. There was also a striking difference in the performance of supporters of evidence based change compared to those advocating retention of a morality based approach. The Premier... began well by opening the Summit with a plea for open minds. Although the leader of the Opposition responded well, the Leader of the National Party proudly announced that members of his party were not going to change their opinions just because of evidence presented at the Summit. The Government came across as disciplined and strategic. The Opposition case was often argued by an irascible and

⁴⁴² NSW Drug Summit 1999 – Summit Outcomes, Consideration of Resolutions, Working Group No. #, Health Maintenance and Treatment Services, Extract from report of proceedings of 20/05/99, accessed online at www.sydneymsic.com/PF/Pfdsummitoutcome1.htm on 23/4/05.

⁴⁴³ *ibid.*

poorly informed National Party backbencher who would be a liability to any side of a debate.⁴⁴⁴

Wodak observed that battles around establishment of the Wayside Chapel tolerance room previous to the Drug Summit lead to members of the gay community providing assistance to advocates of SICs.

When leaders of the gay community saw public health advocates fighting all too familiar battles over discrimination and HIV control, they generously provided to users and their supporters consummate strategic skills, discipline and a sense of focus. If this new coalition is sustained, the future of advocacy involving drug use and public health in Australia will be changed forever.⁴⁴⁵

For scholars of illicit drug policy, the amalgam of the issues of injecting drug use and HIV/AIDS was a familiar one, as the issue of HIV/AIDS had precipitated and was instrumental in the implementation of harm reduction programs ten years previously. Wodak also noted that the process employed by the Summit was also instrumental.

The combination of all involved parties – parliamentarians, drug users, families of drug users, lawyers, police, clinicians, researchers and government officials – talking to each other directly rather than through the media was time consuming and costly. But in the long run this process will be seen as an efficient and effective way of achieving progress with some of our difficult to resolve social policy issues.⁴⁴⁶

The working group at the Summit voted in favour of instigating a trial of an SIC in Kings Cross. Following the Summit, in July 1999, Premier Bob Carr announced that an 18 month trial would be implemented in Kings Cross, Sydney and run by the Catholic religious order the 'Sisters of Charity' (an order focussed on health and education across Australia). The *Drug Summit Legislative Response Bill* was

⁴⁴⁴ Wodak, A, 1999, 'That was the Summit that was', posted on www.onlineopinion.com.au, accessed on 16/11/05.

⁴⁴⁵ *ibid.*

⁴⁴⁶ Wodak, A, 1999, 'That was the Summit that was', posted on www.onlineopinion.com.au, accessed on 16/11/05.

presented to the NSW Parliament in September 1999. Leader of the Opposition, Kerry Chikarovski echoed Prime Minister John Howard's comments about the failed heroin trial, and stated:

It will convey the wrong message to young people and the wrong message to the community. Indeed, it will not convey to the rest of the world that we are serious about tackling drugs in NSW.⁴⁴⁷

Regardless, the Drug Summit Bill was passed in September 1999 and the NSW Government defied the Prime Minister and the International Narcotics Control Board stating that such a facility did not contravene International law.⁴⁴⁸ Further problems surfaced during the implementation of the trial. In July 2000, the Vatican intervened and ordered the Sisters of Charity to withdraw from the trial. Cardinal Ratzinger (now Pope Benedict), head of the Vatican's Congregation for the Doctrine of the Faith, in a letter tabled in NSW Parliament stated:

...these facilities encourage the abuse of and illegal trafficking in drugs, undermine respect for the law, degrade social mores, and often represent the first step toward decriminalisation of drugs.⁴⁴⁹

As a result of this, the catholic 'Sisters of Charity' organisation withdrew from the trial and the Uniting Church was funded to provide a SIC in Kings Cross. The Kings Cross Chamber of Commerce also had reservations about the impact the facility would have on local businesses and challenged the legality of the operating license to the Uniting Church. Despite this, the trial started on 2001 in Kings Cross, Sydney and was extended in 2002.⁴⁵⁰

⁴⁴⁷ Kerry Chikarovski quoted in NSW Hansard, 11/11/1999.

⁴⁴⁸ Gunaratnam, P., 2005, *Drug policy in Australia: The supervised injecting facilities debate*, Asia Pacific School of Economics and Government, ANU, accessed online: www.apseg.anu.edu.au, 7/9/2005

⁴⁴⁹ Gunaratnam, P., 2005, *Drug policy in Australia: The supervised injecting facilities debate*, Asia Pacific School of Economics and Government, ANU, accessed online: www.apseg.anu.edu.au, 7/9/2005.

⁴⁵⁰ *ibid.*

Heroin Prescription and Supervised Injecting Rooms: Is the ACF adequate to explain policy success and failure?

This chapter examined the way in which the harm reduction coalition advocated for prescription heroin in the ACT and SICs in Victoria and New South Wales in the 1990s. As described above, only the trial of the Medically Supervised Injecting Room in Kings Cross, Sydney was successful. Below is a discussion regarding particular aspects of the ACF as charted in Table 1 accompanied by an evaluation of their utility in the analysis of events and debates regarding prescription heroin and SICs in Australia.

ACF Concept 1: Advocacy Coalitions

The notion of advocacy coalitions is a useful mechanism to aggregate a multitude of actors around a particular stance to a policy issue. In debates around SICs and prescription heroin there were two major identifiable advocacy coalitions – the harm reduction coalition and the moral abstinence coalition. Both coalitions, as mentioned in chapters three and four, have been active in illicit drug policy debates from 1980 to 2000. Moreover both groups recycled their respective arguments for debates around prescription heroin and SICs as outlined in this chapter.

As described in this chapter, those that advocated for harm reduction programs consisted of law enforcement officials, medical research personnel, alcohol and other drug workers, affected communities, politicians and community workers. The ‘intellectual glue’ binding the harm reduction coalition was a belief in the instrumental value of prescription heroin and SICs to achieve public health outcomes

that would benefit society as a whole not just the communities directly affected. For example, the outcomes argued to arise from the implementation of each program included a reduction in the prevalence and transmission of BBVs and the amelioration of public order problems associated with public injection of heroin. One of the interesting departures for the harm reduction coalition however in the debate around SICs was the 'moral' component. Notes from the proceedings of the 1999 NSW Drug Summit showed a relatively new strategy for harm reduction advocates: claiming intellectual ground familiar to advocates of moral-abstinence approach. That SICs had the capacity to reduce the number of fatal overdoses meant that such facilities were considered as ethical and the 'right thing to do'. Indeed such claims were made by many religious groups and drug workers as noted above who, indeed, found it morally repugnant to continue the status quo. The expression of moral repugnance toward the practice of intravenous drug use, while not a usual approach of harm reduction advocates that traditionally remain value neutral to such activities, was a politically shrewd measure that effectively pre-empted the usual accusations directed towards opponents of harm reduction advocates as being pro-drug and subsequently, pro-drug use. Consequently, facilities such as SICs were then labelled as a 'necessary evil' rather than as being 'good' for society. The final component of the 'moral' approach was in appointing carriage of the program to the Sisters of Charity (and later the Uniting Church) rather than, for example, a self-help drug user organisation. This further reinforced the moral nature of such a facility through its placement in the carriage of moral agents. There are drawbacks to emphasising the morality of SICs in this manner however and this will be discussed in the next chapter.

As described above, the moral abstinence coalition consisted of members of Parliament (mainly Liberal and National parties and minor parties located on the Christian right), Christian interests (for example, from the Vatican and Fred Nile), Prime Minister John Howard and some past drug consumers and their families and friends. Further, the United Nations Narcotic Control Board also opposed instigation of both prescription heroin and SICs. The moral abstinence coalition's 'intellectual glue' was a position that such programs condone, promote and encourage illicit drug use through normalisation of the activity. The claim that such programs 'send the wrong message to the community' was a key point used by many members. This argument further suggested that SICs were the first step towards decriminalisation and then legalisation of illicit drugs.

Thus the ACF was accurate in its depiction of a subsystem in which actors are grouped into two or more advocacy coalitions around particular beliefs and thus share policy core ideas and solutions. Both coalitions displayed consensus on policy core ideas that prescribed whether or not prescription heroin trials and SICs should be implemented. Sabatier was correct in the assumption that coalition members might differ in opinion on deep core or secondary aspects of the policy problem. Evidence from the proceedings of the NSW Drug Summit – whereby NSW Premier Carr expressed repugnance towards injecting drug use (harm reduction ideas typically express a value neutral position towards the practice of injecting) might differ from other harm reduction advocates such as drug user groups (for example: the Australian Illicit Drug Users League) that may advocate the activity of illicit drug use as a fundamental human right. Indeed, a survey of the key actors of the harm reduction coalition could measure the degree of consensus on beliefs such as the nature and role of drug use in society.

ACF Concept 3: Guidance Instruments

The upsurge in problematic heroin use in the mid 1990s created a window of opportunity for coalitions to generate policy responses. Chapter two outlined Sabatier's taxonomy of the ways in which coalitions can use such changes to affect policy change. The main ways that the harm reduction coalition responded to the rise in problematic heroin use was through presentation of research and information exchange at appropriate forums such as the NSW Drug Summit and also through intergovernmental groups such as the MCDS and ICDS. As detailed above the harm reduction coalition had a vast array of research that supported their programs and indeed broadened their function from helping drug consumers to producing positive public health outcomes. Information exchange also involved ongoing extensive consultation with local communities (as well as opinion polls to measure community attitudes to prescription heroin) and other stakeholders. The prescription heroin process that began in 1989 employed extensive consultation with a range of groups as listed in Box 1.

The consultation process was so effective and thorough that most of the supporters of a trial of prescription heroin held elite prestigious positions and included organisations and actors from law enforcement, medical research bodies, Bishops and religious organisations more generally. The extensive consultation process meant that stakeholders were briefed and educated about prescription heroin with questions and concerns able to be regularly answered by the proponents of the trial. In this sense the proponents of the trial could work with local communities and stakeholders to negotiate mutually appropriate terms for the trial. Moreover due to the ongoing nature of consultation through such formal channels, officials from other

sectors such as law enforcement could be regularly updated and have input into the process. Such a process leads to increased ownership of a program by those that participate in its design.

With regard to Sabatier's list of guidance instruments, most of the harm reduction's responses were classified under number five: "trying to gradually alter the perceptions of a variety of actors through research and information exchange". A specific type of information exchange occurred with regard to prescription heroin: namely the use of community development processes. While such approaches can be broadly classified as information exchange, community development is a particular type of information exchange with a specific agenda. It is suggested that such a device be included in Sabatier's taxonomy of guidance instruments.

ACF Concept 6: Policy oriented learning and types of data

It was hypothesised in the ACF that policy oriented learning is more likely to occur in systems conducive to the gathering and analysis of quantitative data. The illicit drug policy subsystem necessarily concerns issues of a social and moral nature whereby such types of data are more likely to succumb to politics than equivalent data in natural systems. In debates and advocacy regarding prescription heroin and SICs, the harm reduction coalition used scientific evidence and social research (such as opinion polling or program evaluation) to support advocacy. This was a key strategy for the harm reduction coalition and not inconsistent given the membership of personnel from medical and general research communities. Such evidence was systematically ignored or treated with scepticism by moral entrepreneurs, the approaches of which, were quite different. Their position consisted of strong

convictions that drug use was an immoral act (bolstered by the prevailing Christian values of Australian society) and by extension such harm reduction programs by their very nature encourage/promote and ultimately normalise such an immoral act. As such, the moral-abstinence coalition relied on moral convictions and testimonials from politicians and concerned citizens about their observations about the evils and destructive consequences of heroin use. Occasionally such an approach was peppered with the expert views regarding the legality of such initiatives.

Ultimately, the role of quantitative/technical data in affecting policy change in the illicit drug policy subsystem is as an important and compelling device for policy makers. To a large extent the moral-abstinence coalition are bolstered by historical and political factors that have supported prohibition regimes. Sabatier's hypothesis holds in this analysis: that in social systems, quantitative data in policy change is not as persuasive as it may be in natural systems.

ACF Concept 8: Policy oriented learning and professional forums

Proponents of the prescription heroin trial used professional forums such as the MCDS and regular briefings of such bodies as ACT Drug Squad, Australian Bureau of Criminal Intelligence, Australian Federal Police Association, ACT Intravenous Drug Users League (ACTIV), Australian Medical Association as well as contact with individuals from police, health and alcohol and other drugs professions. Such interchanges with professional bodies and individuals meant that the project elicited support from a variety of sources as noted earlier in this chapter. With regard to implementation of SICs, the issue was discussed in the context of the Joint Select Committee into Safe Injecting Rooms and the NSW Drug Summit. All of the forums

listed above were prestigious enough to enable coalitions to participate and all were dominated by professional norms.

Explaining policy failure

This section will examine the extent to which the ACF can account for policy failure referring specifically to an analysis of why the prescription heroin trial was abandoned in the ACT. Sabatier's work provides explanations of policy change and essentially attributed it to two factors. Firstly policy change was seen to occur through 'policy oriented learning' within policy subsystems: this is where the hegemonic coalition refines and adapts its belief systems through interaction with other coalition/s in the subsystem. Secondly, 'non cognitive external events' (such as the advent of HIV/AIDS virus in the 1980s) was the other likely precursor to policy change as such phenomena had the capacity to affect resources and knowledge regarding a policy problem. For a more detailed examination of this approach please see chapter two.

The ACF is helpful to account for some aspects of why the ACT was unsuccessful in a bid to secure a trial of prescription heroin. The ACF is useful to explain how policy change can be thwarted by a hierarchically superior jurisdiction such as the Howard Federal Government intervention into the stopping prescription heroin from taking place in the ACT. The capacity of the Howard government to stop the trial after it was passed by the ACT Parliament is accounted for in the following ACF hypothesis:

The policy core attributes of a governmental program in a specific jurisdiction will not be significantly revised as long

as the subsystem advocacy coalition that instituted the program remains in power within that jurisdiction – except when the change is imposed by a hierarchically superior jurisdiction.⁴⁵¹

Even though that hypothesis refers to policy change rather than policy failure, the ACF still can account for the intervention of the Federal Government into the prescription heroin trial. The Federal Government had the authority to override legislation enacted in territory parliaments such as that of the ACT and in this case chose to do so.

ACF Concept 4: Policy Brokers in strategic policy posts

When key players that believe vehemently in the ideas expressed by advocacy coalitions occupy certain influential and important roles in a political system, policy outcomes are affected. Similar to Neal Blewett, then Federal Health Minister, being a key actor in the emergence of the harm reduction coalition in the 1980s, Prime Minister John Howard was a key player in the moral-abstinence coalition. In the case of the proposed prescription heroin trial, Prime Minister Howard used his statutory powers to override territory legislation. Moreover comments such as the following indicate his personal commitment against prescription heroin:

While ever this Government is in office and while ever I am Prime Minister of this country...there will be no heroin trial.⁴⁵²

Granted as the Prime Minister is necessarily part of a political party (in this case the Federal Liberal Party), such a position is not a sole decision making entity, however,

⁴⁵¹ Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe, *Journal of European Public Policy*, 5:1, March, p106.

⁴⁵² Sydney Morning Herald, Editorial, 10/8/2001.

his personal interest in illicit drug policy (as illustrated by the carriage of the MCDS in his personal Ministerial portfolio and his appointment of Major Brian Watters of the Salvation Army as Chairperson of that committee) demonstrated a particular interest in this field of policy. It is argued that this interest along with his role as Prime Minister meant that his allegiance with the moral-abstinence coalition was a key factor in influencing policy in this period. Moreover, the trial of prescription heroin had been approved and was ready for implementation until a last minute intervention by the Prime Minister as described above. Thus the ACF would benefit from the inclusion in the ACF theory of the relative degree of influence of policy players within coalitions or at least the recognition that this is a factor that can influence the nature of policy change.

Role of policy brokers

The ACF states that a group of actors known as ‘policy brokers’ mediate conflict between coalitions with the function of reaching compromise between coalition positions.

Conflicting strategies from various coalitions are normally mediated by a third group of actors, here termed ‘policy brokers’ whose principal concern is to find some reasonable compromise that will reduce intense conflict. The end result is one or more governmental programs, which in turn produce policy outputs at the operational level.⁴⁵³

In the case of prescription heroin, medical interests led the developmental process in which operational policy parameters around prescription heroin were developed. Granted the process was highly consultative and involved many groups as described

⁴⁵³ Sabatier, P., ‘The advocacy coalition framework: revisions and relevance for Europe, *Journal of European Public Policy*, 5:1, March, p104.

in Box 1, however, it was clear that policy in this case was led by coalition members rather than ‘policy brokers’ as described by Sabatier. Similarly, in the case of the Medically Supervised Injecting Centre in Kings Cross, the process was led by harm reduction coalition members. Due to the nature of the debate, compromise was minimal. The proceedings from the Drug Summit did show that instead of implementing several SICs, a trial of one facility was settled upon.⁴⁵⁴ A number of other minor compromises in terms of location was brokered yet this was done at the ‘Health Maintenance and Treatment Services’ Working Group at the 1999 NSW Drug Summit rather than by a set of actors divorced from either coalition.

Conclusion

Using an exploration of policy debates in response to the issue of increased problematic heroin use, the explanatory power of the ACF was examined and supported, however, particular limitations of the ACF were exposed. An examination of roles of key coalition actors and their capacity to influence policy would expand the capability of the ACF to explain policy change, major or minor. Further the inclusion of community development processes as particular types of guidance instruments to affect policy change would also strengthen the ACF. Moreover, this chapter also provided further information on the nature and strategies employed by advocates of harm reduction policy and programs.

The following chapter will have two aims, first, findings from chapters three to five will be synthesised and used to evaluate the ACF and specifically respond to discrete

⁴⁵⁴ NSW Drug Summit 1999 – Summit Outcomes, Consideration of Resolutions, Working Group No. #, Health Maintenance and Treatment Services, Extract from report of proceedings of 20/05/99, accessed online at www.sydneymsic.com/PF/Pfdsummitoutcome1.htm accessed 23/4/05.

research questions formulated in Table 1. Second the ACF will be used to understand the nature of illicit drug policy making in Australia in the period 1980 to 2000.

Chapter 6: 20 years of Epistemological Struggle over Illicit Drugs: Can the ACF Explain Illicit Drug Policy Change?

Introduction

...several people have wondered whether the ACF applies to policy domains – such as abortion, gun control, human rights, gay rights, school prayer and gender politics – in which technical issues are completely dominated by normative and identity concerns. Our own perception is that it should work very well. These subsystems seem to be characterized by well defined coalitions driven by belief driven conflict, which resort to a wide variety of guidance instruments at multiple levels of government.⁴⁵⁵

An important question underpinning this thesis is an evaluation of the extent to which the ACF can be employed to examine a social policy arena. A fundamental characteristic of the illicit drug policy subsystem is that the basic ideas and assumptions (such as the role of the state in managing illicit drug use and the nature and role of drug use in society) held by various stakeholders about the direction of illicit drug policy are highly variable. A further complication is a lack of consensus on the appropriate way to evaluate such questions. In the analysis of natural systems, rational/scientific approaches dominate the way such issues are considered. In contrast, analysis of illicit drug policy gives rise to a pattern of systemic rhetorical skirmishes whereby various interests question the validity of the way policy ideas and beliefs are intellectually manufactured.

This final chapter synthesises findings from the previous three chapters. Trends and key patterns are identified across the 20 year period of analysis drawing on several

⁴⁵⁵ Sabatier, P., & Jenkins Smith, H., 1993, 'The Advocacy Coalition Framework: An Assessment', *Policy Change and Learning: An Advocacy Coalition Approach*, Westview Press, San Francisco, p 152.

research questions (see Table 1.). In some cases these were addressed and answered in previous chapters, however in this chapter a synthesis of all the findings is presented and questions posed in chapter two are directly addressed. This chapter has three overarching research aims: first, to evaluate the theoretical power of the ACF when applied to the illicit drug policy subsystem; second, to use the ACF to explain the nature of policy making in the illicit drug policy subsystem and third, to provide information on the performance of the harm reduction coalition in realising policy objectives.

Differences and tensions became evident in preceding chapters with regard to the way the ACF had been developed according to its applications to natural systems. While the ACF was a highly capable tool to explain changes to illicit drug policy between 1980 and 2000, some difficulties were encountered. The lack of consensus, mentioned above, between coalitions resulted in a fundamental deadlock regarding the appropriate way to think about drug policy. Regardless of whether information was quantitative and technical in nature, the discord occurred at a deeper level whereby the relative validity of moral and scientific approaches was questioned.

Advocacy Coalitions

Research Question 1.1: What type of actors constituted the harm reduction and moral abstinence coalitions?

In Australia, the predominant type of actor that advocated for harm reduction policies was from the medical and research communities where problematic drug use was seen from a health or sociomedical perspective. Such actors have been highly instrumental in their continuing advocacy efforts with such individuals as Dr Alex

Wodak providing ongoing commentary in relation to drug trends and associated policy/public health challenges. Moreover, personnel such as Dr. Wodak have also contributed to operational advances in harm reduction practice, for example being part of a team at St Vincent's Hospital that instigated the first unsanctioned NSP in Sydney in the mid 1980s. Similarly, Dr Gabrielle Bammer drawn from the National Centre for Epidemiology in Canberra was a key advocate in the case for prescription heroin. Moreover, the chief advocator for SICs in NSW was Dr Ingrid van Beek, who had previously worked in the field of cardiac surgery. Undoubtedly, there were many more individuals from medical/research fields that took a leading role in harm reduction advocacy in this period, these were three key players identified in the period of analysis.

Harm reduction advocates were also drawn from the government arena. Key members of the bureaucracy and executive government were identified in chapter three in the period 1980 to 1990 as being key advocates of harm reduction policies and programs. Senior bureaucrat Les Drew and then Federal Minister for Health Neal Blewett were also highly instrumental in achieving policy outcomes. Over the period of analysis, the support base for harm reduction expanded. Support for prescription heroin programs in the 1990s was from a variety of fields including medical, research, legal, Police, community groups, some Church groups, peak bodies such as the Australian Drug Foundation, HIV/AIDS Organisations and affected communities. "Grassroots" workers such as those from the alcohol and other drugs field had also campaigned for such policies based on their experiences from working with injecting drug users.

What is termed the ‘moral-abstinence’ coalition was examined in chapter five with regard to debates around SICs and prescription heroin. Such actors were predominantly drawn from so called conservative religious groups such as the Catholic Church (including the Vatican) and Fred Nile’s Christian Democratic Party and supported by the United Nations Narcotics Control Board and Prime Minister (from 1996 onwards) John Howard. Further advocates of this approach tended to be drawn from concerned parents and friends of drug users and members of society that provided testimonials to peak groups of inquiries into drug policy over the 20 year period.

Research Question 1.2: Was there any change in the type of actors over a 20 year period in illicit drug debates?

As mentioned in chapter three, harm reduction ideas had been used in medical practice for many years. Furthermore, key notions of harm reduction approaches such as a focus on ‘drug related harm’ and operational practices such as dissemination of syringes to drug users existed a decade before the term was recognised as a cohesive approach in its own right. The six Inquiries and Royal Commissions that were established in the 1970s supported (in hindsight) key aspects of what became known as the harm reduction approach to illicit drug use. Between 1980 and 1990 there were three broad changes to the membership of the harm reduction coalition.

Coalition Genesis (early 1980s)

As recounted in chapter three, in the early 1980s, individuals and groups of actors were beginning to speak of 'harm reduction/minimisation' while questioning the efficacy of traditional prohibitionist approaches. Debate was lead by medical groups (Australian Medical Society on Alcohol and Other Drugs, Australian Foundation on Alcoholism and Drug Dependence) and echoed by the bureaucracy (for example, by senior federal bureaucrat Les Drew and also when NSW State Health Department adopted 'harm minimisation' as chief policy goal for illicit drugs) and international organisations (such as WHO). Further changes to terminology to facilitate data collection and analysis in regard to illicit drug problems reflected the influence of the bio-medical community both in Australia and internationally. For example, value-laden terms (abuse and misuse) were replaced with neutral terms (harmful and hazardous) so to avoid moral judgements on levels of drug use. Indeed, such reorientation to focus on the measurement and evaluation of the consequences of drug use enabled a level of objectivity endemic to the scientific endeavour.

Crisis time (mid-1980s)

Debate in the mid-1980s was lead by public health advocates concerned about the potential impact of HIV/AIDS. The advent of HIV/AIDS broadened the support for the harm reduction coalition from medical/health fields to include members of the gay community through the connection between injecting drug use and HIV/AIDS transmission. Further, the virus also meant changes to illicit drug policy whereby harm reduction services such as the expansion of MMT and instigation of self-help

drug user groups and NSPs were enacted. Consequently the harm reduction coalition was expanded to include those involved with such services. In this period the Federal Minister for Health, Neal Blewett was a key advocate for harm reduction policy and programs as was then Prime Minister Bob Hawke.

Post-HIV/AIDS (late 1980s –2000)

In this period debate was lead by medical/research interests evidenced in the discourse surrounding the policy problems presented by HCV and the increase in problematic heroin use in the mid 1990s. The third change to the membership of the harm reduction coalition occurred in the 1990s and was linked to the structure of successive NDS'. The systemic collaboration between health and law enforcement sectors since the 1985 NCADA was accompanied by increased support of the latter for the former. This was particularly evident in debates in relation to SICs and prescription heroin in the mid to late 1990s. Further support for the ideas of harm reduction was evidenced in changes to policing in the 1990s. The election of the Federal Howard Government in 1996 galvanised the harm reduction coalition as it signalled the end of support from the Federal ALP Government. While the Howard Government continued programs such as NSPs and self-help drug user groups, the Prime Minister intervened to reject such initiatives as SICs and prescription heroin. In this sense, Prime Minister Howard was a key member of a group of individuals and organisations described earlier as advocating for programs and policies that have an abstinence-oriented approach.

Research Question 1.3: What was the nature of the change? Gradual or sudden?

The membership of the harm reduction coalition was generally stable over the 20 year period with two exceptions. The principal policy actors were derived from the medical/research communities with some grassroots/community groups also providing ongoing support for harm reduction organisations. In the case of the latter this was logical due to their involvement in the development and implementation of harm reduction services and close proximity to affected communities. In terms of changes to the constitution of the coalition, the advent of HIV/AIDS as a major public health issue did have a sudden and profound impact in two ways. First, the perceived crisis of HIV/AIDS resulted in a sudden expansion of harm reduction ideas and associated personnel working in those programs in illicit drug services. Second, HIV/AIDS also generated the initiation of, and ongoing collaboration between, homosexual and medical/research interests and other illicit drug policy stakeholders in advocating for public policy to reduce transmission rates for HIV/AIDS. Such an expansion of support in the mid 1980s was the result of major policy change.

The other change to the coalition described above was the increased support of harm reduction programs by law enforcement personnel, however and in contrast to above, such a change was gradual and reflected the broad structure imposed on the sector by successive NDS'. Thus the following ACF hypothesis was generally supported by the findings of this thesis:

On major controversies within a policy subsystem when policy core beliefs are in dispute, the lineup of allies and

opponents tends to be stable over periods of a decade or thereabouts.⁴⁵⁶

The membership of the harm reduction coalition was generally stable over the 20 year period between 1980 and 2000. The two changes described above were the result of changes in the subsystem: the sudden and profound change in the mid 1980s was in response to the advent of HIV/AIDS that had impacted the illicit drug policy subsystem; in the latter case the change was a result of policy oriented learning between health and law enforcement sectors. It may be interesting in future examinations of the ACF to encourage study of the effect of such external system events not only on policy change but also on coalition membership. Indeed, an inspection of the interplay between changes in exogenous factors and instances of policy oriented learning can redefine the policy problem and in the process reconfigure coalitions might further provide interesting commentary on the policy process.

Policy Beliefs

Research Question 2.1: Did the harm reduction coalition display consensus on policy core over 20 years?

The hypothesis in the ACF that advocacy coalition actors will show substantial consensus on issues pertaining to the policy core was supported in the analysis with advocates for harm reduction generally choosing to focus on programs/policies/theory in which the focus on ameliorating the consequences of problematic drug use (such as overdose, BBV transmission, public order problems,

⁴⁵⁶ Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe', *Journal of European Public Policy*, 5:1, March, p103

general health risks) was regarded as a greater priority than reduction in levels of drug use. In contrast to the moral-abstinence coalition that framed the illicit drug problem as a moral issue, the harm reduction coalition considered issues related to problematic drug use from medical/scientific/public health perspectives. While increases in drug use were of a concern to the harm reduction coalition, advocacy efforts were steered towards health interventions rather than criminal sanctions. While there was some minor discussion on whether the term 'harm reduction' could include abstinence-oriented approaches, the overall focus of the term was on reducing drug related harm without requiring a reduction in use.

It is argued that HIV/AIDS played a major role in uniting the harm reduction coalition both in practice, through the flurry of policy development and implementation around the virus, and also in theoretical linkages between HIV/AIDS, injecting drug use and public health problems. In the absence of a crisis such as HIV/AIDS the extent of support for harm reduction programs is surmised to be considerably less.

The following ACF hypothesis was supported in this analysis:

Actors within an advocacy coalition will show substantial consensus on issues pertaining to the policy core, although less so on secondary aspects.⁴⁵⁷

Advocacy efforts at the NSW Drug Summit in 1999 were a good example of where there was a divergence, however, in advocacy approaches. Traditionally, advocates of harm reduction have a value-neutral outlook towards drug use, however when advocating for SICs in 1999 the then Premier Bob Carr, made personal statements

⁴⁵⁷ Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe', *Journal of European Public Policy*, 5:1, March, p106.

expressing moral repugnance at the practice of intravenous drug use. Such statements acted as a disclaimer that the Premier was not pro-drug use, as such allegations are often aimed at those that support harm reduction. It is suspected however that other members of the harm reduction coalition would not share the same view. Regardless, it was clearly a politically expedient move that acted as a disclaimer on behalf of himself and the NSW Labor Party. As noted in chapter one, some writers on harm reduction argue that drug use is inevitable in human societies across time and culture and therefore efforts to prohibit such an activity are close to futile. It is surmised that the extent of consensus on such a view from all harm reduction coalition actors might also diverge somewhat. Such a divergence was accounted for in the ACF as such an outlook regarding the role of drug use in societies is classified as part of deep core beliefs.

Guidance Instruments

Research Question 3.1: How did the harm reduction coalition capitalise on changes that occurred external or within the subsystem?

Between 1980 and 2000 several changes transpired that had implications for policy makers, these are listed as follows:

- Periodic interest in a perceived increase in prevalence of all illicit drug use and associated drug related harm (both to individual drug user and wider, community). Identified first in late 1960s and continuing into the 1970s with the issue the subject of several Royal Commissions,

- Identification of two BBVs, HIV/AIDS and HCV, as potential threats to public health, and,
- Increased problematic heroin use and associated rise in rates of overdose and general public nuisance issues in the mid 1990s.

While there were other minor incidents that occurred (for example the death of four babies as a result of HIV infected blood transfusions in 1984), this analysis focused on the wider changes over the 20 year period of analysis.

In the early 1980s a coalition for harm reduction was beginning to crystallise within the medical community as a result of growing disillusionment with traditional approaches to respond to the issue of increasing drug use. The early stages of coalition building involved agenda setting processes whereby professional organisations called for empirically based policies and a shift away from value-driven policy. It was argued that existing terminology in policy did not enable scientific endeavour into the issue. Further, criticism of traditional abstinence-oriented strategies and the capacity of such approaches to respond to growing levels of drug use was also raised by individuals and organisations both within Australia and internationally. Such commentary was primarily in the form of research and information exchange through conferences and scholarly journals.

The way in which the harm reduction coalition mobilised to capitalise on the impact of the virus included energising a research program and trying to alter the professional and public perceptions of the injecting drug use problem. As noted in chapter three the notion of a 'second aids epidemic' was a persuasive concept for policy makers interested in protecting public health. Moreover, that state

governments were unequipped to respond to the HIV/AIDS crisis, coupled with the deaths of four babies from HIV infected blood transfusions, also left a vacuum requiring the Federal Government to act promptly. This meant that the coalition for harm reduction through then Health Minister Neal Blewett could opportunistically provide policy options to combat the public health threat posed by the virus. Moreover, the process was managed astutely by Blewett through the convening of committee structures that discussed controversial subject matter away from the public arena. Lastly, the involvement of affected communities was another mechanism used to ensure that harm reduction initiatives such as safer drug using education and NSPs were appropriately targeted.

Another mechanism employed by the harm reduction coalition, frustrated by Government inactivity in relation to the provision of sterile injecting equipment to illicit drug users, was through resorting to civil disobedience and instigating an unsanctioned NSP at St Vincent's Hospital, NSW in 1986. In this case police action was not taken and the following year such programs were approved. There was a second instance of civil disobedience in 1999 when a group set up an unsanctioned SIC in Kings Cross, NSW. While the facility was closed soon after opening, the issue was debated at the 1999 NSW Drug Summit. To an extent, such civil disobedience, lead by doctors and clergymen, served an agenda setting purpose.

The advent of HCV as a public health issue also provided opportunities to influence policy. Advocates of harm reduction programs mobilised around the issue through participation in committees advocating for harm reduction measures to curb transmission rates and research and information exchange about the nature of the virus. Identification of the virus as a threat to public health was not accompanied by

similar levels of urgency as was with HIV/AIDS and moreover it was regarded that HIV/AIDS structures were already in place to respond to such problems.

The increase in problematic heroin use in the 1990s also generated opportunities for the harm reduction coalition. Systemic presentation of research and information through a variety of formal and informal channels meant that the coalition was armed with a cache of research and policy solutions. Indeed the extensive community development activities undertaken by the architects of the prescription heroin trial also contributed to the way in which a controversial initiative had been accepted by local communities prior to the intervention of the Howard Government. Furthermore, that the proponents of the prescription heroin trial had undertaken community development activities systematically, as were the scientific and evaluative components of the trial, also meant that the local community in which the project would be conducted and illicit drug and Government sectors more widely were not only accepting of the initiative but also were cognisant of the nature of such a policy. Such a process raised both the feeling ownership of such groups of the trial and also the capacity to discern myths and misinformation about the aim and scope of the trial. In sum, the community development activities undertaken meant that when problematic heroin use was identified as an issue in the mid 1990s the harm reduction coalition was 'policy ready'.

Research Question 3.2: Did these conform to Sabatier's taxonomy of guidance instruments?

The following guidance instruments were identified in the ACF:

- (1) trying to change the incumbents of various positions, whether they be agency appointees, agency civil servants, or elected legislators and chief executives
- (2) seeking to influence legislatures to alter the budgets and legal authority of administrative agencies through testimony and campaign contributions;
- (3) trying to affect public opinion ... via the mass media; attempting to alter target group behaviour via demonstrations of boycotts
- (4) trying to gradually alter the perceptions of a variety of actors through research and information exchange.⁴⁵⁸

Below is a summary of the strategies identified in this thesis that contributed to the way in which coalition advocates responded to changes within or external to the illicit drug policy subsystem:

Ongoing research and information gathering and opportunistic policy ambush

The harm reduction coalition had, since the early 1980s, conducted and evaluated research into several aspects of illicit drug policy. The vacuum in HIV/AIDS policy and an associated urgency to respond to the problem, saw medical/research interests capitalising on this gap through the provision of targeted research and potential responses to address the perceived threat to public health posed by HIV/AIDS and HCV. In the case of increased problematic heroin use in the 1990s, the coalition sorted through their extensive research cache and presented policy options of SICs and prescription heroin trials. With regard to the latter, community development activities preceded this opportunistic research exchange. It is argued that such approaches were critical precursors to the acceptance of such controversial policy initiatives and moreover constituted a particular type of research and information exchange.

⁴⁵⁸ Sabatier, P., & Jenkins Smith, 1993, 'The Advocacy Coalition Framework: An Assessment', *Policy Change and Learning: An Advocacy Coalition Approach*, Westview Press, San Francisco, p142.

Circumventing controversy through strategic channels

Debates about illicit drug use can often deteriorate into ideological polarities whereby rational discussion underwritten by empirical study is overshadowed by morally driven symbolism. The image of the 'junkie' or an insulin syringe discarded in a school ground can overpower research into harm reduction programs that are often regarded as encouraging drug use despite some evidence suggesting otherwise. In the case of employing harm reduction programs to combat HIV/AIDS transmission, the instigation of bipartisan committee structures by Blewett enabled such sensitive topics to be debated and problems solved away from the spotlight of the media. Similarly, in the case of the lead-up to prescription heroin trials, extensive community development activities were undertaken whereby local communities were given a formal channel to express discontent and/or to have questions answered. Both initiatives lead to increased support of the proposed initiatives without interference from the media or other groups that attempt to sidetrack or in some cases misrepresent debate.

Civil disobedience as a mechanism for policy change

When a stalemate occurs and the unsuccessful policy actors possess the requisite personal conviction that the decision made by sovereign authorities is in fact the wrong one, then disobedience of process and rules can ensue. This can have several effects: in the case of disillusioned workers opening the first NSP in Australia in 1986, the facility was allowed to continue and within a year more were opened in NSW. Several years later each state and territory had implemented NSPs; in the case

of the opening of an unsanctioned SIC, such a process had an agenda setting function. In both of these examples the principal personnel involved in the civil disobedience processes were from respected backgrounds, being medical and religious organisations, as such this may have strengthened the way others perceived their actions.

While the list of guidance instruments in the ACF included the first point above (research and information exchange), it might benefit from including the notion of a 'policy ambush' and the way in which some coalitions systemically gather information and take advantage of subsequent opportunities. Second, community development approaches also should be included in types of guidance strategies. Such processes, whereby the proponents of a program systematically engage with stakeholders and in some cases approach other groups not necessarily instantly associated with the initiative, are often used in many different settings. The process of getting diplomatic experts in a particular policy area to engage with the uninitiated on a controversial subject matter on a regular and ongoing basis whereby issues and questions can be raised and answered directly is a constructive tool. Such an approach is similar to the one undertaken by Blewett in the 1980s whereby committee structures circumvented controversy through providing other channels to respond to questions and debate the subject matter. Furthermore, in the case of social systems in which quantitative data is not as readily accepted as in natural systems, coalitions that are underwritten by such information must be more careful to employ strategies (such as above by Blewett and community development activities undertaken by proponents of prescription heroin trial) to ensure such data does not become overshadowed by more controversial aspects of the initiatives. It is proposed that the above list is considered for inclusion in the ACF schedule of guidance

instruments is amended to include the above categories where relevant when examining advocacy of potentially controversial issues.

Policy Brokers

Research Question 4.1: Do policy brokers have membership of any coalition?

Very little is written about policy brokers in the ACF. The most extensive description follows, taken from one of the earlier articles written in 1987:

...there will almost certainly be a category of actors – here termed “policy brokers” – whose dominant concern is with keeping the level of political conflict within acceptable limits and with reaching some “reasonable” solution to the problem. This is a traditional function of some elected officials (particularly chief executives) and, in some European countries such as Britain and France, of high civil servants... The courts, “blue ribbon commissions” and other actors may also play the role of policy broker. The distinction between advocate and broker is however a continuum. Many brokers will have some policy bent, while advocates may show serious concern with system maintenance. The framework merely insists that this is an empirical question that may or may not be correlated with institutional affiliation. While high civil servants may be brokers, they are often policy advocates – particularly when their agency has a clearly defined mission.⁴⁵⁹

Further writing⁴⁶⁰ on policy brokers in the ACF however do not emphasise the notion of a continuum whereby policy makers are endowed with the capacity to be both advocates and intermediaries between coalitions to varying degrees.

⁴⁵⁹ Sabatier, P., 1987, ‘Knowledge, Policy Oriented Learning, and Policy Change’, *Knowledge, Creation, Diffusion, Utilization*, 8:4, June, pp649 – 692.

⁴⁶⁰ Sabatier, P., 1989, ‘An advocacy coalition framework of policy change and the role of policy-oriented learning therein’, *Policy Sciences*, 21, 129-168; Sabatier, P., & Jenkins-Smith, H., 1993, *Policy Change and Learning: an Advocacy Coalition Approach*, Westview Press, Colorado; Sabatier, P., & Jenkins-Smith, H., 1994, ‘Evaluating the Advocacy Coalition Framework’, *Journal of Public*

Three policy actors were identified in preceding analyses as occupying dual roles of policy brokers/makers and coalition members. Out of the three, senior bureaucrat Les Drew is most easily classified as a 'policy broker' as he was a member of the bureaucracy and directly charged with the drafting of policy (specifically the NCADA in 1985). The other two policy actors identified were then Federal Health Minister Neal Blewett and Prime Minister John Howard. Blewett recounted at length his personal involvement in making HIV/AIDS policy⁴⁶¹, particularly the way in which study trips conducted around the time of the crisis influenced the details of policy and the use of parliamentary committees to avoid overt partisan conflict regarding sensitive and controversial issues to do with HIV/AIDS and injecting drug use. As identified, both Drew and Blewett strongly supported, and were responsible for the implementation of, harm reduction policies in Australia. Prime Minister Howard's personal interest in illicit drug policy was evidenced in a number of ways: through intervention into stopping the prescription heroin trial from proceeding, his personal appointment of Salvation Army Major Brian Watters as head of the peak body, the MCDS, and also locating the MCDS in his personal portfolio as well as numerous statements with regard to his personal opinion on the direction of illicit drug policy all suggest some direct involvement in the shape and nature of policy. Indeed, Prime Minister Howard was a strong and vocal supporter of the moral-abstinence coalition since winning Government in 1996.

With these examples in mind it is suggested that the conceptualisation of a continuum that encompasses the roles of coalition advocate and policy broker at

Policy, 14:2, pp175-203; Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe', *Journal of European Public Policy*, 5:1, March, pp1350-1763.

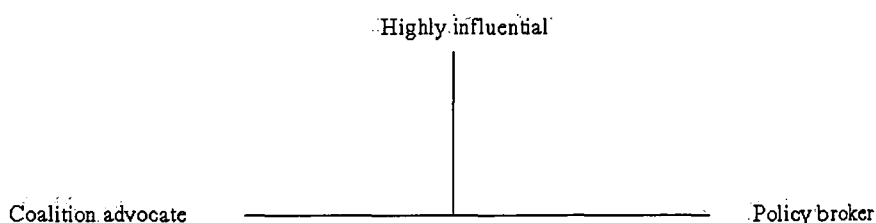
⁴⁶¹ Blewett, N., 2003, *Aids in Australia: Reflections on Australia's policy response to the AIDS Epidemic*, Australian Health Policy Institute, University of Sydney.

either end be expanded and re-emphasised in further writings of the ACF. The extent to which such actors are coalition advocates or policy brokers is a key variable that has the potential to contribute to whether a policy is adopted.

The government actors playing a critical role in the process are the executive, bureaucracy and legislature. In most cases the bureaucracy plays the main role, though high profile issue or the talents and determination of individual ministers are likely to encourage a greater role for the executive.⁴⁶²

Thus exploration of the degree of influence of key coalition members that are policy brokers requires further consideration. To have a coalition representative in a strategic role (such as a Federal Minister or a Prime Minister) within the subsystem is a substantial variable when it comes to examining policy change. With this in mind it is suggested that a second continuum be added that gauges the degree of influence of such a position.

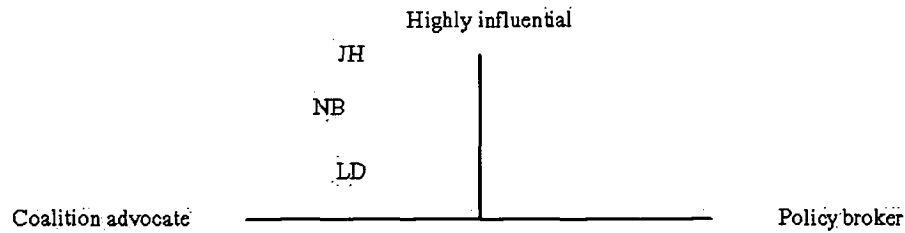
Figure 2: Policy broker axis of role and influence



For example if such a tool was used in this thesis and the roles and relative degree of influence of senior bureaucrat Lew Drew (LB), Federal Health Minister Neal Blewett (NB) and Prime Minister John Howard (JH) were plotted on these axis the following would result:

⁴⁶² Howlett, M & Ramesh, M., 1995, *Studying Public Policy: policy cycles and policy subsystems*, Oxford University Press, Ontario, p199.

Figure 3: Policy broker axis of role and influence



In sum, such a tool could be considered for inclusion into the ACF and provide further explanatory power into the relative power of individual members and the consequent implications for policy success.

The work by Kingdon,⁴⁶³ specifically the concept of ‘policy entrepreneurs’, is highly relevant and could compliment the ACF in this area. Kingdon conceptualises policy entrepreneurs as stakeholders who develop proposals and solutions to problems and who act opportunistically when such problems arise in the public debate. Such opportunities are coined ‘policy windows’. A critical function of the entrepreneur is to change beliefs and attitudes about particular issues through investing time and resources to advance a position or policy when such an opportunity presents. Such a conceptualisation of policy actors in the context of illicit drug policy in Australia in this period aptly describes individuals such as Les Drew and Neal Blewett, among many others in this period, for example, Dr Alex Wodak.

Further, Kingdon’s work could be helpful to describe the opportunity structure inside the Government and the way this allows for coalition formation and for new ideas to enter the institutional world. Harm reduction policy entrepreneurs regularly encounter opposition with the more politically expedient moral abstinence ideas that are commonly espoused by most members of the political executive unless and until

⁴⁶³ Kingdon, J., 1984, *Agendas, Alternatives and Public Policies*, Little Brown, Boston.

(as the ACF correctly predicts) an external shock triggers a policy window and thus engenders policy entrepreneurs into action. An amalgamation of Kingdon's and Sabatier's models could well strengthen the explanatory power of both. The ACF provides the systemic contextual factors as well as the triggers for policy change with Kingdon's work, where relevant to the subject under investigation, providing further detail on how those ideas are translated into policy through the agency of key individuals.

Research Question 4.2: To what extent do policy brokers 'make' policy? Do policy brokers receive conflicting strategies? Do policy brokers reach compromise between coalitions?

This analysis explores the policy making cycle as described in the ACF and the role of policy brokers as described as follows:

Conflicting strategies (advocated by each coalition) are submitted to 'policy brokers', a group of actors that represent the Government and are responsible for reaching compromise and limiting conflict, whose principal concern is to find some reasonable compromise that will reduce intense conflict. The end result is one or more governmental programs, which in turn produce policy outputs at the operational level.⁴⁶⁴

The wording of this process does not reflect the extent to which policy makers can occupy both roles of advocates and brokers and the impact that this has on the process of policy-making. Moreover, different types of policy forums are also not adequately reflected in the above summation. For example, the process of deliberating the operational parameters of a proposed SIC was undertaken at the

⁴⁶⁴ Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe', *Journal of European Public Policy*, 5:1, March, p104.

NSW Drug Summit. Working groups were convened to discuss and vote for a number of recommendations and conditions related to implementation of such a facility. In such a forum representatives from both the moral-abstinence (for example Reverend Fred Nile, Leader of the State Opposition Kerry Chikarovski) and harm reduction (for example Premier Bob Carr, Clover Moore) coalitions debated various aspects of the topics that were subsequently subjected to a vote from the group. The results of the vote formed the basis for policy on the SIC in Kings Cross. In this sense ‘compromise’ was reached through this participative process which is quite different from the process described in the ACF.

External Variables

Research Question 5.1: Were such phenomena, as categorised in the ACF, stable from 1980 to 2000?

As described in chapter two, the ACF contains two sets of exogenous variables. It is hypothesised that ‘stable system parameters’ are rarely targeted by coalition members for reform because, as the name suggests, such factors are less likely, or more difficult to, change. Such a notion was generally supported in this analysis with two exceptions identified. Both changes occurred in the category entitled ‘basic attributes of the problem area’ in the ACF and are outlined below.

Emergence of a new language

In this period the harm reduction coalition, buoyed by medical/research interests, presented an alternative way to examine illicit drug policy, namely using empirical research to underwrite and evaluate policy and practice. Such an approach, reinforced and spearheaded by medical and academic personnel, was characterised by a scholarly approach to examination of the illicit drug problem. Examples of the types of research conducted by harm reduction advocates are evident throughout this thesis. Previous to this approach, there was little in the way of systemic investigation into the efficacy of services or phenomena that generated drug related harms. Furthermore, such research was also conducted in arenas other than health. Law enforcement agencies also examined the link between police practice and illicit drug harms⁴⁶⁵ providing further information on the interaction between law enforcement and health sectors and the former's capacity to manufacture (albeit unintended) drug related harm. The general shift in the bureaucracy towards incorporating performance reporting to underscore public programs and policies also presented an opportunity for harm reduction advocates to further strengthen the legitimacy of their programs through demonstration of cost effectiveness and positive outcome based evaluations of programs. Indeed, the *Return on Investment in Needle and Syringe Programs in Australia* report stated that NSPs were highly cost effective in terms of

⁴⁶⁵ For example: Weatherburn, D., & Lind, B., 1997, 'The impact of law enforcement activity on a heroin market', *Addiction*, 92:5, pp557-569; Hellawell, K., 1995, 'The Role of Law Enforcement in Minimizing the Harm Resulting from Illicit Drugs', *Drug and Alcohol Review*, 14, pp317-22; Aitken, C., Moore, D., Higgs, P., Kelsall, J., & Kerger, M., 2002, 'The impact of a police crackdown on a street drug scene: evidence from the street', *International Journal of Drug Policy*, 13, pp193-202; Chilvers, M., & Weatherburn, D., 2003, 'The impact of heroin dependence on long terms robbery trends', *Crime and Justice Bulletin*, 79.

the prevention of HIV and HCV infections and also improvements in the general health of drug users.⁴⁶⁶

It is posed here that the research focus of the harm reduction project presents an indirect yet ongoing challenge (in the long term) to the moral-abstinence coalition. That a core tenet of the practice of harm reduction is that policies and programs must be underwritten by empirical research that focuses on a rational calculation of costs and benefits⁴⁶⁷ poses a challenge to the moral-abstinence coalition to replicate this approach in order to justify its policy positions. This is particularly pertinent in an age where policy outcomes and cost effectiveness is increasingly scrutinised. In this period, discourse that emphasised the morality or immorality of drug use was often not underscored by research. Further, advocates of the moral-abstinence approach sometimes expressed scepticism toward research that supported harm reduction. It is argued that the continual application of research (propagated by such groups such as National Drug Research Institute and National Drug and Alcohol Research Centre) would serve to provide further support to harm reduction programs and policies through provision of an evidence base.

Despite the emergence of a new language to discuss illicit drug issues, morality driven arguments continued to feature throughout the period of analysis. Indeed, since the election of the Federal Howard Government in 1996 such arguments seemed more prolific in the period 1995-2000 than in the previous 15 years. This is possibly explained by the degree to which Prime Minister Howard personally subscribed to such thinking and his direct intervention in policy.

⁴⁶⁶ Commonwealth Department of Health and Ageing, 2002, *Return on investment in needle and syringe programs in Australia*, Department of Health and Ageing, Canberra, available at: <http://www.health.gov.au/pubhlth/publicat/hac.htm> (accessed Jun 2003).

⁴⁶⁷ Riley, D., & O'Hare, P., 2000, 'Harm reduction: History, Definition and Practice', in J., Inciardi et al. (eds) *Harm Reduction: National and International Perspectives*, Sage, California, p7.

Emergence of a new disease and reconfiguration of the 'problem'

As well as a new language with which to debate policy, the illicit drug problem also increasingly became seen as a 'health' issue. During the 1980s, the role of health in responding to illicit drug use was expanded, encapsulated by the first national drug strategy in 1985. This expansion coincided with the appearance of HIV/AIDS and its link with injecting drug use. Previous to HIV/AIDS the harms resulting from illicit drug use included: harm to individuals, conceptualised as experiencing some kind of 'sickness' (predominantly that associated with overdose and dependencies); the direct impact of such sickness on friendship, familial and community groups; and last, economic consequences (costs of rehabilitation and drug related crime). HIV/AIDS, however, added another dimension to the nature of the problem (captured in the phrase 'second aids epidemic') whereby injecting drug use could potentially result in major illnesses of people who did not inject. As stated this dramatically changed the nature of the problem. In contrast, the advent of HCV did not dramatically alter the nature of the problem as the virus was/is relatively contained within the injecting drug user population and also does not always result in chronic illness or death.⁴⁶⁸

Ever-changing drug trends between 1980 and 2000

While increases in illicit drug use can be exaggerated and sensationalised in the media, there were some changes in the prevalence of drug use and availability of illicit drugs.

⁴⁶⁸ It is recognised that the disease has the potential to pose a substantial threat to government health budgets in the long term however.

The prevalence of injecting drug use has increased significantly in Australia in recent years. Using the nationally representative 1998 National Drug Strategy Household Survey we estimate the size of the lifetime prevalence injecting drug use population at 302710 people, compared to 67474 in 1988. Those who have injected drugs in the previous year are estimated at 108750 people in 1998. Amphetamines have displaced heroin as the most popular drug to inject among the general population.⁴⁶⁹

While falling just outside the period of analysis the shortage in heroin availability in early 2000s meant an increase in the popularity of amphetamine use.

A number of studies have consistently suggested that between 2000 and 2001, there was a sizeable decrease in both prevalence and frequency of heroin injection among injecting drug users. These changes were accompanied by increased prevalence and frequency of stimulant injection.⁴⁷⁰

The illegality of some drugs means that their supply is not easily controlled. While some drugs such as marijuana can be grown with relatively little infrastructure or effort, supply of the other drugs such as amphetamines rely on the availability of precursor chemicals⁴⁷¹ whereas heroin supply is contingent on relatively sophisticated concealment methods⁴⁷² (and a degree of luck) in order to import it. Therefore, while there has been a steady supply of different illicit drugs throughout 1980 to 2000, to a degree the prevalence of some drugs has fluctuated during this

⁴⁶⁹ McAllister, I., & Makkai, T., 2001, 'The prevalence and characteristics of injecting drug users in Australia', *Drug and Alcohol Review*, 20:1, p29.

⁴⁷⁰ Topp, L., Day, C., & Dehenhardt, L., 2003, 'Changes in patterns of drug injection concurrent with a sustained reduction in the availability of heroin in Australia', *Drug and Alcohol Dependence*, June, 5:70 (3), p275.

⁴⁷¹ "...precursors will be imported illicitly, or licit precursor chemicals will be diverted to syndicates manufacturing amphetamine in Australia." From Mahoney, P., 2000, 'Illicit Drugs in Australia: an overview', in G., Stokes, P., Chalk & K., Gillen (eds), *Drugs and Democracy*, Melbourne University Press, Carlton South, p66.

⁴⁷² For example heroin was smuggled in via plastic chairs: Australian Federal Police, 2005, 'Plastic Chairs attempt to hide massive heroin import', *Media Release*, 13/5/2005 available at: http://www.afp.gov.au/_data/assets/pdf_file/1908/mr050513operationdomini.pdf and Australian Federal Police & Australian Customs Service, 'Heroin found concealed in hard sided suitcase', *Media Release*, 26/4/2006, available at http://www.afp.gov.au/media_releases/national/2006/heroin_found_concealed_in_hard-sided_suitcase both accessed on 25/5/2006.

time. This means that one of the basic characteristics of the problem area is this ever-changing prevalence of use due to fluctuations in availability. This is an interesting feature when analysing policy change in relation to the illicit drug policy subsystem through the lens of the ACF. Of the two sets of variables classed in the ACF as external to a subsystem, this systemic feature of the illicit drug policy subsystem fits best in one of the stable categories entitled 'basic attributes of the problem area'. That ongoing change is a constant in the illicit drug policy subsystem presents a conundrum for the ACF. As the majority of applications of the ACF have been directed toward analysis involving natural systems (for example investigations of energy policy, nuclear waste and weapons, water policy, environmental policy, forest policy, public lands, auto pollution control, water pollution, professional fora, climate change, oceans waste, roads policy⁴⁷³) is reflected in the ACF as basic attributes of such systems change over a slower time scale. In contrast, the open and unregulated nature of illicit drugs markets results in changing drug use patterns based on availability of source materials and consumer demand over a relatively quicker time period. According to the ACF, the other set of dynamic exogenous factors entitled 'external system events' (this category includes: changes to socio economic conditions, public opinion; systemic governing coalitions and policy decisions and impacts from other systems) constituted the major means to affect policy change. It is argued here that changes such as HIV/AIDS and drug trends were highly significant factors and should be classified under this set of dynamic external variables.

⁴⁷³ Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe, *Journal of European Public Policy*, 5:1, March, p100-101.

Research Question 5.2: Did coalitions target these parameters for reform?

It is illogical that coalitions could target such parameters as the emergence of a new disease and also changes to illicit drug trends between 1980 and 1990 as such events are beyond the control of regulatory agencies. It is clear, however, that the harm reduction coalition was quick to react to such changes. The public health challenge presented by HIV/AIDS was an opportunity for coalition actors to advocate for policy that responded to the threat of widespread transmission of the virus. The upsurge in problematic heroin use in the mid 1990s resulted in increased calls for policy responses from the community. The exception, however, in this time period, was the increase in medically driven and program evaluation research regarding drug policy and programs. In a sense, such research challenged traditional approaches to illicit drug policy that were not typically evidence-based and generally enacted without requiring proof of their efficacy. That the harm reduction coalition took such an approach was a product of their membership including scientists actively involved in research. The extent to which such personnel deliberately set out to derail other approaches to illicit drug policy at the start of the period is unknown, however by the close of the 1990s, it was evident that harm reduction coalition actors were consistently armed with a cache of research with the aim of both justifying their policy and also critiquing other policy approaches.

Policy Oriented Learning

Research Question 6.1: What was the role of quantitative data/information in policy oriented learning

From 1980 to 2000 there was an increase in research into illicit drug pharmacology and harms. Through the NCADA, funding was provided for research institutes in the late 1980s that continued through to 2000 and beyond. The National Drug and Alcohol Research Centre (NDARC) at the University of New South Wales, established in 1987, examines key research areas such as evaluation of treatment modalities and epidemiological research. Such research aims to increase knowledge about the nature and extent of drug related harms generally and the range and effectiveness of treatment available to substance users in Australia. Moreover, epidemiological research conducted in each state and territory monitors the price, purity and patterns of use of the main illicit drugs used in Australia, acting as an “...early warning system for emerging trends in illicit drug market.”⁴⁷⁴ The National Drug Research Institute (NDRI) at Curtin University in Western Australia, established in 1986, also has a research focus on examining issues related to drug related harm. Priority areas for research included: the monitoring of drug consumption, stopping BBV transmission among injecting drug users (for example through informing the development of initiatives that aim to prevent HCV), evaluation of educational, legislative and regulatory strategies, evaluation of school drug and education programs, increasing understanding of community based drug prevention and investigating the ways in which educational, legislative and regulatory strategies impact on the social contexts of alcohol and other drug use to

⁴⁷⁴ From National Drug Alcohol Research Centre website:
<http://notes.med.unsw.edu.au/NDARCWeb.nsf/page/IDRSa> accessed 11/3/06

produce or reduce harm. Other research groups such as Turning Point⁴⁷⁵ (operating since 1994) and the Centre for Harm Reduction⁴⁷⁶ (operating since 1986) also have produced research relevant for personnel working in harm reduction programs. Many of the research projects and papers from the above institutes were cited in this thesis. Moreover and as noted throughout the thesis, Dr Alex Wodak⁴⁷⁷ also contributed a substantial amount to the harm reduction project. Similarly, Dr Nick Crofts⁴⁷⁸ has conducted research on BBVs and the connection with injecting drug use is another high profile contributor to harm reduction research. It is acknowledged that many other individuals and organisations (especially self-help drug user organisations) have also contributed to the production of research in relation to harm reduction theories and practice. Indeed research into the effectiveness of harm reduction policies and programs from other countries⁴⁷⁹ was also effective when advocating for equivalent policies in the domestic context. In the case of advocating for SICs in NSW, an evaluation of the European experience was critical to forming a case to debunk myths such as the assertion that harm reduction initiatives lead to an

⁴⁷⁵ from Turning Point website: <http://www.turningpoint.org.au/index.html> accessed 11/3/06

⁴⁷⁶ from Centre of Harm Reduction website: <http://www.chr.asn.au/home> accessed 11/3/06

⁴⁷⁷ Examples of Dr Wodak's work follow: Wodak, A., 1997, 'Injecting nation: achieving control of hepatitis C in Australia', *Drug and Alcohol Review*, 16; Wodak, A., & Owens, R., 1996, 'Drug Prohibition a Call for Change', *Frontlines*, University of New South Wales Press, Sydney; Wodak, A., & Saunders, B., 1995, 'Special issue on harm reduction', *Drug and Alcohol Review*, 14; Wodak, A., 1999, 'What is this thing called harm reduction?', *International Journal of Drug Policy*, 10, pp169-171; Wodak, A., 2000, 'Developing more Effective Responses', in *Drugs and Democracy*, G Stokes, P., Chalk & K., Gillen (eds), Melbourne University Press, Carlton South; Wodak, A., Fisher, R., & Crofts, N., 1993, 'An evolving public health crisis: HIV infection among injecting drug users in developing countries', in *Psychoactive Drugs and Harm Reduction: from faith to science*, N., Heather, A., Wodak, E., Nadlemann & P., O'Hare (eds), Whurr, London; Wodak, A., & Moore, T., *Modernising Australia's Drug Policy*, UNSW Press, Sydney; Wodak, A., 1997, 'Public health and politics: the demise of the ACT heroin trial', *MJA*, 167.

⁴⁷⁸ Examples of Dr Croft's work follow: Crofts, N., & Aitken, A., 1997, 'Incidence of bloodborne virus infection and risk behaviours in a cohort of injecting drug users in Victoria 1990-1995', *eMJA*, accessed at <http://www.mja.com.au/public/issues/jul7/crofts/crofts.html> on 20/2/06; Crofts N., Louie R., Rosenthal D., & Jolley D., 1996, 'The first hit: circumstances surrounding initiation into injecting', *Addiction*, 91, pp1187-1196; Crofts, N., & Aitken, C., & Kaldor, J., 1999, 'The force of numbers: why hepatitis C is spreading among Australian injecting drug users while HIV is not', *MJA*, 170, pp220-221.

⁴⁷⁹ Joint Select Committee into safe injecting rooms, 1998, *Report on the establishment or trial of safe injecting rooms*, Parliament of New South Wales; Dolan, K., Kimber, J., Fry, C., Fitzgerald, J., McDonald, D & Trautmann, F., 2000, 'Drug consumption facilities in Europe and the establishment of supervised injecting centers in Australia', *Drug and Alcohol Review*, 19.

increase in drug use. Such research institutes, funded by Federal Governments since the NCADA, contributed to the research base used by harm reduction advocates used to both justify and advocate for policies and programs.

Research Question 6.2: Was such data accepted by both coalitions?

Research Question 6.3: If not what were the barriers to its acceptance?

When referring to policy oriented learning in this thesis, it is clear that there are two possible avenues in which this can occur. The first opportunity is for learning to take place was between harm reduction and moral-abstinence coalitions, whereas the second opportunity was between health (with regard to learning on harm reduction more specifically) and law enforcement groups. It was expected that the latter will be more conducive to cross pollination as there was ongoing and systemic contact between the two groups as outlined in chapter four.

With regard to the relationship between health/medical/harm reduction and law enforcement sectors, in the early days of the establishment of harm reduction programs (especially NSPs) there was some resistance. Some police were not supportive of harm reduction interventions as NSPs as such programs were regarded as both undermining police work and also condoning drug use.⁴⁸⁰ By the late 1990s, as noted in chapter four, many law enforcement personnel were outwardly supportive of harm reduction programs and policies and were conducting research into the way in which police practice can generate harms. This was a significant change and related to the systemic and scholarly collaboration between the two sectors.

⁴⁸⁰ From Kutin, J., 1998, 'Law Enforcement and Harm Minimisation', in *Drug Use in Australia: A Harm Minimisation Approach*, M., Hamilton (et al., Oxford University Press, Melbourne, p162.

In contrast, the relationship between the harm reduction and moral-abstinence coalitions was not as collegial. Throughout the period, there was little change in the types of criticism of harm reduction programs from members of the moral-abstinence coalition. Indeed, members were suspicious of the worth and in some cases directly opposed to the harm reduction approach to illicit drug use. Moreover the coalition remained unmoved by the ongoing production of credible, peer reviewed, scholarly research. In this period the moral-abstinence coalition relied more on testimonials drawn from observations of concerned citizens/parents in conjunction with “moral truths” in debates (specifically in those regarding prescription heroin and SICs) than on evidence using the scientific method. Further such groups also treated with scepticism the evidence produced by the harm reduction coalition.

Of interest was the way in which the moral-abstinence coalition was not compelled to justify their positions as much as the harm reduction coalition. This is an interesting phenomenon in illicit drug policy debates and not unique to the Australian setting. That such approaches are adopted in many states and championed by such international bodies as the United Nations Narcotics Control Board with little evidence required of their effectiveness points to the global stranglehold on illicit drug policy by the international moral-abstinence coalition’s approach in relation to illicit drugs. The nature of moral approaches as those based on religious or deep convictions that particular activities are inherently right or wrong is a common theme in many social issues. Issues to do with sexuality (for example, abortion, contraception and homosexuality), gender (for example, policies directed at women in work) and illicit drugs all seem to have coalitions of policy actors that champion the moral basis to policy making. Such beliefs when translated into policy are based on religious or other deep convictions about the way social phenomena should be

governed. With regard to drug use, dependencies are seen as an indication of moral weaknesses and/or lack of willpower and often the fault of the drug itself which is regarded as always associated with physical, moral and social decline.⁴⁸¹ Such an approach often seems impervious to scholarly information exchange due to the following factors:

- Moral-abstinence advocates require different types of proof or verification of their policy beliefs such as morality or religious beliefs,
- Such approaches are the antithesis of the rational scientific method,
- A rejection of the rational scientific method as a mechanism to examine moral issues, and,
- Suspicion that the harm reduction coalition has a secondary agenda of promoting or encouraging drug use, and an associated general disregard for society.

Such qualities result in a deadlock. As was seen in the 1990s, some members of the harm reduction coalition were uncomfortable with the inclusion of abstinence-oriented approaches in the term harm reduction.⁴⁸² By 2000, the harm reduction coalition had accepted that a range of approaches was necessary to give service consumers greater choice in drug treatment.⁴⁸³ In terms of curbing HIV/AIDS and HCV, however, the harm reduction coalition were adamant programs such as NSPs were critical to reducing the impact of the virus on public health and indeed those countries that did not implement such programs experienced worse outcomes.⁴⁸⁴

⁴⁸¹ Kellehear, A., & Cvetkovski, S., 1998, 'Grand theories of Drug Use', in *ibid*, p49-50.

⁴⁸² Lenton, S., & Single, E., 1998, 'The definition of harm reduction', *Drug and Alcohol Review*, 17.

⁴⁸³ *ibid*.

⁴⁸⁴ "Australia has a 5% HIV infection rate among injection drug users as compared to 14% in the United States. Furthermore, it has been argued that this difference is due to the limited number of needle exchange programs in the United States, from Wodak, A., & Lurie, P., 1997, 'A tale of two

Generally speaking members of the moral-abstinence coalition remained unmoved by the end of the 20 year period of study. In contrast, the law enforcement sector had changed in some ways both in research and practice. Such change was evident from: attitudes of personnel expressed in various reports whereby they expressed support for programs such as SICs⁴⁸⁵ and prescription heroin⁴⁸⁶; operational changes such as harm minimisation policing⁴⁸⁷ and research into police practice and drug related harms.⁴⁸⁸

Research Question 7.1: In cases where policy oriented learning occurred, did the conflict concern secondary aspects of both coalitions or between the secondary aspect of one coalition and the policy core of the other?

Policy oriented learning between the health and law enforcement sectors was facilitated through national drug strategies since 1985. As outlined in chapter four, both sectors shared membership of various national committees and were regularly exposed to each other's perspectives on illicit drug issues. Such committees were collegial and prestigious and reinforced the policy core aspects of both belief systems. Harm reduction approaches were understood to be important public health strategies whereas law enforcement was regarded as having a role to play in the policing of manufacturers and traffickers. That law enforcement strategies could produce drug related harms was a salient point that was investigated further. Moreover, diversion programs and the lowering of some penalties for some drug

countries: Attempts to control HIV among injecting drug users in Australia and the United States', *Journal of Drug Issues*, 27, pp117-134.

⁴⁸⁵ Joint Select Committee into safe injecting rooms, 1998, *Report on the establishment or trial of safe injecting rooms*, Parliament of New South Wales, pxvi.

⁴⁸⁶ Wood, J., 1997, *Royal Commission into the NSW Police Service*, vol 2, NSW Police Integrity Commission, Sydney, p228.

⁴⁸⁷ Drug Policy Expert Committee, *Drugs: meeting the Challenge*, Victorian Government, accessed at www.dhs.vic.gov.au/publications/index.htm, on 12/12/04, p182.

⁴⁸⁸ Australian Bureau of Criminal Intelligence, 1997, *Australian Illicit Drug Report 1996-7*, Commonwealth of Australia.

users was also another concession by the law enforcement sector. Both of these are considered to be secondary aspects of belief systems. Thus this assertion in the ACF holds in this analysis.

As noted above policy oriented learning between the harm reduction and moral-abstinence coalitions was minimal to non-existent. This is surmised to be due to the difference in approaches taken by both coalitions whereby one focuses on scientific reasoning and the other on moral or religious beliefs to inform illicit drug policy. The differing philosophies that underwrite both types of evidence are in opposition and result in a deadlock of debate.

Research Question 8.1: What were the type of forums that facilitated policy oriented learning?

As mentioned in chapter four, policy oriented learning between harm reduction and law enforcement personnel was facilitated by their shared membership on several national committees such as the MCDS, IGCD and ANCD. All three forums also conformed to the typology of successful forums in the ACF as discussed in chapter four. The characteristics of these forums were as follows: shared membership and alternating leadership of both health and law enforcement on the forums; all forums were funded by the Federal Government rather than have funding originating from either coalition; and all the forums were convened regularly, in most cases several times a year. Moreover the forums were underwritten by professional norms and highly prestigious in the sector.

Thus the work on policy oriented learning in the ACF was supported in this thesis with remarkably different outcomes from learning between harm reduction and law enforcement groups in contrast to harm reduction and moral-abstinence coalitions. In the case of the latter, members of the harm reduction and moral abstinence group interacted via the media and other arenas such as the NSW Drug Summit. Some moral abstinence advocates did participate in the peak national forums such as MCDS, IGCD and ANCD, however such forums were underwritten by professional norms and as such this meant that policy core ideas such as the role of harm reduction within the overall framework of the national drug strategy was not overtly challenged in these arenas. Indeed, the more fundamental challenge to harm reduction was enacted outside such forums.

Policy Change

In the period 1980 to 2000 several changes occurred in illicit drug policy as noted in previous chapters. There was one instance of major policy change heralded with the introduction of a national drug strategy (NCADA) in 1985. This major change spawned several minor changes that occurred in following years. Several types of policy change occurred in this period, these are categorised below:

1. 'Major'

Policy change that impacts across a subsystem and necessarily effects the foundations of an issue area is typified as 'major' in the ACF. In this sense the instigation of the NCADA that reorganised the way in which agencies responded to illicit drug use is considered a 'major' change. A key part of the NCADA was an

increase in the role of health agencies and an accompanying change to 'harm minimisation' (in this sense, the term encompasses the three strategies of supply, demand and harm reduction approaches) as the principle overarching concept. Details of this were discussed at length in chapter three. Of particular interest in this chapter is the long-term effect of such major policy change. Indeed it is suggested here that the instigation of the NCADA, a national document that essentially married health and law enforcement sectors resulted in systemic suite of secondary policy changes.

2. 'Secondary'

Policy change that impacts on parts of the subsystem such as localised decisions, rules and budgetary allocations related to the illicit drug problem (for example the problem of heroin overdose) is classified as secondary in the ACF. In the period 1980 to 2000, several secondary policy changes were identified in preceding chapters. The main changes relevant to this analysis are as follows: the implementation of NSPs and safer using education in all states and territories by 1993, the expansion of MMT for injecting drug users with HIV/AIDS, the implementation of programs to divert some injecting drug users charged with possession offences away from court and to treatment programs, and, opening of one SIC in Kings Cross, NSW. The first two examples were initiatives designed to curb the number of transmissions of HIV/AIDS in injecting drug users. Diversion of injecting drug users away from court and to treatment programs and the implementation of a SIC, reflected the way that agencies had increasingly regarded drug use as a health issue. It is suggested that this increased perception was

facilitated by successive national drug strategies and consequent policy oriented learning between health and law enforcement sectors.

3. 'Gradual and systemic'

A third type of policy change was identified in this analysis. While both previous categorisations of policy change have focused on the scope of policy change, whether resulting in system wide or localised impacts, a third type is identified as occurring in the 20 year period of analysis. Gradual and systemic policy change is distinct from that termed 'major' and 'secondary' as such change often takes a longer period of time (usually best examined in hindsight) to germinate results. Moreover, this type of modification to part of a subsystem can signify a wider shift in the philosophical disposition of an issue area. It is also proposed that in the case of illicit drug policy, such gradual and systemic change was the result of major policy change conducted in 1985 noted above. Below are examples of such gradual and systemic policy change identified in the preceding chapters:

Involvement of injecting drug users in the development of policy

Between the late 1980s and 2000, affected communities engaged with policy makers to varying degrees in developmental and consultative capacities. The inclusion of injecting drug users in the development of some drug policy was largely linked to the nature of HIV/AIDS policy and its overlap with illicit drug policy. Chief HIV/AIDS policy architect, then Federal Minister for Health, Neal Blewett championed this approach. The notion of involving affected communities had two effects. First, it contributed to the instigation of self-help drug user groups in most states and

territories that served the purpose of providing policy advice and analysis on the impact of policy on drug related harm of injecting drug users. Such self-help drug user groups contributed to policy throughout the period since their establishment. Such organisations were best placed to convert complex policy issues into appropriate information so to reach marginalised injecting drug users and moreover to feedback information to governments. Second, such groups were able to further the harm reduction project through participating in service delivery. Research⁴⁸⁹ suggests that peer run NSPs and education are particularly effective tools to limit the spread of BBVs into the community. Such contributions from affected communities served to promote and strengthen harm reduction ideas and their role in illicit drug policy.

Harm minimisation policing

In the 1990s, the results of successive national drug strategy frameworks became evident as the law enforcement sector incorporated key ideas of harm reduction into its theory and practice. As described in chapter four, the notion of ‘harm minimisation policing’ meant greater understanding and cooperation between health and law enforcement agencies with an overall aim of affecting a reduction in drug related harm and also a level of introspection regarding the links between police practice and drug related harm. In this example of gradual and systemic policy change, ideas from one coalition or sector had infiltrated another. The way in which such cross pollination occurred is discussed above and encapsulated in the notion of

⁴⁸⁹ 31 “Further decreases in needle-sharing will require increased support for accepted programs (increased funding and reach of needle exchange programs, pharmacy sales, peer education)...” from Crofts, N., Aitken, C., & Kaldor, J., 1999, ‘The force of numbers: why hepatitis C is spreading among Australian injecting drug users while HIV is not’, *MJA*, 170, pp220-221; Davis, A., Davey, J., Hunter, A., Williams, M., Richards, N., & Symonds, T., 2002, *The role of amphetamine injection in hepatitis C and drug use risk behaviours*, Queensland Health, Brisbane.

policy oriented learning. That law enforcement agencies adopted such ideas in operational practice signified a level of acceptance toward the deployment of harm reduction ideas in particular contexts. Lastly such developments also suggested that critiques by harm reduction advocates (written at least a decade previous) that identified ways in which law enforcement practice manufactured drug related harm were taken into consideration. While this was not a direct victory for harm reduction advocates, indirectly it was an important development and also a starting point with regard to challenging the hegemony of law enforcement approaches in illicit drug policy.

The establishment of a national framework to respond to problems associated by illicit drugs in 1985 resulted in both secondary, and, gradual and systemic policy change. The choices made at the time of the advent of HIV/AIDS affected the way illicit drug policy was made over a decade later. While the broader definition of harm minimisation, as noted in chapter four, was contested by some harm reduction advocates, such a description also engendered a more inclusive environment where both agencies were regarded as working toward a common aim.

Research Question 9.1: In cases of changes to the policy core, was there an external shock to the subsystem?

Research Question 9.2: How did coalitions integrate such external events into strategies to realise policy objectives?

HIV/AIDS constituted the major shock to the illicit drug policy subsystem in this period and the effect on changes to the policy core has been documented at length already in this thesis. Moreover the guidance strategies used by coalition members

have also been discussed earlier. Of particular interest is why the identification of another BBV (namely HCV) was not accompanied by a similar level of interest and policy making. Some possible reasons for this may include the following:

- Long term threats are less compelling to policy makers than those with immediate to medium-term ramifications,
- Linkages with other communities (such as the gay community) strengthen the rationale underwriting policies,
- The illegal status of injecting drug use and associated social stigma of the activity limits the efficacy of harm reduction policy.

The existence of HIV/AIDS and BBVs more generally continued to reinforce the currency of policies directed toward current injecting drug users. Since 1985, a key part of advocating for such initiatives as MMT, NSPs, prescription heroin and SICs was the proposed reductions in BBV transmissions that could ensue from such programs. Of secondary concern were the benefits directly afforded to injecting drug users such as better physical, economic and social outcomes associated with such programs. Indeed, from evidence presented in preceding chapters there exists a general indifference, and in some cases open hostility, toward injecting drug users.

Major Policy Change – Condition 2

Research Question 10.1: In cases of changes to policy core, did the subsystem coalition that instituted the program remain in power?

Research Question 10.2: If yes, then was the change imposed by a hierarchically superior jurisdiction?

Research Question 10.3: What was the outcome of major policy change regarding the relative power of coalitions within the illicit drug policy subsystem?

In the ACF, it was suggested that some kind of power shift had to occur between coalitions as a consequence of change to the policy core of subsystems. One qualification to this was that policy core changes could occur without changes to the status of coalitions in a subsystem if the changes were imposed from a “...hierarchically superior jurisdiction.”⁴⁹⁰ This second qualification sums up the way in which the change to harm minimisation in 1985 did not result in diminished authority of the law enforcement sector. The Federal ALP Government instructed bureaucrats to draft a policy that essentially ramped up the role of the health sector in policy while concurrently expanding funding for law enforcement. Throughout the period law enforcement strategies continually received more funding that that directed toward health.

In financial terms, Federal and State Government expenditure in response to illicit drugs in 1992 was estimated at \$US393 million (\$A620 million)...Of this not inconsiderable sum, 84 percent was allocated to law enforcement, 6 percent to treatment and 10 percent to prevention and research. Although these figures are somewhat imprecise, they represent the best indication

⁴⁹⁰ Sabatier, P., A., 1998, ‘The advocacy coalition framework: revisions and relevance for Europe’, *Journal of European Public Policy*, 5:1, March, p106.

available of the uneven proportions of government expenditure allocated to supply reduction and demand reduction. Federal and State expenditure on methadone programs has been estimated at \$A30 million per year. In 1991, Australian expenditure on needle syringe programs was estimated at \$A10 million.⁴⁹¹

Indeed the prevailing attitude toward illicit drug policy in Australia and many other western states around the world is that it is an activity that should be discouraged due to the opinion that it presents unacceptable levels of risk. In this sense the changes in 1985 to illicit drug policy with the instigation of the framework of the NCADA did not debunk the existing paradigm of law enforcement as the chief instrument with which to ameliorate the illicit drug 'problem', and the associated power of the law enforcement agencies within the subsystem.

Conclusion

This final section summarises and discusses potential additions and/or directions for future research concerning further theoretical development of the ACF identified in this research. The following points require further attention in the ACF:

- An external shock, such as HIV/AIDS, has the capacity to generate both secondary and gradual policy change, fortify coalitions and change the makeup of coalitions,
- The extent to which policy brokers can also act as coalition advocates is an important contributing factor to policy change,

⁴⁹¹ Wodak, A., 2000, 'Developing more Effective Responses', in *Drugs and Democracy*, G Stokes, P., Chalk & K., Gillen (eds), Melbourne University Press, Carlton South, p184.

- The policy-making cycle in the ACF needs to be reworked to include such phenomena as policy-making forums whereby deliberative processes contribute to the nature of policy,
- Categories of guidance instruments need to be expanded to include community development and other forums that facilitate face-to-face meetings with experts and laypeople. Additionally acts of civil disobedience can also serve an agenda setting function, and,
- Basic attributes of the (illicit drug) problem area were more changeable than allowed for in the ACF.

Furthermore, while the ACF seems to cope reasonably well in applications to social problems like drug use, there are some limitations in the framework when examining social phenomena. Such limitations are also discussed below.

In this analysis it became clear that the main external shock (HIV/AIDS) to the subsystem in the period of analysis was responsible for not only major policy change but also a suite of secondary policy changes. The multitude of secondary changes that occurred as a result of HIV/AIDS, were implemented both at the time of identification of the virus but also a decade later. HIV/AIDS prompted an explosion of policy activity to curb the spread of the virus into the mainstream population in the late 1980s and, moreover, the structures set up for HIV/AIDS in this time resulted in changes to drug policy a decade later. For examples, please see the section on 'gradual and systemic' policy change identified earlier in this chapter. Furthermore, HIV/AIDS acted to fortify the harm reduction coalition from being a group that advocated for a new way to address problems associated with illicit drugs to a group that offered solutions to ameliorate the potentially disastrous impact of HIV/AIDS on

public health. Moreover, HIV/AIDS had a profound effect on the makeup of a coalition as identified earlier in this chapter. In sum, some external shocks have the capacity to have more of a profound impact upon a policy subsystem and as such warrants further development in the ACF.

Further development of the conception of the policy making cycle, and the role of the policy broker within it, in the ACF is also required. The cycle of policy making as described in the ACF does not reflect types of policy forums (such as the 1999 NSW Drug Summit) whereby 'compromise' was reached through deliberative face-to-face processes with stakeholders. Moreover, this research has shown, in three cases, whereby policy makers from the bureaucracy or executive government have also been passionate advocates of a particular policy stance. Indeed, the personal convictions of senior health bureaucrat Les Drew, then Federal Health Minister Neal Blewett and Prime Minister John Howard clearly impacted upon the direction of policy. This research has suggested that an axis of role and influence be used to map the nature of the policy broker in order to qualify and quantify the extent of influence and allegiance to a particular coalition. Moreover, the ACF could be strengthened by consideration of Kingdon's concept of 'policy entrepreneurs' in order to explain in more detail the ways in which particular influential individuals impact on policy change.

The idea that coalitions use 'research and information exchange' as 'guidance instruments' or strategies to convert beliefs into policy was supported in this analysis, however, it is suggested that sub-types of 'research and information exchange' be expanded upon. Community development strategies undertaken by the proponents of the ACT heroin trial and also the bipartisan parliamentary committees

enacted under Blewett were two examples of mechanisms whereby information about policy positions was disseminated in a particular way. Such forums provided an opportunity for the dissemination of politically sensitive or controversial information in face-to-face encounters between experts and stakeholders (often populated by many a layperson). Such an approach allowed questions to be answered and dissemination of correct information directly to stakeholders and was a clever way to curb misinformation or misrepresentation of policy positions that often occurs when controversial information and/or policy is disseminated through other channels such as the media. The use of strategies to circumvent controversy and misrepresentation of policy positions was a shrewd tactic used by members of the harm reduction coalition. Misrepresentation and other tactics used to discredit harm reduction ideas, policies and programs was an ongoing obstacle to harm reduction advocates looking to convert ideas into policy. Indeed such mechanisms that circumvent controversy and misinformation, it is posited, are more important to policy success in social systems than in natural systems. Information on controversial topics such as abortion, sexuality and drugs may be best disseminated in such forums. Moreover, morality-based undercurrents to such debates means that scientific information does not hold the same degree of legitimacy as in natural systems and as such the requirement to keep messages simple and accurate is a critical, yet difficult to achieve imperative especially when the topic to be disseminated challenges preconceived notions about human nature and social behaviour. Moreover, research and information gathering and exchange also, if conducted systematically, means that some coalitions are in a permanent state of being 'policy ready' should a window of opportunity present. This was the case in the 1990s with the harm reduction coalition quick to respond to policy problems with detailed solutions.

Another category or type of guidance instrument was identified in the research, namely the use of civil disobedience tactics as having an agenda setting function. As noted, this occurred twice in the period of analysis and resulted in the implementation of the program (for examples NSPs and SICs) a short time after. One caveat to this however, was that the civil disobedience actions in the two examples noted in this thesis were led by medical practitioners and a church group, ergo such groups enjoy a degree of legitimacy and/or prestige to their occupations and thus it is suggested that this lent credence to their actions.

An unresolved issue generated by this research concerns the nature of stable system parameters in social systems. As noted earlier, changes to the 'basic attributes of the subject area' occurred more regularly than accounted for in the ACF. Changes such as the identification of HIV/AIDS and HCV (that changed the harm profile of injecting drug use) and the emergence of a new language in which to discuss policy were two examples of fundamental changes to system parameters that occurred in the period. Moreover the ever-changing nature of the availability and purity of illicit drugs meant that that change was a constant and fundamental factor of the illicit drug policy subsystem. Thus, the basic attributes of the problem area were more changeable than accounted for in the ACF. As noted earlier the ACF was formulated to initially examine natural systems in which change is hypothesised to occur on a slower time scale than in social systems. Moreover, phenomena in social systems are highly subjective and many critical variables are themselves active strategists. The illicit status of drugs also contributes to make the activity highly changeable and reliant on a number of volatile factors along the production cycle and commercial

transactions. In this sense, the changeable nature of some of the fundamental parameters in illicit drug policy presents a challenge to the ACF.

Conclusion

This thesis had three broad aims: to explain the nature of policy change in the illicit drug policy subsystem; to provide direction for future development of the ACF; and to analyse the politics of harm reduction within the Australian setting. First, with regard to the nature of policy change, the persistent prevalence of illicit drug-related harm (for example: rates of overdose, problematic dependencies and drug related crime) mirrors the sustained deadlock in policy debate – a deadlock which, in turn, narrows the array of palatable policy responses. This thesis has explained the nature of this standoff between the two major coalitions within the illicit drug policy subsystem, as resulting from a difference in methods in which information is validated. Indeed, when advocates have vastly different ways of understanding and evaluating social problems (in this case the example was scientific/evidence-based approach versus morality-based appraisals), the result is a standoff between coalitions resulting in a ‘dialogue of the deaf’, with coalitions talking past each other. Scientific, evidence based accounts of social problems are treated with suspicion by moral-abstinence coalition (who suspect a wider agenda of normalisation of drug use), and similarly, the emphasis on moral beliefs in debates does not impress the harm reduction coalition (who suggest that such an approach is based on inaccurate assumptions). Consequently this inhibits debate as coalitions struggle with each other’s basic assumptions about the way to evaluate the problem and thus find it difficult to entertain proposed policy solutions. Thus, both groups look to like-minded individuals located in the policy making arena (which includes both executive government and the bureaucracy) in order to further their policy objectives. In contrast, the relationship between health and law enforcement agencies more generally is more collegial and consequently conducive to engendering secondary policy change. As noted, both sectors regularly engage in

prestigious, high-level forums and accept each other's relative positions - and as a result can co-exist within the illicit drug policy subsystem. Such a relationship means that problems regarding controversial subject matter can be discussed with relative dispassionate complexity thus facilitating policy oriented learning. Sabatier would rightly argue that this discussion would occur only at the 'secondary' level of policy beliefs, as the 'policy core' level of beliefs (that encompass, for example, beliefs about the roles of each agency in illicit drug policy) are agreed upon before the discussion occurs.

Ultimately this thesis has identified a 'dialogue of the deaf' between some members of the harm reduction and moral-abstinence coalitions that runs parallel to the more constructive relationship between health and law enforcement agencies. The phrase 'dialogue of the deaf' characterises the precise nature of the irrationality of illicit drug policy and, with the aid of the ACF, this thesis provided some explanation as to the reasons for the stalling of harm reduction policy in the 1990s. Indeed, such a stagnation in policy also explains the seeming apparent inability of the state to address problems connected to drug use and why they continue to occur. The search for a common language and epistemological tools by which illicit drug policy can be evaluated remains elusive and continues to stifle further implementation of harm reduction ideas in illicit drug policy and rational debate on this issue of injecting drug use more generally.

With regard to the second aim of the thesis, the research questions posed in chapter two, that provided a framework to test the applicability of the ACF to policy change in illicit drug policy subsystem, were answered in chapter six. This thesis has clearly shown that the ACF can be applied to understand policy change in relation to illicit

drug policy, however there were some aspects of the ACF identified in this thesis that could be amended and/or addressed in the future in order to better respond to such scenarios. Indeed, further applications of the ACF to explain change in policy subsystems in which the activity studied is illicit and therefore unable to be controlled by Governments, would be useful in order to examine how the ACF can explain systems in which a fundamental and constant variable is change itself. Studies of social/moral policy questions (for example, abortion and sex work policy) in which a policy deadlock is more likely to occur due to epistemological differences between the main coalitions would complement and build upon the work conducted in this thesis, especially the implications for policy oriented learning.

The third aim of this thesis, a discussion of the politics of harm reduction in Australia, has shown that the approach intersects with philosophies and debates that describe human nature and the role of drug use in society more generally. This thesis has shown that there is a ceiling that inhibits the further implementation of harm reduction approaches and that the oft-levelled accusation that such programs lead to an increase in illicit drug use is a key issue to be resolved. Harm reduction programs should invest in further research to debunk and/or respond to this argument⁴⁹², as it is an unresolved question that thwarts the implementation of, and discredits the notion of harm reduction policies in the wider community.

It is clear that throughout the period of analysis in most writing on illicit drugs (whether such writing was derived from harm reduction or moral-abstinence coalitions, from Government, research institutes and other materials used in this thesis) that there was a ubiquitous image of the 'typical drug user'. This image relied

⁴⁹² While there have been some sporadic analyses however more systemic appraisals might be required.

on a simplification of the central image of a 'typical' user, their type of use, and the consequences of this use for mainstream society. The images associated with this popular construction of the illicit drug use problem are pervasive, for example: people overdosing in public areas; emancipated people at the mercy of dependencies; untidy appearances of drug users; labels such as 'welfare-seeking', 'work avoiding' and 'lazy'; and people subject to the 'disease' of drug use. This representation of the typical illicit drug user as ostensibly a 'hopeless junkie' that experiences problematic consequences as well as a chaotic lifestyle associated with their illicit drug use implies a homogeneity of the issue. From the perspective of the harm reduction coalition, while many advances had been made in illicit drug policy in Australia between 1980 and 2000 (for example: the lessening of penalties towards illicit drug users; implementation of NSPs; self-help drug user groups; and the recognition that licit drugs cause more harm than illicit drugs), by the end of this period the notion of the 'hopeless junkie' (and all the imagery associated with it) was still pervasive. Moreover, such stereotypes were used and/or perpetuated (whether consciously or inadvertently) as key constructs in the stages of problem definition and formulation of solutions by nearly all stakeholders – be they part of the harm reduction or moral-abstinence advocacy coalitions - to varying degrees in the illicit drug policy subsystem.

Such constructs as the 'hopeless junkie' notion are based on an assumption that illicit drugs are inherently harmful, and consequently that use of illicit drugs will result in negative outcomes (in terms of health, social, economic, moral and legal dimensions of harm) for most (if not all) people that use them. While it is understandable to direct social policies towards those with an identified need, the entire issue of illicit drug use in society seems to be represented by just one of its parts, and consequently

this focus has the function of defining *all* illicit drug users in relation to this ‘hopeless junkie’ construct. The largest proportion of illicit drug consumers – the vast number of drug users that enjoy medium to high socio economic status, maintain relationships and otherwise experience minimal or no harms from recreational illicit drug use - were often forgotten in the (many types of) literature reviewed in this thesis when discussing illicit drugs and drug related harms. This ubiquitous usage of the ‘hopeless junkie’ as the image of the ‘typical’ drug user has the function of discounting and marginalising other possible variables such as socio-economic status, employment status, educational backgrounds and prohibition policy as factors that contribute to the experience of adverse consequences associated with illicit drug use. This homogeneity in the portrayal of drug consumers in the policy problem serves a clear political purpose, namely to reinforce core notions associated with the ‘war on drugs’ rhetoric. This is a relic of the anti-drug social conditioning project that occurred alongside the implementation of prohibition regimes in the twentieth century (discussed briefly in chapter one). Assumptions underpinning this ‘hopeless junkie’ construct are key elements of the moral abstinence coalition’s approach. It follows that if all drugs are *inherently* destructive in terms of physical, social, economic and moral harms, then abstinence from such drugs is the best approach in order to avoid such harms from occurring in both the context of the individual user and wider society.

In its attempts to gain political support for its approaches to illicit drug policies, the harm reduction coalition often, perhaps inadvertently, reinforced the notion of the ‘hopeless junkie’. One example of this was in relation to the debates justifying the instigation of a SIC in NSW. Harm reduction advocates (in this case Dr. Ingrid van Beek) drew upon the notion of the disenfranchised, chaotic, problematic drug user

and appealed to moral arguments to help such people when advocating for the facility. Moreover, as recounted in chapter five, Premier Bob Carr qualified his support for the facility with a statement on the immorality and personal abhorrence of the activity of injecting drug use. Indeed in advocacy attempts by the harm reduction coalition regarding SICs, the facility was generally advanced as a necessary evil rather than as a program to address public health problems of injecting drug users. Another example of the tacit reinforcement of the notion of the 'hopeless junkie' was with regard to the emphasis of harm reduction programs as either treatment gateways (in the case of NSPs) or treatment programs (in the case of SICs). Emphasis of the treatment gateway function of NSPs assumes that the majority of service consumers are in need of treatment.

However, such a pragmatic approach to advocacy has worked well for the harm reduction coalition. While many a subset of harm reduction coalition members do attempt to deconstruct the 'hopeless junkie' notion to varying degrees, often, perpetuation of such an image is the entry price to mainstream debate. Membership of the harm reduction coalition is at its largest when the policy battlefield is closest to the mainstream. Echoing and reinforcing mainstream values, and emphasising the utility of harm reduction subjugated within that dominant framework was, and continues to be, a highly pragmatic strategy in order to realise policy objectives in the short term. This over-emphasis on the treatment function of NSPs reflects the way in which harm reduction advocates have to function within the dominant approach and avoid offending the sensibilities of mainstream society. Nevertheless, the strategy of ignoring or downplaying the existence of drug users that are high functioning with minimal harm connected to their drug use reinforces the hopeless junkie stereotype and the idea that all illicit drug use has negative consequences.

The example of HCV demonstrated that when a policy issue is confined to being ostensibly about improving the health of drug users (in contrast to HIV/AIDS whereby the threat to the mainstream health was more obvious and thus compelling) the size and potency of the harm reduction coalition shrinks. Indeed, in the case of HCV, the harm reduction coalition seems unable to get any traction with regard to policy change directed towards reductions in transmission within the drug using community. For transmission rates of HCV to be reduced, supply reduction initiatives must be reformed on a number of fronts as discussed in chapter four (in order to remove the stigmatisation and counter-productive environment that contributes to the ongoing transmission of HCV). This is a trade-off that most politicians are not prepared to make. The trade-off is essentially to decriminalise illicit drug use in order to reduce the health problems of those that choose to undertake the activity. Ultimately such a change to drug laws *may* also increase the number of users while concurrently reducing the harm associated with the activity. Such a situation is described by Wodak:

Nevertheless, the view that society is better off with a tiny minority badly damaged by the high costs of drug use rather than a larger population only slightly injured is difficult to displace. This is the nub of the argument between supporters of supply reduction and advocates of harm reduction. A hypothetical world where policy relaxation might, by making drug use less hazardous, double the number of drug users but more than halve the number of casualties, would be applauded by harm reduction supporters and condemned by supply reduction supporters.⁴⁹³

Authors of the ACF quite rightly theorised that phenomena such as drug laws are recognised as very hard to change by coalitions and therefore are rarely the subject of

⁴⁹³ Wodak, A., 1997, 'Injecting nation: achieving control of hepatitis C in Australia', *Drug and Alcohol Review*, 16, p281.

coalition strategising. There is a drug law reform group⁴⁹⁴ that shares some membership with, but is visibly separate to the harm reduction coalition. It is anticipated that the harm reduction coalition would reconfigure and most probably shrink in size if it was to pursue a longer-term agenda that agitated mainstream values. Sabatier and Jenkins-Smith were correct when they hypothesised that the fundamental glue of coalitions is at the level of policy core rather than deep core beliefs. It is hypothesised in this thesis that there would be a disparity between the deep core beliefs of harm reduction coalition members derived from church groups, self-help drug user groups and the medical community regarding the role of drug use in society. Indeed, this disparity would be apparent both between and within the groups. If harm reduction coalition members attempted to, on a large scale, dismantle the image of the 'hopeless junkie', in the short term they would be open to accusations of having a pro-drug stance. Consequently, allegations that the harm reduction approach is linked to a broader agenda of normalising (and by extension encouraging the uptake of) illicit drug use would ensue. Obviously this accusation would sully future advocacy attempts.

There are many benefits that may ensue from the reconstruction of the notion of the illicit drug user away from the 'hopeless junkie' construct and toward a more complex representation of the issue by the harm reduction advocacy coalition. By reconstructing the popular image of illicit drug takers as those that occupy all levels of socio-economic status and experience different degrees of harm from their use might broaden the relevance of harm reduction programs such as NSPs to a wider audience of existing drug users (some might not currently wish to access such programs due to a fear of breach of confidentiality or associating with problematic

⁴⁹⁴ Australian Drug Law Reform Foundation website: <http://home.vicnet.net.au/~adlrf/ouraims.html>

drug users) and in turn engender more adventurous and more effective harm reduction practice. Consequently, harm reduction programs might not be seen as a 'necessary evil' by Governments, subordinate to prohibition and contingent on the existence of BBVs such as HIV/AIDS and HCV to survive. Finally, such a direction might also serve to de-stigmatise drug use and drug users - in the process improving health outcomes as the activity of drug use is not something that consumers need to necessarily conceal to the extent that occurs currently. Such concealment of the practice arguably compounds the instance of drug-related harm as stated in earlier chapters. Meanwhile, other groups in society, such as the drug law reform group could pursue a more radical agenda independent of the harm reduction coalition, for example suggesting that:

...drugs should be appreciated as a cultural asset, similar to religion and art. In the "high" an inner field of experience is opened up that would remain closed forever without mind-altering substances. Temporary but drastic changes in the mind are produced that one could never experience without drugs, just like there is no substitute for a loving relation or a parachute jump. The induced feeling can be wild and ecstatic, or soft and empathic. The experience can be spiritual, oppressive or alienating or on the contrary endlessly serene. The user can "go through the roof", observe a colour never before observed or feel a cosmic 'nothing' on his own skin but everyone who has ever used LSD or ecstasy knows that the experience is unique, and that they who claim that they can reach the same effect just as well "in another way", simply do not know what they are talking about. Now the fact is that a great many citizens of all countries of the world feel deeply attracted to this type of experience.⁴⁹⁵

As noted earlier any challenge to the fundamentals underwriting the dominant thinking on illicit drugs is a momentous task, and to an extent, might confirm the suspicions of those who distrust the harm reduction ethos and/or alienate existing

⁴⁹⁵ van Ree, E., 1999, 'Drugs as a human right', *International Journal of Drug Policy*, 10, p93.

supporters of harm reduction, such as some church groups. Nevertheless this tension within the harm reduction coalition in relation to deep core beliefs may be raised as an issue in the longer term depending on the direction of future illicit drug policies.

In sum, it is apparent from this study of the evolution of harm reduction policy in Australia between 1980 and 2000 that there is a tension between aspects of the original political agenda implicit within the harm reduction ethos (as described in chapter one) and the manner in which harm reduction ideas have evolved as a result of being implemented by governments and manifested in mainstream illicit drug policy. As noted, the tension concerns whether to exist within (and consequently not agitate to a great extent) the dominant paradigm of illicit drug policy and wider cultural norms regarding the 'hopeless junkie', or, whether to attempt to pursue a more political agenda that challenges status quo ideas about the illicit drug 'problem'. To an extent, the trade-off of occupying a role in mainstream policy means that policy advocates must be careful not be perceived as too radical in their policy proposals (in this sense they are occupying a policy strait-jacket), however much could be gained in the long term if advocates would aim to further discredit the 'hopeless junkie' construct, and at the very least, continue to identify the phenomena of problematic drug use as often linked to (and in some cases generated by) prohibition regimes and other variables such as economic status that exacerbate drug-related harms.

It is predicted that, in the future, moral-abstinence advocates will be compelled to produce more evidence than they currently provide to support advocacy efforts, whether focused on new solutions or on criticisms of harm reduction. It is not suggested, however, that this will be a major change or occur in the short term.

Indeed, the current Australian Government lead by Prime Minister John Howard seems entirely resolute to not implement or at very least to vehemently discourage any further types of harm reduction programs that are perceived to be more radical than those that currently exist (specifically more SICs or prescription heroin) while in office. In 2001, the position of the Federal Liberal Government was reaffirmed on the issue of a prospective heroin trial by the then Minister of Justice and Customs, Senator Ellison:

The Government believes that the most effective way to tackle the illicit drug problem is to reduce the supply of illicit drugs in the community. It is in this environment that education about the dangers of illicit drugs for young Australians and health and diversionary programmes are most effective.⁴⁹⁶

In the same press statement Senator Ellison distinguished the Federal ALP's stance from that of the Howard Governments'.

Mr Beazley again confirmed today that the Labor Party would support any State that brought forward a trial for heroin injecting rooms, a clear confirmation of their soft on crime approach to illicit drugs.⁴⁹⁷

It would be naive and somewhat presumptuous to suggest that in the future, the election of a Federal ALP Government in Australia would automatically signify a supportive environment for harm reduction policies and programs to flourish. However, even a change to the leadership of the Federal Liberal Party, would no doubt, generate hope for the coalition that has been regularly thwarted by Prime Minister Howard who has personally buoyed the political power of supporters of moral-abstinence approaches. While such a change in Government might not

⁴⁹⁶ Minister of Justice and Customs, 8/10/2001 'Government rejects heroin trial', *Media Release*, From: http://www.ag.gov.au/agd/WWW/justiceministerHome.nsf/Page/Media_Releases_2001_3rd_Quarter_8_August_2001_-_Government_Rejects_Heroin_Trial

⁴⁹⁷ *ibid.*

engender changes to the policy core of illicit drug policy, secondary changes might be more forthcoming.

Injecting drug use continues to be regarded as an extremely immoral and dangerous activity. Any efforts that attempt to reduce the stigmatisation associated with this activity frightens the majority of the population. That injecting drug use does not always cause harm to the consumer or other people, in combination with the evidence suggesting that the majority of harm associated with injecting drugs is created by government policies, the level of concern about this activity is arguably disproportionate, and at very least, misdirected. The ACF has proven to be valuable in identifying reasons why Australian illicit drug policy has been in a rut since the 1980s and the persistence of drug related harms. While some level of harm is no doubt unavoidable due to the pharmacology of illicit drugs, a secondary layer of harm is directly maintained by the dominant policy framework within which harm reduction operates. In the longer term, harm reduction advocacy will continue to be hamstrung by both its opponents and its own members. The latter is due to the discord in deep core values between members of the harm reduction coalition in regard to the role, and the inherent danger or otherwise, of drug use to society. The diverse membership of the coalition is at least united by pragmatism and a belief in evidence-based approaches, however the elasticity of the support base is often tenuous.

In sum this research has proved useful in understanding advocacy of 'politically difficult' policy. To advocate the spending of public funds on what is often regarded

as undeserving group of people is a brave contention, unless it is framed in the interests of the general public. It can only be hoped in the future that the issue of drug use is examined more critically in the interests of future casualties that occur alongside the deadlock in illicit drug policy debate.

Bibliography

- 'Heroin hot-spots pray for church as lifesaver', *The Australian*, 19/7/99.
- 'Heroin trials not on, says Howard', *The Australian*, 20/8/97.
- 'Heroin toll soars to record level', *The Age*, 15/12/98.
- 'Injecting rooms appeal to users', *The Age*, 14/12/98.
- 'Moralising while the body count rises', *The Sunday Age*, 7/3/99.
- 'Opening injecting room the right thing to do' *The Sydney Morning Herald*, 10/5/99.
- 'Push for civil disobedience campaign', *The Age*, 29/5/99.
- 'Shooting galleries the politics of heroin', *The Sydney Morning Herald*, 5/6/99.
- 'Why more police won't stop heroin dealers', *The Sydney Morning Herald*, 10/3/99.
- 'Injecting room: saving lives or foolish compassion?', *The Sydney Morning Herald*, 7/5/99.
- Aitken, C., Moore, D., Higgs, P., Kelsall, J., & Kerger, M., 2002, 'The impact of a police crackdown on a street drug scene: evidence from the street', *International Journal of Drug Policy*, 13, pp193-202.
- Australian Bureau of Criminal Intelligence, 1997, *Australian Illicit Drug Report 1996-7*, Commonwealth of Australia.
- Australian Bureau of Criminal Intelligence, 1999, *Australian Illicit Drug Report 1998-1999*, accessed online at:
http://www.crimecommission.gov.au/content/publications/aidr_2000/03_Heroin.pdf on 10/7/05.
- Australian Federal Police & Australian Customs Service, 'Heroin found concealed in hard sided suitcase', *Media Release*, 26/4/2006, available at
http://www.afp.gov.au/media_releases/national/2006/heroin_found_concealed_in_hard-sided_suitcase both accessed on 25/5/2006.
- Australian Federal Police, 2005, 'Plastic Chairs attempt to hide massive heroin import', *Media Release*, 13/5/2005 available at:
http://www.afp.gov.au/data/assets/pdf_file/1908/mr050513operationdomini.pdf
- Australian Institute of Health and Welfare, 2005, *National Drug Strategy Household Survey*, Australian Institute of Health and Welfare, Canberra.
- Australian National Council on AIDS, Hepatitis and Related Diseases, 2003, *National Hepatitis C Testing Policy*.
- Australian Royal Commission of Inquiry into Drugs 1977 (Williams Inquiry).

- Ball, J., & Ross, A., 1991, 'The effectiveness of methadone maintenance treatment', Springer-Verlag, New York.
- Bammer, G, 1996, 'When science meets politics: the Australian heroin trial feasibility study', *The International Journal of Drug policy*, 7:1.
- Bammer, G & Douglas, R., 1996, The ACT heroin trial proposal: an overview, *MJA*, 164, pp690-692.
- Berridge, V., 1993, 'Harm minimisation and public health: a historical perspective, in N., Heather, A., Wodak, E., Nadleman & P., O'Hare (eds), *Psychoactive Drugs & Harm Reduction: from faith to science*, Whurr, London.
- Blewett, N., 2003, *Aids in Australia: Reflections on Australia's policy response to the AIDS Epidemic*, Australian Health Policy Institute, University of Sydney.
- Brereton, D, 2000, 'The History and Politics of Prohibition', in Stokes, G., Chalk, P., & Gillen, K., (eds.), *Drugs and Democracy*, Melbourne University Press, Carlton South.
- Brower, K., Blow, F., & Beresford, T., 1989, 'Treatment Implications if Chemical Dependency Models: An Integrative Approach', *Journal of Substance Abuse Treatment*, No. 6., pp147-57.
- Brower, S., Stetson, B., & Beatty, P., 1989, 'Cognitive and Behavioural Features of Adolescent Coping in High-Risk Drinking Situations', *Addictive Behaviours*, 14.
- Buerki, C., 1996, 'HIV risk Behaviour Among Street IVDUs attending a shooting room in Berne, Switzerland, 1990 and 1995', University Psychiatric Services.
- Campbell, A., 2001, *The Australian Illicit Drug Guide*, Black Inc, Melbourne.
- Canrwath, T., 2004, 'Heroin prescription for heroin addiction - an English view', *Acta Neuropsychiatrica*, 16:5, p275, from 'Prescription of Opiates and Controlled Stimulants' accessed on 27/4/05, from <http://www.aidslaw.ca/Maincontent/issues/druglaws/e-iduback/Paper3/prescription-3.htm>
- Centre of Harm Reduction website: <http://www.chr.asn.au/home> accessed 11/3/06. Centre, University of New South Wales.
- Chappell, D, Reitsma, T., O'Connel, D & Strang, H., 1993, 'Law Enforcement as a harm reduction strategy in Rotterdam and Merseyside', in N. Heather, A. Wodak, E. Nadleman, P. O'Hare (eds) *Psychoactive drugs & Harm Reduction*, Whurr, London.
- Chilvers, M., & Weatherburn, D., 2003, 'The impact of heroin dependence on long terms robbery trends', *Crime and Justice Bulletin*, 79.
- Collins, D., & Lapsey, 1996, *The Social Costs of Drug Abuse in Australia in 1988 and 1992*, AGPS, Canberra.

Commission of Inquiry into the Non-Medical Use of Drugs, 1972, *Cannabis*, Information Canada, Ottawa.

Commonwealth Department of Health and Ageing, 2000, *National Hepatitis C Strategy 1999-2000 to 2003-2004*, Commonwealth of Australia, Canberra.

Commonwealth Department of Health and Ageing, 2002, *Return on investment in needle and syringe programs in Australia*, Department of Health and Ageing, Canberra, Available at: <http://www.health.gov.au/pubhlth/publicat/hac.htm> (accessed Jun 2004).

Commonwealth Department of Health and Human Services, 1996, *Partnerships in Practice: National HIV/AIDS Strategy 1996-7 to 1998-99*, AGPS.

Commonwealth of Australia, 1989, *National HIV/AIDS Strategy*, AGPS, Canberra.

Commonwealth of Australia, 1989, *The National Campaign Against Drug Abuse 1985-88: Evaluation and future directions*, AGPS, Canberra.

Commonwealth of Australia, 1993, *National Drug Strategic Plan 1993-97*, Canberra, AGPS.

Commonwealth of Australia, 1997, *National Policy on Methadone Treatment*, Canberra.

Commonwealth of Australia, 1998, *National Drug Strategic Framework 1998-9 to 2002-3*, Commonwealth of Australia.

Commonwealth of Australia, 2001, *National Heroin Overdose Strategy*, Commonwealth Department of Health and Aged Care.

Crofts, N, 1993, 'A History of Peer-Based Drug-User Groups in Australia', *Journal of Drug Issues*, 25, pp599-616.

Crofts N., Jolley D., Kaldor J., 1997, 'Epidemiology of hepatitis C virus infection among injecting drug users in Australia', *Journal of Epidemiology and Community Health*, 51.

Crofts N., Louie R., Rosenthal D., & Jolley D., 1996, 'The first hit: circumstances surrounding initiation into injecting' *Addiction*, 91, pp1187-1196.

Crofts, N, 1996, 'The heroin trial we had to have', *MJA*, 164, p695.

Crofts, N., & Aitken, A., 1997, 'Incidence of bloodborne virus infection and risk behaviours in a cohort of injecting drug users in Victoria 1990-1995', *eMJA*, accessed at <http://www.mja.com.au/public/issues/jul7/crofts/crofts.html> on 20/2/06

Crofts, N., & Aitken, C., & Kaldor, J., 1999, 'The force of numbers: why hepatitis C is spreading among Australian injecting drug users while HIV is not', *MJA*, 170.

Crofts, N., 1995, 'A History of Peer-Based Drug-User Groups in Australia', *The Journal of Drug Issues*, 23:3.

- Crofts, N., Aitken, C., & Kaldor, J., 1999, 'The force of numbers: why hepatitis C is spreading among Australian injecting drug users while HIV is not', *MJA*, 170.
- Darke S., Ross J., Zador D., Sunjic S., 2000 'Heroin-related deaths in New South Wales, Australia 1992-1996', *Drug and Alcohol Dependence* 60, pp141-150.
- Davis, A., Davey, J., Hunter, A., Williams, M., Richards, N., & Symonds, T., 2002, *The role of amphetamine injection in hepatitis C and drug use risk behaviours*, Queensland Health, Brisbane.
- Degenhardt, L., Conroy, E., Gilmour, S., & Hall, W., 2005, 'The effect of a reduction in heroin supply on fatal and non-fatal drug overdoses in New South Wales', Australia, *MJA* 182:1, pp20-23.
- Department of Health and Aged Care, 1999, *Hepatitis C: a review of Australia's response*, Commonwealth of Australia, Canberra.
- Department of Health, 1985, *National Campaign Against Drug Abuse*, AGPS, Canberra.
- Department of Health, 1985, *National Campaign Against Drug Abuse*, AGPS, Canberra.
- DHSS, 1982, *Treatment and Rehabilitation: Report of the Advisory Council on the Misuse of Drugs*, London, HMSO.
- Di Francesco, M., 2001, 'Process not outcomes in New Public Management?: 'Policy Coherence' in Australian Government', *The Drawing Board: An Australian Review of Public Affairs*, 1:3, March.
- Dixon, D. 1999, *Law Enforcement, Harm Minimisation and Risk Management in a Street-level Market*, University of New South Wales, Sydney.
- Dolan, K., Kimber, J., Fry, C., Fitzgerald, J., McDonald, D & Trautmann, F., 2000, 'Drug consumption facilities in Europe and the establishment of supervised injecting centers in Australia', *Drug and Alcohol Review*, 19.
- Dole, A., 1989, 'Methadone treatment and the AIDS epidemic', *Journal of the American Medical Association*, 262.
- Drew, L., & Taylor, V., 1988, *Intravenous Drug Use and the Aids Epidemic*, Paper presented to the National Health and Medical Research Council.
- Drew, L., 1981, 'The need for a regional policy on drugs', *Man, Drugs and Society – current perspectives, proceedings of the First pan Pacific Conference on Drugs and Alcohol*, Canberra, Australia, March 1980.
- Drew, L., 1986, 'Editorial: Cannabis Health issues and Public Policies', *Australian Drug and Alcohol Review*, 5.

- Drew, L., 1987, 'Beyond the Disease Concept of Addiction: Towards an Integration of the Moral and Scientific Perspectives', *Australian Drug and Alcohol Review*, 6, pp45-48.
- Drew, L., 1987, 'The Emperor has no Clothes: The Limits of Science in Dealing with Drug Problems', *Australian Drug and Alcohol Review*, 6, pp265-269.
- Drew, L., 1988, 'Editorial Minimising drug problems: the importance of harm reduction strategies', *Australian Drug and Alcohol Review*, 7.
- Drew, L., 1984, 'Strategies for Minimising Drug Related Health Problems', *Australian Alcohol/Drug Review*, 3:1, January.
- Drug Advisory Council of Australia, *About DACA*, accessed on 12/3/06 <http://www.daca.org.au/injecting/HIV.htm>
- Drug Advisory Council of Australia, *Abstinence Drug Rehabilitation Works*, accessed on 12/3/06 <http://www.daca.org.au/injecting/HIV.htm>
- Drug Advisory Council of Australia, accessed on 12/3/06 <http://www.daca.org.au/injecting/HIV.htm>
- Drug Advisory Council of Australia, *Harm Minimisation Slammed*, accessed on 12/3/06
- Drug Advisory Council of Australia, *Injecting drugs leads to HIV and Hepatitis C*, accessed on 12/3/06 <http://www.daca.org.au/injecting/HIV.htm>
- Drugs Poisons and Controlled Substances (Injecting Facilities Trial) Bill, Victorian Hansard, 7/9/2000.
- Edwards, G., Arif, A., & Hadgson, R., 1981, 'Nomenclature and classification of drug and alcohol related problems: a WHO Memorandum', *Bulletin of the World Health Organization*, 59:2, pp225-42.
- Eldman, M., 1988, *Constructing the Political Spectacle*, University of Chicago Press, Chicago.
- Elliot, A., Chapman, S., 2000, 'Heroin hell their own making: construction of heroin users in the Australian press 1992-97', *Drug and Alcohol Review*, 19, pp191-201.
- Erickson, C., 1992, 'A Pharmacologist's Opinion – Alcoholism: the Disease Debate Needs to Stop', *Alcohol and Alcoholism*, vol. 27, No. 4.
- Erickson, P., 1992, 'Political pharmacology: Thinking about drugs', *Daedalus*, Summer.
- Family and Friends for Drug Law Reform, Supporters of a heroin trial in Australia, accessed at www.ffdlr.org.au/factfile/WhoSupports on 12/12/04.
- Family and Friends for Drug Law Reform, *Supporters of a heroin trial in Australia*, accessed at www.ffdlr.org.au/factfile/WhoSupports on 12/12/04.

Fazey, C., 1992, 'Heroin Addiction, crime and treatment', in P O'Hare, R Newcombe, A. Matthews, E Buning & E Drucker (eds), *The reduction of drug related harm*, Routledge, New York, pp154-161.

Footscray cares web page: accessed at www.paradigm4.com.au/footscraycares/ on 6/12/2004.

From National Drug Alcohol Research Centre website:
<http://notes.med.unsw.edu.au/NDARCWeb.nsf/page/IDRSa> accessed 11/3/06.

Gamble, L., & George, M., 1997, 'Really useful knowledge': the boundaries, customs and folk laws governing recreational drug use in a sample of young people', in Erickson, P, Riley, D., Cheung, Y, O'Hare, P., (eds) *Harm Reduction: a new direction for drug policies and programs*, Toronto, University of Toronto Press.

Gossop M., Griffiths P., Powis B., Williamson S., Strang J., 1996 'Frequency of non-fatal heroin

Gossop, M., 1978, 'Review of the evidence for methadone maintenance as a treatment for narcotic addiction', *Lancet*, 1, pp812-815.

Green, P & Purnell, I., 1996, *Measuring the success of law enforcement agencies in Australia in targeting major drug offenders relative to minor drug offenders*, National Police Research Unit, Adelaide.

Griffin, M., 1995, 'Building on Common Ground', *Connexions*, 15:4.

Gunaratnam, P., 2005, *Drug policy in Australia: The supervised injecting facilities debate*, Asia Pacific School of Economics and Government, ANU, accessed online: www.apseg.anu.edu.au, 7/9/2005.

Gunaratnam, P., 2005, *Drug policy in Australia: The supervised injecting facilities debate*, Asia Pacific School of Economics and Government, ANU, accessed online: www.apseg.anu.edu.au, 7/9/2005.

Hall, W., Kimber, J & Mattick, P., 2002, Breaking the deadlock over an Australian trial of injectable opioid maintenance, *MJA*, 176:2.

Hart, G., Carvell, A., Woodward, N., et. al., 1989, 'Evaluation of needle exchanges in central London: Behaviour change and anti-HIV status over 1 year', *AIDS*, 3, pp261-265.

Hellawell, K., 1995, 'The Role of Law Enforcement in Minimising the Harm Resulting from Illicit Drugs', *Drug and Alcohol Review* 14.

Hellawell, K., 1995, 'The Role of Law Enforcement in Minimizing the Harm Resulting from Illicit Drugs', *Drug and Alcohol Review*, 14, pp317-22.

Henry-Edwards, S., & Pols, R, 1991, *Responses to Drug Problems in Australia*, AGPS, NCADA Monograph, 16.

- HIT, 1996, *Reducing drug related harm in the Mersey region*, HIT, Liverpool;
- Holmes, M & Shand, D., 1995, 'Management Reform: Some Practitioner Perspectives on the Past Ten Years', *Governance*, 8:5.
- Hood, C., 1991, 'A public management for all seasons?', *Public Administration*, 69, 1.
- Horton, S., 1999, 'The Civil Service' in S Horton & D Farnham (eds), *Public Management in Britain*, Macmillan, Basingstoke.
- Howlett, M & Ramesh, M., 1995, *Studying Public Policy: policy cycles and policy subsystems*, Oxford University Press, Ontario.
- Howlett, M., & Ramesh, M., 1995, 'Agenda Setting – Policy Determinants and Policy Windows', *Policy Cycles and Policy Subsystems*, Oxford University Press, Ontario.
- Hughes, O., 1994, *Public Management and Administration*, Macmillan, Great Britain.
- Inciardi, J., & Harrison, L., 2000, 'Introduction: The concept of Harm Reduction', in Inciardi & Harrison (eds), *Harm Reduction: National and International Perspectives*, Sage, California.
- Inciardi, J., & Harrison, L., 2000, 'Introduction: The concept of Harm Reduction', in Inciardi & Harrison (eds), *Harm Reduction: National and International Perspectives*, Sage, California.
- Jenkins-Smith, H & Sabatier, P, 1994, 'Evaluating the Advocacy Coalition Framework', *Journal of Public Policy*, 14:2.
- Joint Select Committee into safe injecting rooms, 1998, *Report on the establishment or trial of safe injecting rooms*, Parliament of New South Wales.
- Jurgens, R., 1996, '*HIV/AIDS in prisons: Final report*', Canadian HIV/AIDS Legal Network and Canadians AIDS Society, Montreal.
- Kellehear, A., & Cvetkovski, S., 1998, 'Grand theories of Drug Use', in M., Hamilton, A., Kellehear & G., Rumbold (eds) *Drug Use in Australia: a harm minimisation approach*, Oxford University Press, Melbourne.
- King, T., 1994, *A Comparative Analysis of Methadone Policy Development in the US, the UK, the Netherlands and Victoria, Australia*, MA Thesis, La Trobe University, Melbourne.
- King, T., 1998, 'The Search for Rationality in Illicit Drug Policy', in M., Hamilton, A., Kellehear & g., Rumbold (Eds), *Drug Use in Australia: a harm minimisation approach*, Oxford University Press, Melbourne, p145-158.
- Kingdon, J., 1984, *Agendas, Alternatives and Public Policies*, Little, Brown and Company, Boston.

Kubler, D., 2001, 'Understanding policy change with the Advocacy Coalition Framework', *Journal of European Public Policy*, Volume 8, No. 4, pp623-641.

Kubler, D., 2001, 'Understanding policy change with the Advocacy Coalition Framework', *Journal of European Public Policy*, 8:4, pp623-641.

Kutin, J., 1998, 'Law Enforcement and Harm Minimisation', in *Drug Use in Australia: A Harm Minimisation Approach*, M., Hamilton (et al., Oxford University Press, Melbourne.

Lang, E., 1998, 'Drugs in Society: A Social History', Hamilton, Kellehear & Rumbold (eds), *Drug Use in Australia: A Harm Minimisation Approach*, Oxford University Press, South Melbourne.

Lenton, S., & Single, E., 1998, 'The definition of harm reduction', *Drug and Alcohol Review*, 17.

Lenton, S., MacDonald, D., Ali, R., & Moore, T., 1999, 'Laws applying to minor cannabis offences in Australia and their evaluation', *International Journal of Drug Policy*, 10:4.

Levy, M., Baum, F., & Thomas, H., 2002, *The Road Not Taken: review of the National Hepatitis C Strategy*, 2002 Reviews of the National HIV/AIDS and Hepatitis C Strategies and Strategic Research, accessed 7/1/04, from Australian Government Department of Health and Ageing website:
[http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-document-metadata-hivhepc_review.htm/\\$FILE/hivhepc_part3.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-document-metadata-hivhepc_review.htm/$FILE/hivhepc_part3.pdf).

Lonie, J., 1979, *A Social History of Drug Control in Australia*, Royal Commission into the Non-Medical Use of Drugs, Research Paper 8, South Australia.

Loxley W., & Davidson P., 1998, *Forgetting to Breathe: opioid overdose and injecting drug users in Perth*, National Centre for Research into the Prevention of Drug Abuse, Perth.

Lurie, P., & Reingold, A., (eds), 1993, *The public health impact of needle exchange programs in the United States and abroad*, University of California Press, Berkley.

MacDonald M., Crofts N., Kaldor J., 1996, 'Transmission of hepatitis C virus: rates, routes and cofactors' *Epidemiology Review*, 18.

MacDonald, M., Wodak, A., Dolan, K., van Beek, I., Cunningham, P., & Kaldor, J., 2000, 'Hepatitis C virus antibody prevalence among injecting drug users at selected needle and syringe programs in Australia, 1995-1997', *MJA*, 172.

MacKellar, M., 1980, *Opening of the First National Conference of the Australian Medical Society on Alcohol and other Drugs Problems*, First National Conference of the Australian Medical Society on Alcohol and other Drugs Problems-Conference Papers.

- Mahoney, P., 2000, 'Illicit Drugs in Australia: an overview', in *Drugs and Democracy*, G., Stokes, P., Chalk & K., Gillen (eds), Melbourne University Press, Carlton South.
- Manderson, D., 1993, *From Mr Sin to Mr Big: a History of Australian Drug Laws*, Oxford University Press, Sydney.
- Marks, R., 1992, 'The costs of Australian drug policy', *The Journal of Drug Issues*, 22 (3).
- McAllister, I., & Makkai, T., 2001, 'The prevalence and characteristics of injecting drug users in Australia', *Drug and Alcohol Review*, 20:1.
- McGregor C., Darke S., Ali R, Christie P., 1998 'Experience of non-fatal overdose among heroin users in Adelaide, Australia' *Addiction* 93:5, pp701-711. *Medicine* 302: pp996-1002.
- Metrebian, N., Shanahan, W., Wells, B & Stimson, G., 1998, 'Feasibility of prescribing injectable heroin and methadone to opiate dependent drug users: associated health gains and harm reductions', *MJA*, 168, pp596-600.
- Ministerial Council on Drug Strategy, 1992, *No Quick Fix*, Commonwealth of Australia.
- Ministerial Council on Drug Strategy, 1998, *National Drug Strategic framework 1998-99 to 2002 – 03*, Commonwealth of Australia, Canberra.
- Ministerial Council on Drug Strategy, 1998, *National Drug Strategic framework 1998-99 to 2002 – 03*, Canberra, Commonwealth of Australia.
- Nadelmann, E., 'Progressive legalizers, progressive prohibitionists and the reduction of drug-related harm', *Psychoactive drugs and harm reduction: from faith to science*, N, Heather, A, Wodak, E, Nadelmann & P, O'Hare (eds), London, Whurr.
- Nadlerman, E., 1993, *Cops Across Borders: The Internationalization of U.S. Criminal Law Enforcement*, The Pennsylvania State University Press, Pennsylvania.
- National Drug and Alcohol Research Centre, 1999, 'Heroin Overdoses Up Over 20%: New Figures Released Today', *Media Release*, Sydney.
- National Health and Medical Research Council and Australian Health Ministers' Advisory Council, 1994, *Hepatitis C: epidemiology, natural history, control and treatment*, AGPS, Canberra
- National Health and Medical Research Council, 1997, *A strategy for the detection and management of hepatitis C in Australia*, AGPS, Canberra, 1997.
- New South Wales Joint Parliamentary Committee Upon Drugs, *Report into Drug Abuses*, Sydney.
- Newman, R., 1987, 'Methadone maintenance: it ain't what it used to be', *British Journal of Addiction*, 71, pp183-186.

Newman, R., 1987, Methadone treatment, *New England Journal of Medicine*, 317, pp447-450.

NSW Drug Summit 1999 – ‘Summit Outcomes, Consideration of Resolutions’, Working Group, Health Maintenance and Treatment Services, Extract from report of proceedings of 20/05/99, accessed online at www.sydneymsic.com/PF/Pfdsummitoutcome1.htm

O’Hare, P., 1992, ‘Preface: A note on the concept of harm reduction’, in P., O’Hare, R., Newcombe, A., Matthews, E., Bunning & E., Drucker (eds), *The reduction of drug related harm*, New York, Routledge.

O’Hare, P., 1992, ‘Preface: A note on the concept of harm reduction’, in P O’Hare, R., Newcombe, A., Matthews, E., Buning & E Drucker (eds), *The reduction of drug related harm*, Routledge, New York.

Osborne, D & Gaebler, T, 1992, *Reinventing Government: How the entrepreneurial Spirit is Transforming the Public Sector*, Addison-Wesley, Reading.

Pal, L., 1992, *Public Policy Analysis: an introduction*, Nelson, Ontario.

Paras, R., 2000, *Medically Supervised Injecting Service: A Primary Health Care Facility*, City of Greater Dandenong.

Peele, S., & Brodsky, A., 1991, *The Truth About Addiction and Recovery*, Simon and Schuster, New York.

Pettingell, J., ‘Harmspeak: The origins of ‘harm reduction’ in Australia”, Winter School in the Sun, accessed from www.adfq.org/pettinge.html, 24/2/2004.

Pollit, C, 2001, ‘Clarifying convergence: Striking similarities and durable differences in public management reform’, *Public Management Review*, 56:2.

Premier’s Drug Advisory Council report, 1996, *Drugs and our Community: Report of the Premier’s Drug Advisory Council (Pennington Report)*, Melbourne.

Rana, S., 1996, ‘Harm reduction in Asia’, *AHRN Newsletter*, 1.

Riley, D., & O’Hare, P., 2000, ‘Harm reduction: History, Definition and Practice’, in Inciardi et al. (eds) *Harm Reduction: National and International Perspectives*, Sage, California.

Riley, D., & O’Scapella, E., 1997, ‘Canada’s new drug law: Some implications for HIV/AIDS prevention in Canada’, *International Journal of Drug Policy*, 7:3.

Riley, D., 1993, *The policy and practice of harm reduction*, CCSA, Ottawa; Riley, D., 1994, *The harm reduction model*, The Harm Reduction Network, Toronto.

Robertson, J., 1990, ‘The Edinburgh epidemic: A case study’, in J. Strang & G. Stimson (eds), *AIDS and drug misuse*, Routledge, London, pp95-107.

- Ronce, C., Coda, P., & Schopfer, R., 1994, *Evaluation der Gassenzimmer I, II und III in Basel*, Institut für Sozial und Präventivmedizin der Universität Basel.
- Sabatier, P., & Jenkins Smith, H., 1999, 'The Advocacy Coalition Framework: An Assessment', *Theories of the Policy Process*, P., Sabatier (Ed), Westview Press, Boulder.
- Sabatier, P., & Jenkins-Smith, H., 1993, *Policy Change and Learning: an Advocacy Coalition Approach*, Westview Press, Colorado.
- Sabatier, P., & Jenkins-Smith, H., 1994, 'Evaluating the Advocacy Coalition Framework', *Journal of Public Policy*, 14:2.
- Sabatier, P., 'The advocacy coalition framework: revisions and relevance for Europe', *Journal of European Public Policy*, 5:1, March.
- Sabatier, P., 1987, 'Knowledge, Policy Oriented Learning, and Policy Change', *Knowledge, Creation, Diffusion, Utilization*, 8:4, June, pp649 – 692.
- Sabatier, P., 1988, 'Knowledge, Policy-Oriented Learning and Policy Change: an advocacy coalition framework', *Knowledge, Creation, Diffusion, Utilisation*, 8:4, June, pp649-692.
- Sabatier, P., 1989, 'An advocacy coalition framework of policy change and the role of policy-oriented learning therein', *Policy Sciences*, 21.
- Sabatier, P., 1998, 'The advocacy coalition framework: revisions and relevance for Europe', *Journal of European Public Policy*, 5:1.
- Sabatier, P., A., & Jenkins-Smith, H., 1994, 'Evaluating the Advocacy Coalition Framework', *Journal of Public Policy*, 14:2, pp175-203.
- Sabatier, P., A., 1988, 'Knowledge, Policy-Oriented Learning and Policy Change: an advocacy coalition framework', *Knowledge, Creation, Diffusion, Utilisation*, 8:4, June.
- Sabatier, P., A., 1989, 'An advocacy coalition framework of policy change and the role of policy-oriented learning therein', *Policy Sciences*, 21, 129-168.
- Sabatier, P., et. al. 1993, *The Advocacy Coalition Framework, Policy Change and Learning*, Westview Press, San Francisco.
- Senate Standing Committee on Social Welfare, 1977, *Drug Problems in Australia: an intoxicated society*, AGPS, Canberra.
- Single, E & Rohl, T., 1997, *The National Drug Strategy: mapping the future*, AGPS, Canberra.
- South Australian Government, 1979, *Royal Commission into the Non-Medical Use of Drugs*.
- South Australian Parliamentary Debates, 1895, 19 December.

Standing Committee on Family and Community Affairs, 2003, *Road to recovery: report on the inquiry into substance abuse in Australian communities*, Commonwealth of Australia, Canberra.

State Government of Victoria, 1996, *Turning the Tide: Victorian Government Response to the Report of the Premier's Drug Advisory Council and Implementation Strategy*, State Government of Victoria, Melbourne.

Stimson, G., 1989, Syringe exchange programs for injecting drug users, *AIDS*, 3, pp253-260; Stimson, G., 1997, *Harm Reduction in practice: How the UK avoided an epidemic of HIV infection in drug injectors*, paper presented at the Eighth International Conference on the Reduction of Drug Related Harm, Paris.

Stimson, G., Alldritt, L & Dolan, K et. al., 1988, *Injecting equipment exchange schemes, Final Report*, Monitoring Research Group, Goldsmiths' College, London. Stone, D., 1988. 'Interests', *Policy, Paradox and Political Reason*, Scott, Foresman and Company, USA.

Strang J., Powis B., Best D., Vingoe L., Griffiths P., Taylor C., Welch, M., Gossop M., 1999, 'Preventing opiate overdose fatalities with take-home naloxone: pre-launch study of possible impact and acceptability' *Addiction* 94:2, pp199-204.

Sutton, A & James, S., 1996, *Evaluation of Australian Drug Anti-Trafficking Law Enforcement*, National Police Research Unit, Adelaide.

Sydney Morning Herald, Editorial, 10/8/2001.

The Australian Government National Drug Strategy website:
<http://www.nationaldrugstrategy.gov.au/councils/mcids.htm>, accessed 15/3/05.

The International Heroin Trials Debates: To Prescribe or not Prescribe: the State of Heroin Trials Around the World, Report from 10th International Conference on the reduction of drug related harm 21-25 March 1999, accessed from <http://cfdp.ca/heroin.htm> on 20/4/2005.

The New South Wales Joint Parliamentary Committee Upon Drugs, 1978, *Report into Drug Abuse 1978*.

The New South Wales Royal Commission into Drug Trafficking 1976 (Woodward Inquiry).

The Royal Commission into Drug Trafficking 1982 (Stewart Inquiry).

The Senate Standing Committee on Drug Trafficking and Drug Abuse 1971 (Marriot report).

The Senate Standing Committee on Social Welfare, 1976, *Drug Problems in Australia: an intoxicated Society*, (Baume Inquiry).

The South Australian Royal Commission into the Non-Medical Use of Drugs 1979 (The Sackville Inquiry).

The Woodward Royal Commission 1980, The Senate Standing Committee on Social Welfare 1981 (Waters Inquiry).

Thompson, J., 'There isn't room for ambiguity', accessed from Aids Action Council website:
http://www.aidsaction.org.au/content/events/reflections/there_isnt_room_for_ambiguity.php, accessed on 2/5/06.

Topp, L., Day, C., & Dehenhardt, L., 2003, 'Changes in patterns of drug injection concurrent with a sustained reduction in the availability of heroin in Australia', *Drug and Alcohol Dependence*, June, 5:70 (3).

Trebach, A., & Inciardi, J., 1993, *Legalize it? Debating American drug policy*, American University Press, Washington DC.

Turning Point website: <http://www.turningpoint.org.au/index.html> accessed 11/3/06.

Uchtenhagen A. Summary of the synthesis report. In: Uchtenhagen A, Gutzwiller F, Dobler-Mikola A, editors, 1997, *Programme for a medical prescription of narcotics: final report of the research representatives*, Institute for Social and Preventive Medicine, University of Zurich, Zurich.

van den Brink, W., Hendricks, V, van ree, J., 1999, 'Medical co-prescription of heroin to chronic, treatment resistant methadone patients in the Netherlands', *Journal of Drug Issues*, Summer, accessed:
http://www.findarticles.com/p/articles/mi_qa3733/is_199907/ai_n8841987/pg_8

van den Hoek, J., van Haastrecht, H., Coutinho, R., 1989, 'Risk reduction among intravenous drug users in Amsterdam under the influence of AIDS', *American Journal of Public Health*, 79, pp1355-1357.

Victoria Police, 1997, 'Needle Exchange Program', section 5.1.6 of the *Operating Procedures, Victoria Police Manual*, Victoria Police, Melbourne.

Warner-Smith M., Lynskey M., Darke S., Hall W., 2000, *Heroin overdose: prevalence, correlates*,

Weatherburn, D., & Lind, B., 1995, *Drug Law Enforcement Policy and Its Impact on the Heroin Market*, New South Wales Bureau of Crime Statistics and Research, Sydney.

Weatherburn, D., & Lind, B., 1997, 'The impact of law enforcement activity on a heroin market', *Addiction*, 92:5, pp557-569.

Website of the Australian Illicit Drug Users League at <http://www.aivl.org.au>.

Wodak, A, & Owens, R., 1996, 'Drug Prohibition a Call for Change', *Frontlines*, University of New South Wales Press, Sydney.

Wodak, A, 1992, 'HIV infection and drug use in Australia', *The Journal of Drug Issues*, 22:3.

Wodak, A., 1997, 'Hepatitis C: waiting for the grim reaper', *MJA*, 166, p283 accessed at <http://www.mja.com.au/public/issues/mar17/wodak/wodak.html> on 28/3/2006.

Wodak, A., 1999, 'That was the Summit that was', posted on www.onlineopinion.com.au, accessed on 16/11/05.

Wodak, A., & Lurie, P., 1997, 'A tale of two countries: Attempts to control HIV among injecting drug users in Australia and the United States', *Journal of Drug Issues*, 27, pp117-134.

Wodak, A., & Moore, T., *Modernising Australia's Drug Policy*, UNSW Press, Sydney

Wodak, A., 1997, 'Public health and politics: the demise of the ACT heroin trial', *MJA*, 167.

Wodak, A., & Saunders, B., 1995, 'Special issue on harm reduction', *Drug and Alcohol Review*, 14.

Wodak, A., 1990, 'AIDS and injecting drug use in Australia: A case control study in policy development and implementation', in J. Strang & G. Stimson (eds) *AIDS and drug misuse*, Routledge, London, pp132-141.

Wodak, A., 1992, 'HIV Infection and injecting drug use in Australia: responding to a crisis', *The Journal of Drug Issues*, 22:3.

Wodak, A., 1995, 'Needle Exchange and Bleach Distribution Programmes: The Australian Experience', *International Journal of Drug Policy*, 6:1.

Wodak, A., 1996, *Harm Reduction works*, Paper presented at the Harm Reduction Satellite to the XIth International Conference on AIDS, Vancouver.

Wodak, A., 1997, 'Injecting nation: achieving control of hepatitis C in Australia', *Drug and Alcohol Review*, 16.

Wodak, A., 1997, 'Public health and politics: the demise of the ACT heroin trial', *MJA*, 167.

Wodak, A., 1997, 'Injecting nation: achieving control of hepatitis C in Australia', *Drug and Alcohol Review*, 16.

Wodak, A., 1999, 'What is this thing called harm reduction?', *International Journal of Drug Policy*, 10, pp169-171.

Wodak, A., 2000, 'Developing More Effective Responses', in *Drugs and Democracy: in search of new directions*, G., Stokes, P., Chalk & K., Gillen (eds), Melbourne University Press, Carlton South.

Wodak, A., 2001, 'Overseas heroin trials point the way ahead', *Sydney Morning Herald*, 10/8.01. Also available at : <http://www.forensics.edu.au/article.php?sid=41>

Wodak, A., Fisher, R., & Crofts, N., 1993, 'An evolving public health crisis: HIV infection among injecting drug users in developing countries', in *Psychoactive Drugs and Harm Reduction: from faith to science*, N., Heather, A., Wodak, E., Nadlemann & P., O'Hare (eds), Whurr, London.

Wodak, A., Symonds, A., & Richman, R., (2003), 'The role of civil disobedience in drug policy reform: how an illegal safe injection room led to a sanctioned medically supervised injecting centre', *Journal of Drug Issues*, 33:3, p609.

Wood, J, 1997, *Royal Commission into the New South Wales Police Service*, The Government of the State of New South Wales, Volume 2.

World Health Organisation, 1982, 'WHO Project on the Development of Strategies and Guidelines for the Prevention of Drug Dependence', *Report of the Advisory Group Meeting*, 20-24 April 1982.

World Health Organisation, 1989, *The uses of methadone in treatment and management of opioid dependence*, World Health Organisation, Geneva.

World Health Organisation, 1990, *The content and structure of methadone treatment programs: A study in six countries*, World Health Organisation, Geneva.

Zook C., and Moore F., 1980 'High-cost users of medical care' *The New England Journal of Medicine*, 302:18, pp996-1002.