Overcoming obstacles to reform?
Making and shaping drug policy in contemporary Portugal and Australia

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ABSTRACT

National drug policy development is essential for effective drug policies, yet the process through which they emerge, the role of evidence and the theoretical basis for drug policy development are poorly understood. The present research adopted a cross-national analytical-descriptive approach to examine drug policy development between 1994 and 2006 in two nations: Portugal and Australia. Through contrasting atypical reforms - namely decriminalisation in Portugal and the Illicit Drug Diversion Initiative (IDDI) in Australia – with the preceding periods of typical reform, it provides a detailed examination of how atypical reforms are proposed, negotiated and adopted. Moreover, it critically analyses the application of three public policy theories – Multiple Streams, Advocacy Coalition and Punctuated Equilibrium – to identify common drivers and processes underpinning the developments.

Through a primarily qualitative approach involving interviews with 42 expert policy makers, supplemented with secondary sources and publicly available evaluations, this research demonstrates that the major drivers of atypical reform are policy advocates and their ability to convert opportunities into pragmatic responses. In Portugal policy entrepreneurs utilised the emergence of a problem opportunity, typified by a public health crisis in Casal Ventoso, to form an alliance between experts and politicians and adopt a paradigmatic change: decriminalisation. Policy entrepreneurs in Australia used the emergence of a highly politicised opportunity to convert what was initially a doctrinal solution of “zero tolerance” into a more humane response: drug diversion.

The research reveals that the process of policy formulation has critical impacts upon the mechanism, implementation and potential outcomes of reform, most notably whether there is evidence-based policy or policy-based evidence. It concludes by identifying practical and theoretical implications for more effective drug policy development, including the need for greater application of the theory of Punctuated Equilibrium. The current research asserts that policy makers must have realistic expectations over the role of evidence in policy making, but that the likelihood of pragmatic reform may be enhanced through expanding attention from “what works” to include alternative tools of persuasion. It further recommends that greater attention to the latter may increase the likelihood of effective reform. Due to the formation of an alliance between politicians and experts the Portuguese policy making process facilitated a more pragmatic reform. However, a paradigmatic change – and hence the potential for effective drug policy – would not have been possible without advocacy for a new vision of the drug user as a citizen.
DECLARATION

This is to certify that

1) the thesis comprises my own original work towards the PhD
2) due acknowledgement has been made in the text to all other material used
3) the thesis is less than 100,000 words in length, exclusive of tables, figures, references and appendices

Signed: _________________________________             Date: __________________

Caitlin Elizabeth Hughes
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From the streets of Lisbon – the picture perfect skies, meandering alleyways, corner stores with fresh cheese and red wine, and the constant but somber chatter originating from the life and soul, the cafes, restaurants and bars, of Portugal – this thesis has taken a long and winding journey. Never again will I assume that Melbourne has the best coffee. I salute the goulão and the delectable Pastel de Nata. Never again will I drink Port without thinking of the Douro and Porto, and nor strangely enough will I ever think of Portugal without also thinking of laundry. White sheets against red roofs, tiled and medieval façades made for a poignant and lingering vision.

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### Portugal

- CATs: Centres for Drug Treatment
- CDTs: Commissions for the Dissuasion of Drug Addiction
- CNDS: Commission for the National Drug Strategy
- ENLCD: National Strategy in the Fight Against Drugs
- EMCDDA: European Monitoring Centre for Drugs and Drug Addiction
- GNR: National Republican Guard
- GPCCD: Drug Fighting Coordination and Planning Office
- INA: National Institute of Administration
- IDT: Institute for Drugs and Drug Addiction
- IPDT: Portuguese Institute for Drugs and Drug Addiction
- PCP: Portuguese Communist Party
- PJ: Criminal Police
- PS: Socialist Party
- PSD: Social Democratic Party
- SPTT: Service for the Prevention of Drug Addiction

### Australia

- ADCA: Alcohol and Other Drugs Council of Australia
- ANCD: Australian National Council on Drugs
- COAG: Council Of Australian Governments
- HOI: Health Outcomes International
- IDDI: Illicit Drug Diversion Initiative
- MCDS: Ministerial Council on Drug Strategy
- NCADA: National Campaign Against Drug Abuse
- NDSF: National Drug Strategic Framework
CHAPTER ONE: INTRODUCTION

We are tired of imposing penalties with the same result. We have a history of prohibition and for what? Drugs, drug addicts, drug-related crime; it is necessary to change, to experiment.

Professor Poiares - Portuguese academic - [6]

The 2006 World Drug Report claims that “drug control is working and the world drug problem is being contained” (Antonio Maria Costa as cited in United Nations Office on Drugs and Crime 2006, p. 1). Yet many including the International Drug Policy Consortium (2006) dispute such a claim and see this assertion as based upon ideology rather than evidence of effective drug policy. Assertions that the “war is won”, or that effective policies have been achieved, appear questionable at best given the immensurable harms associated with illicit drug use and trafficking. Yet despite the need for more effective drug policies, researchers bemoan the dearth of political support for evidence-based reforms. Given the knowledge that “what works” will not alone overcome ideological and moral support for drug control and the “war on drugs” approach, there is a clear need to understand how nations obtain more effective drug policies.

On 30 November 2000, Portugal undertook what many perceived to be a radical new experiment, when it decriminalised by law the acquisition, possession and use of all illicit drugs. In so doing it opened the frontiers to a new approach: treating drug use as a health and social issue, not a crime. Opponents of the reform suggested that Portugal would become a “drug paradise”, a haven for British tourists. As Paulo Portas, the leader of the Populist Party, famously said “we promise sun, beaches and any drug you like” (Tremlett 2001, p. 20). Supporters of decriminalisation countered, that Portuguese society not only deserved but also, needed drug policy reform. As

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1 Translation of one of the key informants: “Estamos fartos de impor penalidades sempre com o mesmo resultado. Temos uma história da proibição e para quê? Drogas, viciados em drogas, crimes relacionados com as drogas. É necessário mudar, experimentar.” See Chapter Three for details of study.

2 It should be noted that this made Portugal one of the few nations in the world to have introduced de jure decriminalisation for use, possession and acquisition. Italy and Spain introduced similar legislation in 1990 and 1992 respectively, however drug users are still sanctioned (in the form of administrative penalties) through criminal justice courts. The Portuguese approach in contrast explicitly separates the drug user from the criminal justice system. See Van Het Loo, M, Van Beusekom, I & Kahan, J 2002, 'Decriminalization of drug use in Portugal: The development of a policy', The Annals of the American Academy of Political and Social Science, vol. 582, no. July, pp. 49-63.
Portuguese academic Professor Poiares contended above, the futility of drug prohibition gave rise to courage and the will to experiment.

The Portuguese decriminalisation appears to be a rational response to increasing drug use, addiction and drug-related crime. However, like many public policies, drug policy is an arena where rationality rarely drives reform. So why were the Portuguese Government not only willing to change their drug policy, but to adopt a radical reform – decriminalisation – that appears significantly at odds with their strong Catholic heritage? Moreover, what role did international, ideological and political pressures play in this development? The present thesis contends that examination of drug policy reform, such as the Portuguese decriminalisation, offers potential insight into a number of unresolved issues concerning national drug policy development, namely: why and how do nations adopt reforms? How, in short, do nations produce more effective drug policy?

The constraints on reform

The history of international and national drug policy is often painted as a picture of gloom (for example Manderson 1993). The United Nations Conventions on Narcotic Drugs demand the criminalisation of drug users. Opportunities for major reform appear to be scant. Moreover proposals for evidence-based or harm reduction initiatives often fail to be adopted. Consequently, as Danilo Ballotta sums up, drug policy is often deemed to be immutable:

Drug policy as other policy, it started in the beginning of last century, people do not know anymore why drugs aren’t free. They know they are banned. Drugs are banned, we should fight drugs, we should fight heroin, we should fight all these things and because we are told to do so and because certain powers go in this direction, even if evidence would show that another system would be more economic, more socially reliable, better for us, drug use is a continuing sin. It is a sin and we live in a society with the control of the Government, independent of the Government, the control of public and individual liberty is stronger.


International and political pressures and the continued dominance of the law enforcement and prohibitionist response have given rise to increasing pessimism about the potential for effective drug policy, due to both the limited opportunities for

³ Key informant from the current research.
reform, and the belief that prohibition has and will continue to fail (Bertram, Blachman, Sharpe & Andreas 1996; Brereton 2000; Wodak 1993).

The infamous “war on drugs”

The United States (US) has often been cited as evidence of the failure of prohibition. It has earned an infamous reputation for its “war on drugs” and insistence upon a drug-free society. While it is by no means the only nation to hold such an objective – one in contrast to the more moderate objective of harm reduction – it has been associated with extreme consequences. Characterised by its punitiveness, intrusiveness and expense of $35 billion per year, and by its extreme levels of drug-related crime, violence and HIV/AIDS, the US has the biggest drug problem in the Western world (Boyum & Reuter 2005; Kleiman 1992; MacCoun & Reuter 2001; Nadelmann 1989; Sharp 1994). Moreover, it has disproportionately targeted racial and ethnic minorities contributing to family break ups, joblessness, restrictions upon access to student and financial aid, disenfranchisement and deportation (Jensen, Gerber & Mosher 2004). But can these consequences be attributed to the failure of prohibition? This issue is far from resolved.

While the failure or success of prohibition remains subject to heated debate and research, researchers have increasingly demonstrated that US drug policy making is problematic. In particular, it is the resistance to reforming drug policy that is facilitating a war on drug users (Reuter 1997; Sharp 1994). Resistance to learn and to adapt dooms the “war on drugs.” As summed up by the National Research Council’s report on US drug policy, US opposition to evidence-based practice, particularly towards the assessment of current policies, is legendary: “It is unconscionable for this country to continue to carry out a public policy of this magnitude and cost without any way of knowing whether and to what extent it is having the desired effect” (Manski, Pepper & Petrie 2001, p. 11). US drug policy is unlikely to improve without addressing the resistance to reform.

Opposition to reform has a second and somewhat forgotten impact. Caulkins, Reuter, Iguchi and Chiesa (2005, p. 30) have identified that short-term policy making as characterised by US drug policy has “fostered inattentiveness to the future.” They point out that negative outcomes are often not due to policies per se, but to cultural and societal trends. Globalisation is one factor that has had a considerable impact upon the
expansion of the drug market and may be expected to continue. Other factors, including decreased price of ecstasy and the manufacture of novel substances may contribute to new epidemics of drug use. Thus, nations that fail to examine and adapt to future trends risk considerable harms – health, social and economic – to drug users and broader society.

**Effective drug policy**

Drug policy development is therefore essential for effective policies, to enable adaptation to past deficiencies and changing circumstances. Yet the challenge remains to obtain evidence-based policy in spite of international, political and ideological constraints. Nowhere is this more evident than in the 2006 World Drug Report and the express opposition by Antonio Maria Costa to nations that have experimented with non-traditional criminal justice responses, approaches which were deemed to have *lessened* the international efforts towards effective drug policy. He concluded that “…each society faces the drug problem it deserves” (United Nations Office on Drugs and Crime 2006, p. 2).

Statements such as these have sparked fierce opposition and a call for drug policies and judgements of their effectiveness to be based on evidence, not ideology. As noted by The Beckley Foundation (Trace, Roberts & Klein 2004, p. 2) there is a need for an “open consideration of options informed by the best available evidence from across the world.” Yet while there have been increasing calls to adhere to the evidence, to change policies that are proven not to work, and to try policies that are proven or suggested to work, it remains unclear as to what extent this will have a practical impact upon policy making. Moreover, it is unclear what role evidence *can* and *should* play in the policy making process. To what extent can policy makers expect to obtain reform through the demonstration of “what works”?

There is some evidence that research may be contributing towards more pragmatic reforms. Evidence of the counter-productive impacts from the traditional criminal justice response has long been accumulated. More evidence-based and pragmatic responses to drug users have arisen in a significant number of nations. This trend is exemplified in Europe, where discontinuance of arrest and prosecution for drug use and possession (EMCDDA 2002a) and, more recently, a preference for treatment over punishment of drug users, have become the norm (EMCDDA 2005b). Similar patterns
have been noted outside of Europe, particularly in Australia through the expansion of drug diversion programs, and in the United States with US drug courts and Proposition 36 in California (Bull 2003; Riley, Ebener, Chiesa, Turner & Ringel 2000). Yet, such a trend is by no means worldwide, which begs the question as to what role evidence is playing in this trend, and what other factors are shaping whether or not pragmatic reforms emerge.

**Theoretical framework**

In spite of the clear need for more effective policies and the push for more evidence-based policies, the process through which national drug policy is formulated and enacted – particularly how evidence-influenced reforms get adopted – remains unclear. Drug policy researchers have tended to shy away from examination of the process of drug policy development (McDonald, Bammer & Breen 2005). Due to the lack of a clear theoretical framework, drug policy theorists have started to apply public policy theories. Considerable questions remain as to the resonance of such theories, and in particular whether a common theoretical framework can be applied to this arena. There is now a need for an analytical approach to investigate how and why drug policies develop.

The emergence of the Portuguese decriminalisation as part of a broader international trend suggests that opportunities for pragmatic reforms may have increased. It is not yet known whether common drivers and processes underlie such reforms, nor is it known whether some processes are more effective and offer greater opportunity to improve drug policy. Public policy theorists suggest that some processes are more effective, that different modes of development may encourage more or less consideration of evidence and more or less adaptive reforms. Moreover, they contend that the potential outcomes from reform are shaped by the process of reform.

Critically, public policy theorists contend that opportunities for major reform – atypical reform such as the Portuguese decriminalisation – offer significant benefits, including the potential for dramatic shifts in attitudes, practices and paradigms (Howlett & Ramesh 2003; True, James, Jones & Baumgartner 1999). Atypical drug policy reform thus offers the potential to increase the effectiveness of drug policy: to reduce drug use, crime, drug-related harm and cost. To test this contention and its
applicability to drug policy development, it is necessary to contrast how the process impacts upon the framing and outcomes of reform.

**Need for a cross-national approach**

To compare and contrast the process and impacts of drug policy making a cross-national methodology is required. The present thesis therefore examines the reform from Portugal but also an apparently analogous reform that occurred in Australia; the Illicit Drug Diversion Initiative (IDDI). The IDDI was similarly introduced with the purpose of diverting minor drug users from the criminal justice system to education and treatment. These two countries were selected because the reforms appear analogous and occurred at around the same time: decriminalisation was adopted in 1999 and the IDDI in 2000. More importantly, the reforms have quite different mechanisms, most notably that drug use remains a crime in Australia, but not in Portugal. These reforms thus provide the opportunity to compare and contrast how different reforms emerge.

Moreover, these reforms were selected since they offer insight into how harm minimisation proposals – proposals that seek to reduce harm without necessarily reducing use – are advocated, adopted and put into practice. These reforms have a personal interest to the researcher since I adhere to the strong tradition of harm minimisation in Australian drug policy. Harm minimisation does not imply an ideological position on drug law reform, but does favour policy making through evidence rather than ideology (Blewett 2006). Given the abundant literature demonstrating that criminal justice sanctions often cause more harm than good to drug users, I have been persuaded that diversionary policies are likely to be a positive step. I therefore have a commitment to seeing whether these reforms can and do make a difference. That said, this thesis is not an examination of the merits of the reforms, or indeed of harm minimisation. It is instead an examination of *how* nations respond to the evidence-base and undertake pragmatic drug policy reform.

**Research questions**

The thesis builds upon the deficiencies in our current theoretical knowledge on the process of drug policy development. Through examination of the analogous atypical drug policy reforms of decriminalisation in Portugal and the Illicit Drug Diversion
Initiative in Australia, this research explores how effective drug policy reforms emerge. This exploration is guided by the following four questions:

1. What are the primary drivers of national drug policy development?
2. How and why does atypical drug policy reform occur?
3. How does policy formulation influence the mechanism and implementation of atypical reform?
4. How adequate are contemporary theoretical frameworks for explaining the process of national drug policy development?

The thesis uses a cross-national methodology to examine the process of drug policy development between 1994-1995 and 2004-2005 in Portugal and Australia. Such a period of study enables examination of not only the development of the atypical reforms (1999-2000), but also the periods preceding the reforms, periods of so-called incremental reform. Semi-structured interviews with expert policy makers are supported with research and publicly available statistics and evaluations of the atypical reforms.

The current study serves to provide a sustained scholarly analysis of the development of the phenomena of decriminalisation and the Illicit Drug Diversion Initiative. Through unravelling the stories of experienced policy makers, it seeks to provide rich insight into the process of drug policy making: advocacy, negotiation and compromise. In so doing, it illuminates how and why policy choices emerged, were considered and selected, and the implications for the adopted reforms.

At the same time, this thesis fulfils a broader purpose of advancing the theoretical and practical understanding of national drug policy development. Given the absence of a clear consensual theoretical framework of drug policy development, this research scrutinises the applicability and relevance of three public policy theories. The current research endeavours to move beyond criticism of the irrationality of policy making towards a more advanced understanding of the process.

Finally, this research serves to delve into the process of drug policy formulation and illuminate the implications of similarities and differences for the framing, mechanism and implementation of reforms. This provides the first steps to see whether there are more effective means of policy making and hence whether policy advocates can
increase control over policy making, over the role and input of evidence and, most importantly, the outcomes from reform. Societal demands for more effective drug policy will go unheeded without first understanding the process of drug policy development. The present research goes some way to assisting this endeavour.

**Structure of thesis**

Chapter Two situates the thesis in the current state of knowledge. It outlines the three public policy theories that are used to analyse the incremental and atypical developments and suggests foci for the subsequent research. It critically examines the strengths and limitations of the existing application of the public policy theories to drug policy development. Findings from existing drug policy research are highlighted, namely the drivers of incremental and atypical development and conflicts and deficiencies in this knowledge. The final section outlines the national contexts of the two case studies and the drug policy trends and drivers.

Chapter Three describes the development of an appropriate research design for exploring the process of national drug policy development. It overviews the approaches and methodologies of existing cross-national drug policy research, and justifies the approach taken in the current thesis; a qualitative descriptive-analytical approach. Chapter Three examines the methodological, conceptual and logistical challenges in conducting the current cross-national research. It identifies the chosen data sources, methods and analytical procedures, and concludes by reflecting upon the problems and limitations of the research design.

Chapters Four and Five highlight findings from Portugal and Australia. They demonstrate the key characteristics that have influenced the national drug policies, followed by the process of both incremental and atypical reform. These chapters focus upon the adoption of the atypical reforms and weave together the expert stories to demonstrate the evolution, negotiation and adoption of decriminalisation and the IDDI. The chapters conclude by examining the mechanism and framing, and how the policy making process influenced the shape of the reforms.

Chapter Six draws together the statistical and qualitative impressions of the atypical reforms to date. It uses national trends in drug use and crime between 1996-1997 and 2004-2005 and evaluations of the atypical reforms to examine the outcomes to date.
Chapter Six concludes by identifying strengths and weaknesses in implementation, particularly, the roles of evidence and politics in such a process.

Chapter Seven examines the development of the atypical reforms through the lens of the theoretical frameworks and identifies strengths and weaknesses, and hence the resonance of the theories to the study of drug policy development. Chapter Eight assesses the major findings from this research and critiques the policy making process in Portugal and Australia. It suggests theoretical and practical implications for understanding and promoting drug policy reform. Finally, Chapter Nine identifies the primary conclusions from the research, reconstructs the process by which these were obtained and draws implications for the promotion of more effective drug policy.
CHAPTER TWO: LITERATURE REVIEW

Chapter One overviewed the context of the research, and highlighted a quandary, namely that while researchers frequently bemoan the lack of opportunities for evidence-based policy making, the increase in diversionary and pragmatic responses appears counter to this trend. Moreover, while it highlighted the necessity of policy development, it identified limited attention to how drug policy develops. The following chapter situates the questions highlighted in Chapter One in the current state of knowledge. The review of the literature is presented in five parts:

1. Theoretical frameworks of policy development
2. Common influences upon drug policy development
3. Drug policy development: Continuity and change
4. Drug policy in Portugal and Australia
5. Conclusions and tensions created

The first section of the literature review outlines the theoretical framework for the current research. It draws upon the public policy literature to highlight the meaning and significance of “atypical” periods of policy development and outlines the three public policy theories that are used as the basis of this study: Multiple Streams; Advocacy Coalition; and Punctuated Equilibrium. The second section of the literature review identifies key factors from national and cross-national research that are argued to facilitate or constrain opportunities for national drug policy development. Key contests in this knowledge are discussed and explored through in-depth studies of atypical reforms.

The third section examines reasons for incremental and atypical reform. It further examines the recent applications of the public policy theories to understanding drug policy development. It identifies the resonance of these theories to the drug policy reforms, but also unresolved issues and gaps in the theoretical understanding of the process of development. The fourth section overviews key characteristics of the two case studies: Portugal and Australia. This includes recent developments in national drug policy and legislation and contests over the process, rationale and impacts of the
atypical reforms. The final section concludes by identifying a number of unresolved tensions that this research seeks to explore.

**Theoretical frameworks of policy development**

*What is drug policy?*

Prior to examining drug policy development it is necessary to clarify the meaning of “policy,” a somewhat elusive term which has been construed in a variety of ways. At a basic level, policy or more specifically drug policy can be understood to mean an objective or strategy, and thus a statement of government intention. This is reflected in the definition used by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), which describes drug policy as the “the overall philosophy, principles, actors, actions and initiatives of the government in the field of drugs” (EMCDDA 2002d, p. 12). This definition is commonly used in cross-national comparisons of drug policy where countries are distinguished on the basis of their objectives (EMCDDA 2002d; MacCoun & Reuter 2001; Wardlaw 1992b). The most common distinction is between countries which aim for abstinence or drug-free societies (such as Finland and Sweden) and those that aim for harm reduction or to reduce drug-related risks and harms (such as Belgium and Ireland). While this definition is useful to compare policies, and particularly for examining the impacts of policy differences, it is less useful for examining the process of policy development.

A more “dynamic” definition views policy as a *process* of responding to a given issue. As asserted by Lin (2003, p. 5) policy can be viewed as a “web of decisions.” Policy ideas and proposals are not static, but rather evolve through the process of development, particularly through negotiation and compromise. Accordingly, the process by which a problem is conceptualised, placed on the government agenda and negotiated is integral to the resulting initiative or strategy. This is an important distinction for the public policy theories and for the current research. The current research therefore adopts this definition; that policy proposals and solutions evolve through the process of development. It is therefore important to examine how the process impacts upon the framing and resulting strategies that are put into practice.

*Incremental and atypical reform*

Public policy theories distinguish between incremental and atypical reform. Incremental reform is the norm, subject to minor adjustments and path dependency,
whereby past policies and choices become self-reinforcing and constrain future directions (Hayes 1992; Sabatier 1999). In contrast, atypical reforms are infrequent but potentially significant changes which represent a challenge to past beliefs, assumptions or dominant images. The significance of such periods of reform is their potential to create new understandings of old problems and/or introduce new institutions, resources and practices (Baumgartner & Jones 1993). Moreover they may give rise to paradigmatic shifts – what Kuhn (1970) termed major shifts in epistemology and beliefs – something that may result in a dramatic and radical break from the status quo. Atypical reform therefore brings considerable opportunity to not only adapt the system, but to create new legacies that resonate for decades to come.

Despite the recognition that policies are driven by both incremental and atypical reform, there are limited theories that seek to explain both processes. Three notable exceptions include the theories of Multiple Streams (Kingdon 1995), Advocacy Coalition (Sabatier & Jenkins-Smith 1999) and Punctuated Equilibrium (Baumgartner & Jones 1993). These theories illuminate the differences between incremental and atypical reform and help elucidate the determinants, process and likely impacts of atypical change.

While all three theories have been utilised in studies of drug policy development; there has been considerable variation in their application. To date, Multiple Streams has been the theory of greatest application to drug policy reform. In particular it has been utilised to study licit and illicit national drug policy development in Australia (Gunaratnam 2005; Lenton 2004), USA (DiChiara & Galliher 1994; Greenfield, Johnson & Giesbrecht 2004; Sharp 1994) and the UK (Greenaway 2003a). The Advocacy Coalition has been employed in Switzerland (Kübler 2001) and Australia (Fitzgerald & Sowards 2003) and Punctuated Equilibrium has been applied in the UK (Greenaway 2003a) and Scotland (Cairney 2005). While these studies have demonstrated that the public policy theories resonate with drug policy reforms, some theories appear to show greater consistency, as is highlighted later in this chapter. The present thesis is the first to apply the three theories to cross-national drug policy developments. The following section overviews the primary contentions of the three theories.
**Multiple Streams**

Political scientist John Kingdon (1995) developed the theory of “Multiple Streams” to explain the observation that only limited issues register on the policy agenda and result in policy development. His basic premise was that there are three “streams” of policy development which operate relatively independently: problems (nature, size and visibility of a problem), policies (policy proposals generated by policy communities) and politics (elections, changes in political leadership or interest group pressure). Each stream has the potential to serve as an impetus or a constraint for policy change, however the likelihood of atypical change is considerably enhanced by the coupling of the three streams to produce “policy windows” (Kingdon 1995, p. 20).

From this perspective, the mere existence of a drug problem is unlikely to provoke change unless the problem is recognised, the political climate is receptive, constraints are minimal and a policy proposal or solution is available. This theory suggests that incremental reform will be the norm since policy windows are rare. Despite this, Kingdon (1995, p. 175) argues that “the major changes in public policy result from the appearance of these opportunities.”

From the perspective of Multiple Streams, policy actors and communities play a key role in devising ideas and new policy proposals. Moreover, this theory builds upon the Garbage Can Model of Cohen, March and Olsen (1972) and contends that proposals and solutions will not be devised in a rational manner. Kingdon’s theory (1995) emphasises the need for policy actors to pre-develop proposals, test or “soften up” other members of the policy community, and wait for the right climate – policy windows – in which to put forward their proposals. This theory asserts that many policy actors will vie to get their proposals adopted, but the most successful proposals will fit with broader community values, have proven technical feasibility and obtain at least some support from the policy community. Moreover, Kingdon (1995) contends that many solutions will be forgotten, due to the lack of an opportune time or missed opportunities. To capitalise upon emerging opportunities requires the presence of policy entrepreneurs to link the three streams and attach and re-frame the policy proposal to fit emerging circumstances:

Without the presence of an entrepreneur, the linking of the streams may not take place. Good ideas lie fallow for lack of an advocate. Problems are unsolved for lack of a solution. Political events are not capitalized for lack of inventive and developed proposals (Kingdon 1995, p. 191).
This theory suggests that for atypical reform to occur, policy communities, and in particular policy entrepreneurs, must be ready and willing to capitalise upon opportunities. Like a surfer “entrepreneurs are ready to paddle, and their readiness combined with their sense for riding the wave and using the forces beyond their control contributes to success” (Kingdon 1995, p. 190). Chance, but also expertise, personal connections and persistence are therefore necessary to obtain reform.

According to the theory of Multiple Streams windows of opportunity can be created in two manners, the choice of which is likely to shape the policy proposal that is adopted. A particularly problematic and visible problem can give rise to a problem window or a “politically propitious event,” for example a change in government may give rise to a political window (Kingdon 1995, p. 174). Zahariadis (1999) has amended Kingdon’s theory to argue that consequential solutions – finding a solution to fit a problem – are more likely through problem windows, but that doctrinal solutions – finding a problem to fit the proposed solution – are more likely through political windows. Further, the brevity of windows encourages compromise and negotiation. Thus, Multiple Streams suggests that policy making is about capitalising upon opportunities and finding an available solution, rather than the “best” solution. Since policy formulation will be shaped by the instigator of the reform and hence by problems or the politically propitious events, this suggests that politically led openings will reduce the potential role of research.

**Advocacy Coalition Framework**

The Advocacy Coalition Framework of Sabatier and Jenkins-Smith (1999, p. 120) focuses on the actions of policy communities and in particular how groups within the policy communities, so-called “advocacy coalitions,” operate on the basis of shared values and beliefs. From this perspective, policy communities operate through one to four coalitions. Coalitions merge individuals from different institutions including the education and criminal justice sectors, health professionals and media. They are held together through three sets of values and beliefs: deep core beliefs (ontological beliefs) on how the world is viewed; policy core beliefs, which include beliefs on the seriousness and cause of problems; and secondary beliefs on desirable practices used to achieve policy core beliefs. Sabatier and Jenkins-Smith (1999) assert that institutional differences and roles are largely set aside due to the presence of common
values. This means that policy coalitions tend to advocate in a cohesive manner, as a single coalition, for policies and practices that suit their policy core.

According to Advocacy Coalition common policy core beliefs make policy coalitions resistant to change. Moreover, the dominance of particular policy coalitions and their ideological biases means incremental change is the norm. Therefore, Sabatier and Jenkins-Smith (1999) contend most reform will be minor. This theory contends that policy learning may facilitate change to dominant coalitions, particularly through the use of professional forums placing coalitions together. However, policy learning will generally give rise to shifts in practices, not to core beliefs. Major reform will require a shift to the core beliefs and/or a shift in the dominant coalition.

In rare opportunities of major upheaval the dominant coalition may be challenged resulting in paradigmatic change and shifts in practices. Atypical reform, from the perspective of Advocacy Coalition, requires years or decades of policy learning. Moreover it requires the occurrence of a non-controllable disruption or a “significant perturbation” to the policy community (Sabatier & Jenkins-Smith 1999, p. 124). The presence of an election or major socioeconomic change may dramatically alter personnel, and thus enable challenge to the dominance of the leading policy coalition, and introduction of policies reflecting the beliefs and policies of the new coalition. As shown by Kübler (2001) the AIDS/HIV crisis in Switzerland acted as a significant disruption that enabled challenge to and succession of the abstinence coalition. This theory therefore takes a different perspective to Multiple Streams since it contends that major reform will tend to take years to develop and occur not through the coupling of streams, but through challenge to and paradigmatic shifts in beliefs. Moreover, it is dependent upon the rare opportunities and non-controllable changes to enhance the influence of minority coalitions and hence change policy directions.

**Punctuated Equilibrium**

Baumgartner and Jones’ (1993) theory of Punctuated Equilibrium, focuses on three causes of incremental and atypical reform: policy images, policy venues and mobilisation. Incremental reform is attributed to closed venues of policy making and dominant images. The expert, closed policy communities through which policy making is conducted restrict input into policy making. Moreover, Punctuated Equilibrium contends that policy communities operate under dominant policy images.
A key difference between this theory and Advocacy Coalition is that dominant images are viewed as tools to aid policy making and facilitate monopolies within the policy community:

Policy images are a mixture of empirical information and emotive appeals. Such images are, in effect, information – grist for the policymaking process (True, James, Jones & Baumgartner forthcoming).

Baumgartner and Jones (1993) contend that while multiple images may be promoted at once, the use of policy communities decreases chances through which to challenge dominant images. Under normal circumstances information that conflicts with the dominant policy images is likely to be counter-mobilised. Therefore, Punctuated Equilibrium contends that the closed venues and dominant images facilitate the maintenance of a policy monopoly and *ipso facto* incremental reform.

The theory asserts that atypical reform may be undertaken through strategic advocacy. Punctuated Equilibrium contends that as consensus with the dominant policy image declines policy advocates can re-define and promote new images (True, James, Jones & Baumgartner 1999). The re-definition of images can attract new ways of looking at problems, draw attention to new ideas and be used to mobilise support for change.

The use of alternate policy venues, which Baumgartner and Jones (1993, p. 32) define as “institutional locations where authoritative decisions are made concerning a given issue” are particularly effective in this context. Further, this theory asserts that the promotion of images that draw upon professional expertise – expert images – may facilitate the role of evidence in policy formulation. This suggests that the promotion of drug use as a health problem may facilitate expert input into policy formulation and hence a more pragmatic response.

From this perspective, new images and venues facilitate the mobilisation of support, something which can be undertaken through public or strategic mobilisation. Both forms of mobilisation build upon the work of Cobb, Ross and Ross (1976). The first method of mobilising support is termed mass mobilisation and involves the successive broadening of advocacy to mobilise larger and larger groups, from specialists to eventually include the public. This can produce a heightened enthusiasm for reform, something which Baumgartner and Jones (1993, pp. 88-9) termed a “Downsian mobilization” after Anthony Downs (1972). Alternatively, mobilisation may result in a wave of criticism called a “Schattschneider mobilization” after Elmer Schattschneider (1960). This theory contends that the former is more likely to
encourage government to tackle a problem, but the latter is more likely to break up existing governance arrangements and responses.

The second method of mobilising support is through strategic venue shifting. This strategy uses “venue shopping by strategically minded political actors” and mobilisation of key sectors (Baumgartner & Jones 1993, p. 36). Through re-framing an image to suit a new venue, reforms can be undertaken through more private means. Due to the emphasis upon new venues, this theory suggests that nations with diverse structural arrangements may facilitate opportunities for venue shifting. That said, the ability to successfully venue shift, is likely to necessitate the presence of external factors such as heightened media attention, to provide positive feedback and facilitate political receptivity to the proposed reform. Moreover, it will be dependent upon careful design of an image and access to a receptive venue (Pralle 2003). For Punctuated Equilibrium the type of images, venues and mobilisation will influence policy formulation and outcomes from reform. Strategic advocacy can therefore be utilised to facilitate opportunities for and shape outcomes from atypical reform.

In summary, the theories of Multiple Streams, Advocacy Coalition and Punctuated Equilibrium suggest national drug policy development will primarily be incremental and based upon previous policies. Incremental reform will be the norm due to closed governance arrangements, dominant beliefs, values or images and inopportune timing. In periods of atypical change there will be opportunities for new or alternate policy actors to draw attention to different solutions. The three theories stress the importance of policy learning and the benefits of opportune times for reform.

However, the public policy theories place different emphases upon the drivers of atypical reform, the process of policy formulation and the outcomes from reform. Multiple Streams suggests that atypical reform will result from an accumulation of events, which may involve a problem or political change. It will also necessitate the presence of policy entrepreneurs. Advocacy Coalition suggests that atypical reform will necessitate a non-controllable event such as a political election, followed by challenges and shifts to the dominance of policy coalitions. Finally, Punctuated Equilibrium suggests that atypical reform will be dependent upon strategic advocacy of a new policy image.
The three theories also emphasise differences in the expected impacts of policy formulation. Kingdon’s (1995) theory suggests the outcomes from reform will depend partly upon the opening of the policy window – problem or political opening – and how entrepreneurs re-fashion policy proposals. In contrast, Sabatier and Jenkins-Smith (1999) contend that the mechanism of reform will by guided by the new core values. Policy formulation and the resulting reform for Baumgartner and Jones (1993) will depend upon the type of image, venue and mobilisation utilised. The key differences between the theories serve as foci for the current research.

**Common influences upon drug policy development**

National and cross-national studies of drug policy development highlight a number of common influences upon drug policy development. The main influences outlined below are crises, policy actors, political factors, research, international factors and other national factors. While this suggests common factors may drive drug policy, there is considerable conflict concerning how and to what degree each factor influences policy development. By compiling the current trends, this section seeks to highlight what is known and what is contested, and therefore provide the basis through which to explore the policy making process.

**Crises**

Crises may have multiple impacts upon drug policy development. Increases in the size or visibility of the drug problem increase the potential for agenda setting and for evidence-based responses. The emergence of the HIV/AIDS epidemic has been deemed one of the leading drivers of evidence-based drug policy (MacCoun & Reuter 2001). It facilitated changes in the framing of drug users, from seeing drug use as a criminal to a public health issue and the expansion of harm reduction approaches to drug users particularly within Europe. Similarly, the AIDS epidemic spurred the swift introduction of Needle Syringe Programs in Australia in 1987 (Health Outcomes International Pty Ltd 2002). In spite of opposition to the philosophy of harm reduction, the AIDS epidemic continues to facilitate harm reduction practices in Asia (Crofts 2006). Thus, the emergence of AIDS facilitated the re-framing of the drug problem as a health problem.
While research suggests crises may facilitate more evidence-based approaches, numerous studies have demonstrated that drug problems may be ignored. Despite increased rates of HIV/AIDS, US opposition to needle syringe programs has been longstanding (Lurie & Drucker 1997). In 2002 fifty states had paraphernalia laws: 14 for syringe prescription; 11 requiring proof of ID; and needle syringe exchange had only been depenalised and hence authorized by state law in 11 states (Burris, Vernick, Ditzler & Strathdee 2002). While the first international review proving the effectiveness of needle syringe programs (Wodak & Cooney 2004) has recently led to the lifting of the US ban on funding NSP research, bans remain on federal funding for needle syringe programs (Sherman 2006; Wodak 2006). Obtaining harm reduction measures continues therefore to prove difficult in spite of the HIV/AIDS crisis.

Further, research also indicates that the recognition of drug problems may give rise to evidence-based responses but may equally lead to more punitive, doctrinal or dogmatic responses. In June 1986 the cocaine-related death of United States basketballer Len Bias prompted widespread media attention and public concern over the “crack epidemic” (Sharp 1994). Four months later President Reagan introduced new mandatory minimum penalties including five years imprisonment for possession of five grams of crack and the death penalty for trafficking of crack (Sharp 1994). The national crusade against drugs and drug users continues to the present day (Caulkins et al. 2005). Clearly therefore, crises may influence the likelihood of drug policy reform, but they will not necessarily lead to more evidence-based responses.

Other research has illustrated that the type of crisis has critical impacts upon how the problem is responded to. In particular, the nature of drug use and characteristics of drug users have often influenced the framing of problems and adopted solutions. The Australian Institute of Criminology (Wardlaw 1992b) argued widespread “unproblematic” use of cannabis and middle class use of opiates influenced the respective emphasis upon a social approach in the Netherlands and medical approach in the United Kingdom. In contrast, marginalised drug users and drug-related crime facilitated the adoption of a criminal approach in the United States. Shifts to a less marginal population of cannabis users in the 1970s facilitated the re-framing of the problem from a criminal to a non-criminal problem and thus selective decriminalisation in some states (DiChiara & Galliher 1994). Since that time the rise of drug-related crime, the strong link between crime and drug use has remained a
distinguishing feature of United States drug use (Caulkins et al. 2005) which has been argued to have facilitated the maintenance of the “war on drugs” approach.

In recent years the efficiency and effectiveness of the criminal justice system itself has come to the fore. As noted in Chapter One there has been a considerable expansion in drug diversionary schemes and drug courts. Many of these schemes have followed the increasing evidence that the criminal justice system itself may be counter-productive or inefficient. The negative impacts of the criminal justice system upon drug users is an argument commonly raised by expert inquiries (Comissão para a Estratégia Nacional de Combate à Droga 1998; Commonwealth of Australia 1994; Fundação da Juventude 1994; Nadelmann 1989; Niza 1998; Premier's Drug Advisory Council 1996). The deterrent effect of the criminal law is questionable, particularly given studies showing that there is a 1-2% likelihood of arrest for drug use or possession (Lenton 2000). Yet the criminal justice response may increase the potential for stigmatisation, criminal offending (particularly drug-related offending), exacerbate the level or frequency of drug use and contribute to poor police and community relations (Lenton, Christie, Humeniuk, Brooks, Bennett & Heale 1999; Maher, Dixon, Lynskey & Hall 1998; Stevens, Trace & Bewley-Taylor 2005). It has therefore been argued that the expansion of diversionary responses reflects an acknowledgement that the criminal justice system is not the best means of dealing with drug users (Bull 2003; Cohen, P. 1994; Fonseca & Quintas 1997; Leuw & Marshall 1994; Single, Christie & Ali 1999). Following a crisis the type of response appears dependent upon whom or what frames the problem.

**Policy actors**

Drug policy development appears highly influenced by the dominant interest or lobby groups in a nation. During the introduction of national drug strategies in the Netherlands, France and Sweden there were noticeable differences between the dominant interest groups (Boekhout van Solinge 1999). The dominance of sociological, psychiatric and medical lobby groups respectively in the nations of Netherlands, France and Sweden facilitated different perceptions of the drug problem and hence national responses. The framing of drug use in the Netherlands as deviant but acceptable behaviour facilitated *de facto* decriminalisation of cannabis. In contrast, in France and Sweden drug use was viewed as an indication of a desire to violate laws and as a contagious disease, which led to the respective emphases upon
the repression of drug use and compulsory drug treatment. Hence, interest groups appear to influence the type of framing and mechanism of response.

Moreover, shifts in interest group dominance may facilitate new responses. The predominance of treatment professionals and law enforcement respectively in the nations of United Kingdom and United States had considerable impact upon the framing of the drug problem. They facilitated framing the problem as a health issue in the former nation and a law enforcement issue in the latter (Wardlaw 1992b). However, a change in the UK policy in the 1980s – namely the removal of private physicians’ power to prescribe opiates – was attributed to the reduced power of the medical profession coupled with changing views on appropriate treatment modalities.

While this suggests that the reduced dominance of interest groups may facilitate atypical reform, this is not guaranteed. The history of American drug policy has shown that despite a decline in the dominance of the law enforcement sector and increased involvement of treatment professionals, supply reduction has remained the dominant objective for the past four decades (Caulkins et al. 2005). One key reason for the dominance of the law enforcement sector is that their messages advocated – “fighting the good fight” – have considerably greater appeal than the pragmatic messages advocated by the health sector (Sharp 1994, p. 144).

Interest group support and opposition can have considerable impact upon the likelihood of reform. Hawks (1988) noted how intense pressure from the alcohol and tobacco lobbyists meant that the National Campaign Against Drug Abuse in Australia was almost devised without licit drugs. The counter-mobilisation by the then Health Minister Neal Blewett was critical in ensuring that alcohol and tobacco were included in the national campaign. Similarly, strong interest group opposition in New York and California led to protracted political battles to achieve marijuana decriminalisation in the United States. DiChiara and Galliher (1994) contended this was the major distinguishing feature which almost led to the failure of the proposed reforms.

In contrast, studies have demonstrated that the presence of strong interest group support may facilitate reform, particularly in the case of political opposition. Ryder’s (1996) study of alcohol policy development in Australia showed that in spite of political opposition to alcohol labels, these were nevertheless introduced as a result of the support from within the alcohol industry. Some South Australian winemakers –
from the Winemakers group – voluntarily adopted the labels, which increased pressure upon the politicians to adopt the reform. Similarly in the development of the Medically Supervised Injecting Centre in Kings Cross, Sydney, vocal advocacy by health professionals helped depoliticise the situation and facilitated the adoption of the proposed reform (Wodak, Symonds & Richmond 2003).

Furthermore, the cannabis decriminalisation reforms in Western Australian (Lenton 2004) and USA (DiChiara & Galliher 1994) showed the importance of police support to enable drug law reform. In particular, Lenton (2004) noted that the lack of support from Victoria Police was crucial in blocking moves for decriminalisation in that state. In contrast, there was very high-level support by the Western Australian police for the introduction of decriminalisation. The Health Minister – Bob Kucera – was a former police officer and was very supportive of the change. This suggests that interest groups can be influential in supporting or opposing policy reform and are particularly influential in problem framing.

**Political changes**

Drug policy is inherently political and studies have attributed both positive and negative influences to the politicisation of the drug problem. Studies from the United States, and more recently Australia, tend to emphasise the role of politics in drug policy reform and suggest that the high politicisation of the drug problem reduces the potential for evidence-based policy (DiChiara & Galliher 1994; Greenfield, Giesbrecht, Kaskutas, Johnson, Kavanagh & Anglin 2004; Sharp 1994; Wodak 2005). Politicisation in USA is perceived to reduce the windows of opportunity for drug policy development and reduce political compromise. This in turn has enhanced the stability of American drug policy. Sharp (1994) has explained the stability through reference to Kingdon’s multiple streams, whereby alternative choices of drug policy are largely ignored due to the increased role of the political stream. Research is frequently criticised for lacking validity and reflecting ideological rationales, which contributes to doctrinal responses:

> Agenda setting and problem definition for the drug issue appear to be driven by political imperatives and crisis events that direct attention away from what we have learned from previous policy cycles. The result is that policy development with respect to drugs has a disjointed, spasmodic character (Sharp 1994, p. 4).

Strong links between politicians and interest groups and ideology are deemed the dominant political constraints upon evidence-based policy making (Reuter 2001).
Consequently, research tends to evaluate the efficacy and effectiveness of drug treatment instead of law enforcement responses. Reuter (1997) contended that this supports a conservative political agenda, whereby the lack of evaluation of drug law enforcement removes the need to “fix the problem.” Consequently the “war on drugs” remains dominant despite the problematic outcomes (Caulkins et al. 2005). This supports the arguments of public policy theorists that politicisation may facilitate doctrinal responses.

However, political involvement is essential and some studies have emphasised how a willing political leader has been crucial to reform of drug policy. In contrast to President Nixon’s “war on drugs,” President Carter supported marijuana decriminalisation (DiChiara & Galliher 1994). This created a constrained political opportunity for cannabis law reform. Political leadership by the Australian Prime Minister Bob Hawke and NSW Premier Bobb Carr has also been attributed to the respective adoption of the NCADA (Blewett 1987; Ryder 1996) and the Medically Supervised Injecting Facility (Courier Mail 1999; Gunaratnam 2005). Leadership by Bob Hawke followed his daughter’s heroin addiction, but also through the presence of a very pragmatic Health Minister, the Honourable Neil Blewett. Political factors therefore have been found to have predominantly a negative impact through constraining opportunities for reform, particularly for evidence-based reforms. However, it is also clear that the presence of a willing political leader can create opportunities for reform, and are often vital in obtaining evidence-based reforms.

Research
Research plays a key role in ongoing policy development through the process of evaluation. Evaluations have increasingly been built into drug strategies and therefore have the potential to feed back into policy development (EMCDDA 2002d). The emphasis upon evaluations has been a key feature of Australian drug policy since its late modern inception. Fitzgerald and Sowards (2002) contended this contributed to pragmatic policy making, and facilitated a more effective policy. However, evaluations are usually deemed to facilitate incremental adjustments, rather than major change. It is considerably more contentious as to what extent nations follow expert recommendations for atypical, evidence-based reform.
Many authors bemoan the lack of attention to evidence. Political objectives are often argued to take precedence over evidence (Crosbie 2000; DiChiara & Galliher 1994; MacCoun & Reuter 2001; Manderson 1987; Wodak & Owens 1996). As noted by Wodak and Owens (1996, p. 12) “consistently, Australian drug policies have been reactive responses rather than products of political vision, leadership or sound scientific scholarship.” The inattention to evidence has been attributed to several factors, including the lack of political willpower, lack of popular appeal and necessity of long-term visions to adopt evidence-based proposals. Other researchers have attributed failures to obtain evidence-based proposals to international, political and community pressure for prohibitionist and “war on drugs” mentalities (Reuter 2001; Wodak 1997).

Evidence-based proposals often fail to be adopted. Arguably, the most notorious in recent years has been the failed proposals for a heroin trial in Australia, for reasons summed up by Dr Alex Wodak:

Six years of careful scientific work on a significant community problem, widespread consultation, publications in peer-reviewed journals, openness to scientific scrutiny, support by the Australian Medical Association, presidents of medical colleges, numerous leaders of the medical profession, police commissioners, directors of public prosecution and a royal commission are not enough. An important, but controversial, scientific research project will be brought down politically if opposed by 51% of respondents in a community opinion poll and if subjected to a relentless campaign of media vilification and misinformation (Wodak 1997, p. 348).

Rowe (1999) came to a similar conclusion following his examination of the development of the Victorian Government’s drug policy. Despite a public health crisis and establishment of an expert inquiry, the Kennett Government failed to adopt the expert recommendations of the Penington Committee. Rowe (1999, p. 348) attributed this to an “irrational” political decision, one “in contradiction of the evidence compiled and the expert advice offered by the Premier’s Drug Advisory Council.”

Even the establishment of expert commissions is deemed to have variable impact upon the likelihood of pragmatic responses. The EMCDDA (2002d) has noted that many European Union states establish commissions prior to introducing a national drug strategy. While in principle this facilitates pragmatic policy making, the mandates of the commissions vary considerably. While some commissions are given “carte blanche” (EMCDDA 2002d, p. 17) and thus have unlimited freedom in the formulation of policy options, other governments require the commissions to keep in line with pre-established policy approach. The latter are far more likely to facilitate
incremental reform. Moreover Bonnie (1998) asserted that US Presidential Commissions tend to have limited impact upon drug policy since they are developed on the basis of political affinity. He therefore asserted that such commissions act to either defend the status quo or be utilised by the President to introduce a pre-decided policy. He says that this is quite different to UK Commissions consisting of experts, and accordingly US Commissions are unlikely to contribute to major reform.

Yet despite the constraints upon research, pragmatic reforms do emerge. Research is deemed particularly influential in the establishment of new drug strategies or directions. The controversial de facto decriminalisation in the Netherlands followed recommendations by the Hulsman Commission and the Baan Commission (Boekhout van Solinge 1999; Cohen, P. 1994; Leuw & Marshall 1994; Uitermark 2004). Cohen argues that the commissions were important in providing the theoretical and practical reasons for reform and paradigmatic change. They were based upon sound knowledge of the type of drug use patterns in Netherlands and research on the negative impacts of giving drug users criminal records, and hence the labeling perspective. Research was also a driving influence in the UK following the Rolleston Report in 1926 (Australian Institute of Criminology 1992) and in the establishment of the National Campaign Against Drug Abuse in Australia (Blewett 1987; Hawks 1988). Numerous Royal Commissions and Inquiries encouraged a more pragmatic approach to policy making in Australia, and reduced the power of lobby groups. However, it has also been argued that proposals would not have been so influential were it not for the contemporary context. In particular Cohen (1994) contended the receptivity to the decriminalisation proposal in the Netherlands was facilitated by the context of non-problematic drug use and criminal justice support. It is also worth noting that the cultural interpretation of research may itself also be influential. The infamous recommendation to “separate the markets” was key in the Netherlands decriminalisation, but substantially different to the recommendation in the United States: to stamp out use early. Both however stemmed from the observation that cannabis use was more prevalent than the use of other illicit drugs (MacCoun & Reuter 2001).

Finally, it has been suggested that perhaps politicians are attentive to research, but interpret the research through different lenses to researchers. Fitzgerald (2005a) notes the continued failure of evidence of harms caused by law enforcement to impact upon Australian drug policy. He says perhaps such research will not drive reform since by
demonstrating that law enforcement is “tough” or “harmful,” it supports the current climate of “Tough on Drugs” policies. Accordingly, there is need to not only look at research, but also how such research is interpreted in the political context. This is a view supported by Lin (2003) who points to the different rationalities that guide political interpretations of evidence. A key impediment to incorporating research into politics is the presence of competing rationalities: political, cultural (perceptions on the desirable responses) and technical rationalities (what works). Lin’s (2003) contention is that often technical rationality is the least important. Political interpretation of research is thus influenced by economic constraints, political expediency, community perceptions and/or changes in ideas, not necessarily evidence. Since interpretation of evidence reflects different perceptions research often fails to spur atypical reform.

**International factors**

Since the introduction of the first United Nations Convention on Narcotic Drugs and framing of the “drug problem” as a criminal matter (United Nations 1961), conflict has arisen as to how nations should respond to drug users. The United Nations Conventions are seen as considerable constraints upon opportunities for reform, particularly more evidence-based reforms for drug users. The three United Nations Conventions on Narcotics Drugs (1961; 1971; 1988) firmly emphasise that drug use – or more precisely, drug possession – ought to be prohibited as a criminal offence. While, Dorn and Jamieson (2001) contend that nations have, as indicated by their report title, considerable “room to manoeuvre,” the latitude within the international conventions is subject to contest.

International bodies including the International Narcotics Control Board (INCB) and the Commission on Narcotic Drugs are frequently viewed as having a constraining influence upon drug policy reform. Despite the support for harm reduction by many international bodies including the World Health Organisation and UNAIDS (Transnational Institute 2002), the INCB (2000) opposes the adoption of harm reduction as a drug strategy objective unless it has the express purpose to reduce demand. The EMCDDA (2004) views their criticism as ideologically driven, since the INCB expressly targets nations that support harm reduction measures and nations that are perceived to liberalise their drug legislation. Portugal was one such target following the adoption of decriminalisation (International Narcotics Control Board
The Beckley Foundation has noted INCB criticism of the effectiveness of harm reduction measures is often at odds with the evidence-base and is biased through the lack of criticism or acknowledgement of the questionable effectiveness of drug law enforcement. This led to their conclusion that the INCB has become a “guardian of the purity of the conventions,” overstepping and enforcing narrow interpretations of the conventions (Bewley-Taylor & Trace 2006, p. 1).

It is evident that allies may have a constraining influence upon drug policy development, particularly nations that have strong ties with the United States. Australian drug policy is perceived to have been more heavily influenced than European nations by its relations with the US. In particular the introduction of the first drug laws was perceived as US led (Manderson 1987) and the Australian Institute of Criminology (Wardlaw 1992b) noted that despite the similar drug policy objectives in Australian and the Netherlands, the stronger influence in Australia upon law enforcement appears due in part to the US relations. More recently there have been visits by US drug czars at particular times, including during discussions of heroin trials, which has been deemed to discourage shifts away from the status quo (Hamilton 2001).

Mexico’s proposal to decriminalise the possession of all illicit drugs in 2006 was subject to particular international pressure. Such a reform reflected the belief that re-focusing criminal justice efforts onto drug trafficking would be a better use of resources and would lead to more effective policy (Stevenson 2006). This proposition met with considerable parliamentary support but staunch criticism from the United States, particularly from the Califorinarian Government who feared such a move would encourage drug tourism. There was resounding support for decriminalisation by the criminal justice system and Government with votes in favour of 349-0 (six abstentions) and 53-26 (one abstention) in the lower house and senate respectively. Nevertheless, on 4 May 2006 the Mexican President, Vicente Fox, vetoed the proposal and stated “The Mexican government will have to deepen the fight against drug trafficking….. In no way is it promoting the use of drugs” (cited in Lynne Walker 2006, pp. A-1). International pressure had a greater impact therefore than national demand.

That said international bodies and nations are also deemed at times to have a positive influence upon pragmatic drug policy. The EMCDDA (2002d) noted that between
1987 and 1997 there were only four national drug strategies in Europe. Between 1998 and 2002, the figure had increased to twenty-five strategy documents including strategies and action plans. The EMCDDA claims the impetus for such change was the United Nations General Assembly (UNGASS) in June 1998, which called for the adoption of national drug strategies. The European Union efforts to adopt its own drug strategy and action plan also occurred during this period and may therefore have contributed to the trend. The EMCDDA (2004) suggests nations particularly in Europe may also be influenced by the policies of neighbouring countries. Recent trends towards reducing the use of criminal justice penalties for drug users is one example. While worldwide or local trends may facilitate the willingness to adopt alternate directions, particularly ones that push the boundaries, the considerable variation between the European nations points to variable influence.

**Other national factors**

Drug policies can reflect national preferences. The role of national characteristics in the adoption of de facto decriminalisation in the Netherlands has been well noted, through the emphasis upon “Dutch tolerance.” Uitermark (2004) argues that the Dutch de facto decriminalisation was aided by two key cultural factors. This included the preference for decision making through consultation and compromise, rather than dogma and a preference for “gedogen” or a pragmatic and minimalistic approach to problems (Uitermark 2004).

Drug consumption was never criminalised in Spain and when possession for personal use was prohibited after ratification of the 1961 United Nations Convention on Narcotic Drugs, the Supreme Courts immediately gave a directive to not apply such a law for cases of personal use (Gamella & Jiménez Rodrigo 2004). This became official policy in 1982 following the depenalisation of drug possession. In spite of changes in the level and type of use, political parties, and international pressure, responses to drug users have remained minimalist. Even in 1992 when the Spanish Government increased penalties for public drug use, administrative rather than criminal penalties were introduced giving rise to decriminalisation (Gamella &

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4 In accordance with the terms used in Portugal and Europe decriminalisation is defined as the removal of all criminal penalties, but often involves the use of alternative sanctions. In contrast depenalisation is the relaxation of the implementation of the laws. It may not therefore involve the application of alternative sanctions. See EMCDDA 2005b, *Illicit drug use in the EU: Legislative approaches*, European Monitoring Centre for Drugs and Drug Addiction, Lisbon.

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However, it is also clear that policies may change in spite of national preferences. Italy provides an example. Italy has had a long term emphasis upon minimal criminal justice responses to drug users (EMCDDA 2002c). However, a reform by the Italian Government on 7 February 2006 resulted in the re-criminalisation of use and possession of all illicit drugs. This imposed sanctions of up to six years imprisonment for quantities exceeding 0.5 grams of cocaine or 5 grams of hashish (Impallomeni 2006). This is notable both because drug possession was previously decriminalised and because Italy now has the smallest threshold quantities for drug possession in Europe. It is contended that the “war on drugs” approach was advocated for political and ideological rationales and rushed through by the Fini-Giovanardi Government days before an election. The laws were therefore adopted in spite of the national preference, something which the new government has expressed a desire to rectify (Corleone 2006).

Finally, other studies suggest that national drug policy reform may be facilitated by changes in contemporary circumstances. While the role of national characteristics in the adoption of decriminalisation in the Netherlands has been well noted, a number of contemporary circumstances were also argued to have aided the reform (Boekhout van Solinge 1999; Cohen, P. 1994). These include a powerful youth movement and religious pressure groups (who desired to show they were connected and still relevant to youth). Similarly Boekhout van Solinge (1999) noted the French Drug Act was passed during a period of student revolt and open drug use and Swedish interventionist illicit drug policy developed after the temperance movement increasingly advocated for a drug-free society and for stricter controls. Rather than drug use itself, mass mobilisation by the Swedish temperance movement during the 1970s and 1980s became the driving force behind Swedish drug policy (Boekhout van Solinge 1997). Thus, national context and temporary national changes appear to also facilitate reform.

The observations above highlight a myriad of questions and unresolved tensions, particularly as to what are the primary drivers of reform and the inter-relationship between the factors. The most conflicting issue concerns the relationship between evidence, problems and politicians. Moreover it is unclear how national factors
facilitate or constrain opportunities for reform. Research to date suggests examination of drivers alone is unlikely to resolve the complexity. There is therefore a need for a theoretical framework to understand the drivers and process of reform.

### Drug policy development: Continuity and change

**Incremental reform**

Comparative research highlights considerable differences between national drug policies, but largely emphasises the stability of these differences. Drug policies are thus perceived as maintaining the trajectory of prior policies or developing by “slow accretion” (Wodak & Owens 1996, pp. 11-2). This can be in spite of increased prevalence of drug use, evidence of policy failure or interest group activism. National drug policies are therefore considered to develop in an incremental and path dependent fashion. Researchers have tended to attribute incremental reform to the framing of the drug problem, politicisation and the policy making structure.

Many researchers have attributed incremental reform to the “framing” of the drug problem. The definition or framing of the drug problem as a health, social or criminal issue is deemed to narrow policy options (Wardlaw 1992a). This is best illustrated in the United States, which is renowned for maintaining a hard line on drugs, despite evidence and protests for reform. Sharp notes that the frame of reference narrows the debate for drug policy reform:

> [The] source of policy failure is the dominance of a policy’s initial problem definition, which channels policy more or less permanently in a particular direction. If the earliest episodes of attention to a particular issue involve mistaken, overly narrow, or otherwise inadequate conceptions of the problem, policy can be tracked toward failure (Sharp 1994, p. 4).

It is thus contended, at least in the US, that a criminal frame limits capacity for change.

Based upon their cross-national comparison of drug policy development in Western Europe, MacCoun and Reuter (2001) argued the framing of the problem was shaped by national characteristics which in turn influenced the type of policy. They attributed differences between the highly interventionist Swedish drug policy with the non-interventionist Spanish drug policy to historical and cultural differences. In particular, they noted that the Swedish policy of mandatory treatment reflects the historical coercive response to alcohol use and is consistent with the national “paternalistic”
government (MacCoun & Reuter 2001, p. 298). In contrast, the Spanish policy of
decriminalisation reflects the Spanish emphasis upon individual rights following the
end to a long-standing totalitarian regime While MacCoun and Reuter (2001) argue
that outcomes from policies will feed back into and encourage minor adjustments,
path dependency and fixed national differences will be the norm.

Incremental reform has also been attributed to the politicisation of drug problems.
Sharp (1994) argues that drugs have largely remained on the political agenda in the
United States which has increased the potential role of the political stream. She
attributes the politicisation of the issue to a number of factors, most notably the
prevalence of political entrepreneurs, the ability to transform the issue and attach it to
related contemporary concerns including AIDS and crime, and the congruence
between the “drugs problem” and core cultural fears including the lack of control over
youth.

However, other studies have suggested that it is not politicisation per se but the
propensity of nations to politicise the drugs issue that contributes to incremental
reform. The Australian Institute of Criminology (Wardlaw 1992a, p. 145) noted the
“striking similarity” in aspects of the Australian, English, American and Dutch drug
policies. This was particularly evident in the common desire for a balanced approach.
However, they also noted vast differences in the goal of the strategies, something
which they attributed to not only differences in the nature of drug problems, but to the
propensity to politicise the drugs issue. This was supported through a study of
Australian drug policy by Fitzgerald and Sewards (2002). They noted that while drug
policy making in Australia tends to avoid political decision making, politicisation was
more likely in some jurisdictions, particularly the Australian Capital Territory. This in
turn was deemed to have reduced the potential for evidence-based policy making in
this jurisdiction.

A few researchers have noted that policy making structures facilitate incremental
reform. This factor is however overlooked by most analysts. Caulkins et al. (2005)
noted that the dispersion of responsibility for drug policy facilitated incremental
reform in the USA since it impedes communication between the elements. Similarly,
Fitzgerald and Sewards (2002, p. 41) noted the multiple governance structures in
Australian drug policy encouraged stability:
The system of financial and advisory structures provides a level of stability to an otherwise highly contested field. Multiple committees with disseminated decision making ensure that it will take an enormous policy rupture to change the system. Thus, it appears that incremental reform is facilitated by the framing of drug problems, the propensity to politicise drug issues, the policy making structures and the lack of attention to evidence. This bears resemblance to the public policy theories.

**Atypical reform**

While studies suggest incremental reform is the norm in drug policy, there are frequent proposals for atypical reform. The following section outlines a number of such proposals for cannabis law reform in USA, Germany, Netherlands and Australia and Supervised Injecting Facilities (SIFs) in Australia. Some involved successful reform and others did not. It thus explores the reasons for success or failure and common themes.

In light of the apparent stability of drug policy in America, examination of the marijuana decriminalisation in 11 states of USA provides a good insight into the windows of opportunity for drug law reform. DiChiara and Galliher (1994) found that there was a window of opportunity, albeit limited, for marijuana decriminalisation between 1973 and 1978. This study showed the short and contracted nature of the window of opportunity for drug law reform and importance of changes in the type of problem (increased middle-class cannabis users), framing the solution (aiming for cannabis decriminalisation not legalisation or reform of all illicit substances), criminal justice support and national mood. They noted a shift in the practices of judges, and non-application of marijuana laws facilitated the opportunity for reform. However, they noted the most important factor which enabled the decriminalisation was the election of President Carter, since it increased political receptivity to reform (DiChiara & Galliher 1994). With the loss of federal support and the rise of new interest groups opposing marijuana decriminalisation including the New Right, the window for cannabis law reform closed.

Atypical reforms appear to necessitate the accumulation of a large number of mutually supporting influences. Lenton (2004) examined windows of opportunity for decriminalisation of marijuana use in two jurisdictions in Australia: Victoria and Western Australia. The window of opportunity closed in Victoria without reform, yet gave rise to reform in Western Australia. Lenton (2004) contended that the release of the National Drug Research Institute report and recommendation for decriminalisation
provided an opportunity for reform. Policy advocates in Victoria failed to capitalise upon the opportunity and hence couple the streams. A state election and lack of law enforcement support were key impediments to reform. In contrast, in Western Australia the re-assessment of the Labor Party’s platform on drug policies, created an opportunity to obtain political support for reform. The Labor party was subsequently elected on a mandate for reform and developed a civil penalties scheme through a Drug Summit (Lenton 2004). The political mandate and drug summit therefore enabled the coupling of the streams. The key difference between the successful and failed reform was political and interest group – law enforcement – support.

Similarly, political receptivity was the defining feature in the success and failure of Australian proposals for supervised injecting facilities (SIFs). While SIFs were proposed in three jurisdictions – Victoria, ACT and NSW – only the latter resulted in reform. The failure of the Victorian and ACT governments to adopt SIFs was ultimately attributed to the absence of politically favorable circumstances. These included the presence of minority governments and unrelated budget compromises (Dolan, Kimber, Fry, Fitzgerald, McDonald & Trautmann 2000; Gunaratnam 2005). Gunaratnam (2005) contended that due to the necessity for legislative reform politicians had the instrumental role in the debates on supervised injecting rooms and the final power of veto. In contrast, the success of the NSW reform was attributed primarily to an act of civil disobedience (Dolan et al. 2000; Wodak, Symonds & Richmond 2003). Health professionals established a temporary injecting room at the Wayside Chapel termed the “Tolerance Room,” which was deemed to have increased the power of the health professionals in the subsequent debate on the establishment of a fixed injecting room, and also depoliticised the issue. These studies indicate the importance of political receptivity, but also highlight that political receptivity may have greater importance for some legislative reforms, and may be enhanced through policy advocacy.

Examination of British alcohol policy development suggests that politicisation may have greater importance during some eras. Greenaway’s (2003a) study of British alcohol policy development from 1830 to the present noted that alcohol became an important political issue in 1870. However, he noted that by 1945 the issue was no longer a high priority, and instead fragmented into different departments. He notes that the dissipation increased reliance upon policy communities and decreased the
politicisation of the issue. Accordingly, this facilitated incremental reform. He notes that since that time there has been increased emphasis upon re-defining alcohol issues in different manners, such as drink-driving to increase control over policies. However, Greenaway’s (2003a) study also highlights a key issue, namely that while the alcohol control movement was successful in increasing education, it was not successful in pushing for more controls such as reduced hours of sale which he attributes to powerful opposition and libertarian attitudes in Britain. This study suggests that the level of politicisation is perhaps more important than politicisation per se, and that the capacity for reform may be reduced by opponents.

A key issue with the studies of drug policy formation to date is that the majority have studied drug policy development in one nation. A notable exception was Scheerer’s (1978) comparison of Dutch and German proposals for cannabis law reform. This attributed the failure of the German proposal to higher politicisation. Following interest group pressure (by the medical profession for punitive laws) a moral panic resulted, where evidence was perceived to have been manipulated against cannabis law reform. Scheerer (1978) contended that mass mobilisation and moral panics were more likely in Germany due to the homogeneity of German society. In contrast, the Dutch proposal of de facto decriminalisation developed through a bipartisan manner, with neither mass mobilisation nor a moral panic. This suggests that differences in policy formation may reflect national styles of policy making, cultural beliefs or contemporary events.

In summary, drug policy research tends to support the theoretical models of policy development, particularly the notion of the need to couple streams to obtain optimal conditions for reform. This indicates that atypical reforms tend to occur in short windows of opportunity following the culmination of factors. The most important factor highlighted in these studies was the necessity of political receptivity. Successful reforms were more likely if there was support from key interest groups and the general community, particularly if the former lead the reform. Failed reforms tended to lack these factors, and had high politicisation and limited interest group support. The majority of these studies utilised public policy theories to illuminate the policy making process. The following section therefore examines the strengths and weaknesses identified to date.
Applicability of the theoretical frameworks

A number of studies have applied the public policy theories of Multiple Streams, Advocacy Coalition and Punctuated Equilibrium to examine drug policy development. While they have found considerable resonance, a number of issues or queries have been raised.

The primary theory utilised to date by drug policy researcher has been the theory of Multiple Streams. Application has concurred on the necessity of swift responses to capitalise upon opportunities for reform. Greenfield, Giesbrecht, Kaskutas, Johnson, Kavanagh, and Anglin (2004, p. 637) studied alcohol policy development in the United States and found policy makers were “assiduously bent on detecting windows of opportunity” to introduce policy ideas and help alter national mood. Opportunities were perceived to occur following shifts in party balance, accumulation of scientific information and media interest. They also noted that there were considerable differences in the interest groups of the alcohol industry and public health activists, which led to ideological differences. This contributed to a stalemate in alcohol policy reform.

The major issues to date with the application of Multiple Streams concerns the role of policy formulation. As noted earlier, the studies of the proposals for cannabis decriminalisation in the USA and Australia contended a political opportunity and the depoliticisation of the issue were the major drivers of successful proposals. However, it is not clear why only some reforms were depoliticised. Further, it remained unclear how differences in the process of policy development and policy formulation impacted upon the likelihood of reform or the outcomes from reform. Multiple Streams thus appears useful for examining and highlighting the pre-requisites for agenda setting, namely through the linkage of the streams, but appears less useful in understanding policy formulation. This was a conclusion that was reached by Gunaratnam in her study of the supervised injecting facility debates in Victoria, NSW and the ACT:

What the policy streams approach does not provide is an understanding of how different policy mechanisms and governance arrangements determine which players will most influence the process. Two issues around implementation of supervised injecting facilities were crucial in the success of failure to establish trials – the need for legislative reform, and the need for funding. There were no obstacles for NSW in regard to these issues ….. In Victoria, legislative reform proved to be an insurmountable barrier, while in the ACT, funding for the trial was sacrificed …. (Gunaratnam 2005, p. 29).
Further, it remains unclear as to whether and how problem windows would differ in policy formation and mechanism. That said, if depoliticisation is essential for successful reform this suggests considerable need to understand whether politicisation can be avoided, particularly in nations such as the United States.

The primary study using the Advocacy Coalition Framework highlighted the resonance of the theory to the development of Swiss drug policy. Kübler (2001, p. 623) illustrated how the HIV/AIDS crisis provided impetus to increase the dominance of the harm reduction coalition, therefore overcoming the “hegemonic” abstinence coalition. The HIV/AIDS crisis and rise of the harm reduction coalition proved critical in the introduction of the Needle Park in Zurich. However, Kübler (2001) identified a major problem with this theory; it provided limited guidance as to the method of policy formulation. He contends that while Advocacy Coalition could explain the rise of the harm reduction coalition it provided a poorer explanation of how they maintained dominance. The author supplemented Advocacy Coalition with another theory of mobilisation. This was necessary since the introduction of the Needle Park was followed by the growth of crime and disorder which provoked a threat to the dominance of the harm reduction coalition. A harm reduction focus for drug users was however maintained through compromise and expansion of the harm reduction objectives from the individual rights of drug users to include rights to public order.

Application of Punctuated Equilibrium also showed resonance to understanding a rise in pragmatic alcohol reforms. Greenaway’s (2003a) study of British alcohol policy development showed that expert input into policy formulation was aided by the promotion of a new image of alcohol, namely from teetotalism to “problem drinking.” The new image facilitated a successful venue shift and change in government policy. Most notably experts maintained increased control over policy making following the venue shift. However, he noted that this theory was less applicable when alcohol was a highly politicised issue prior to 1945. Thus, while Punctuated Equilibrium resonated in the new era of policy communities and depoliticised policy making, it was less applicable in highly politicised environments.

In conclusion, these studies tend to support the notion that the theoretical models of policy development can be used to understand drug policy development. It is unknown however, whether all theories show equal resonance, or whether it will depend upon the type of reform or nation of application. Further, it remains to be seen
whether some approaches provide better understanding and greater practical implications. The present thesis explores whether the application of the three public policy theories illuminates these issues. In particular, it addresses a key gap, namely how the process impacts upon the mechanism and implementation of reform, and hence what occurs following agenda setting.

To assist in this endeavor the research draws upon the stages heuristic. This distinguishes between five stages: agenda setting; formulation; adoption; implementation; and evaluation (Anderson, J. 1979). Such a heuristic has frequently been criticised for being overly simplistic, implying a linear or rational approach to policy making, one in which problems are identified, proposals sought, and then enacted (Howlett & Ramesh 2003; Sabatier 1999). Further, Considine (1994) has argued that the linear notion of policy development tends to premise the power of government over that of policy advocates or contemporary circumstances. It therefore assumes that the process of policy adoption (a Government decision) is the major factor in policy development. This is at odds with the fluid notion of policy adopted by theorists including Baumgartner and Jones (1993) and downplays the importance of the policy formulation phase.

While the current research concurs with these critiques it does suggest that reference to the stages heuristic may assist in understanding the process of policy making. In particular, the stages heuristic can help distinguish when and how policy is placed on the government agenda, how the policy solution is decided upon and legitimised and who is involved in decision making. The thesis contends that these are critical elements for policy making. Rowe (1999) utilised the stages heuristic as part of his policy analysis of the Victoria Liberal Government’s response to a heroin problem. This approach helped to disaggregate the process, and highlight the breakdown between the policy formulation and adoption phases, which he ultimately attributed to an “irrational” policy decision. The current thesis similarly uses the stages heuristic to guide analysis of the chosen national developments and thus assist in assessing the resonance and adequacy of the stated theoretical frameworks.
Drug policy in Portugal and Australia

The following section turns to the case studies: Portugal and Australia. It introduces the national contexts for the current research, specifically the geographic locations, demographic details and prevalence of illicit drug use. It then provides an overview of the primary elements of the Portuguese and Australian national policies, and legislative responses to drug users, and identifies conflicts that form the basis for the study. The points raised in this section are developed in Chapters Four and Five.

Context: Portugal and Australia

Portugal was founded in 1143 and was made a republic and member of the European Union in 1976 and 1986 respectively. Mainland Portugal is located in South-Western Europe on the Iberian Peninsula. It consists of 18 administrative regions, including Lisboa, which hosts the capital city Lisbon (see Figure 1). Portugal also hosts two autonomous regions, the Archipelagos of Azores and Madeira Islands, located in the Strait of Gibraltar.

Figure 1: Map of Portugal

Source: Yahoo! Travel

5 Sourced from http://travel.yahoo.com/p-travelguide-577866-map_of_portugal-i on 09.15.06.
Australia is located in Oceania, between the Indian and the Southern Pacific Ocean (see Figure 2). While Australia has a long history of Indigenous occupation, it was not settled by Europeans until 1770 and subsequently federated in 1901. It consists of six states and two territories, including the Australian Capital Territory which hosts the capital city of Canberra.

Figure 2: Map of Australia

Portugal has about half the population of Australia and has tended to have the weakest economy in Western Europe. The population of Portugal in 2001 was 10.1 million (Instituto Nacional de Estatística 2001) compared to 20.0 million in Australia (Australian Bureau of Statistics 2004). In both nations, 67% of the population was aged between 15-64 years. Comparisons of economic output indicate that in 2005 Australia had a per capita Gross Domestic Product\(^7\) of US$ 30,200 compared to US$ 19,400 in Portugal (Organisation for Economic Co-operation and Development 2005).

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\(^6\) Sourced from http://travel.yahoo.com/p-travelguide-577486-map_of_australia-i on 09.15.06.

\(^7\) Comparisons of economic output are commonly undertaken with reference to the per capita Gross Domestic Product (GDP) which is a measure of a nation’s total production of goods and services minus expenditure per head of population. Alternatively, differences in GDP between nations can be compared in US dollars using Purchasing Power Parities (PPP).
Accordingly, Australia had almost double the GDP of Portugal and had therefore a stronger economy (1.37 Purchasing Power Parity compared to 0.66 PPP).

**The prevalence of drug use in Portugal and Australia**

Lifetime prevalence of illicit drug use is considerably smaller in Portugal than Australia. Lifetime prevalence of any illicit drug use in 2001 was 37.7% amongst Australians aged 14 and over (Australian Institute of Health and Welfare 2003) compared to 7.8% amongst Portuguese aged 15-64 (Balsa, Farinha, Urbano & Francisco 2004). The most popular drug in both countries was marijuana, although different forms were used in Australia (cannabis) and Portugal (hash). There appeared to be similar rates of problematic drug users, with between 6.1 and 8.6 problematic drug users per 1000 inhabitants in Portugal, which corresponded to between 41,720 and 58,980 problematic drug users (Negreiros 2002). In Australia figures from 1997-98 indicated there were around 6.9 dependent heroin users per 1000 inhabitants, which corresponded to between 67,000 and 92,000 dependent heroin users (Hall, Ross, Lynskey, Law & Degenhardt 2000). More recently it was estimated that there were around 136,000 regular injecting drug users in Australia (Australian National Council on AIDS Hepatitis C and Related Diseases 2002). These figures suggested a lower prevalence of illicit drug use in Portugal, but similar levels of problematic drug use.

Portugal’s location on the south-western border of Europe means it is a gateway for drug trafficking. It is a transit nation for trafficking of cocaine from Brazil, heroin from Spain and Lямba from Angola. The United Nations Office on Drugs and Crime (2006) noted that during 2004 Portugal had the third largest seizures of cocaine in Europe. However, the principal challenge for Portuguese Police remains trafficking of hash from Morocco, with at least 53% of drugs seized in 2003 originating in Morocco (Instituto da Droga e da Toxicodependência 2004b). In contrast, Australia is not known as a transit country.

**Portuguese drug policy and legislative response**

The rationale and process of Portuguese drug policy development has been the subject of limited research. Portuguese drug policy appears to have preceded the development of a “drug problem” which grew through the 1980s-1990s. A brief history of Portuguese legislation shows that drug laws increased in severity in Portugal, after
ratification of the UN Conventions. The first drug law in Portugal (*Decreto 12 210, de 24 de agosto 1926*) adopted a fiscal position whereby the drug trafficking was perceived as an issue of border control. This law did not mention the issue of drug consumption. Consumption became a criminal offence in 1970 but the criminalisation was deemed a symbolic measure (*Decreto-Lei n.º 420/70, de 3 de setembro 1970*). In 1983 Portugal incorporated components of the 1961 and 1971 UN Conventions which were ratified by Portugal in 1971 and 1979 respectively (*Decreto-Lei n.º 430/83, de 13 de dezembro 1983*). This resulted in increased penalties for drug users and a distinctly juridico-penal approach to trafficking and consumption (Fonseca & Quintas 1997). Again, the legislators stated that drug consumption was supposed to be punished in a symbolic function. Carlos Rodrigues Almeida (1997) contended that, in practice, this increased the punishment of drug users. It was further argued that the major focus was on minor as opposed to major drug traffickers (Mouraz Lopes 1998).

The 1993 introduction of Decree-Law 15/93 increased penalties for drug users and introduced threshold quantities to distinguish between small and large quantities. The law distinguished between consumption, trafficking-consumption and trafficking. During this period the maximum penalty for occasional or habitual consumers in possession of small quantities of drugs was three months imprisonment (*Decreto-Lei n.º 15/93, de 22 de janeiro 1993*). The penalty for possession of a larger quantity was up to one year imprisonment. In practice, however fines were commonly used. Maximum penalties for drug trafficking were 12 years imprisonment.

There have been two main emphases in Portuguese drug policy: law enforcement (supply reduction) and prevention (demand reduction). In 1987, Portugal introduced its first national campaign against drugs. Projecto VIDA (Life Project) had the fundamental objective to prevent drug use, encourage abstinence and healthy lives for drug users (*Resolução do Conselho de Ministros n.º 23/87, de 21 de Abril 1987*). Projecto VIDA went through numerous iterations but retained an emphasis upon prevention rather than cure (Ministro da Juventude 1989). The first stage used shock tactics to warn of the dangers of drug use, publicly condemn drug trafficking and punish drug traffickers through the law.

Particular focus was placed upon the education of youth through a telephone line – “Linha Aberto” – an open line for counseling and abstinence-based slogans and campaigns (Gabinete do Ministro da Juventude 1989). The first public health slogan
“Droga - Loucura – Morte” implied that drug use lead to madness and death (Niza 1998). Later iterations of Projecto VIDA included education and prevention in schools, treatment in community centres and reintegration. However, the emphasis upon treatment and reintegration did not occur until 1994 and 1995 respectively (Mendes 1994) and indeed the primary treatment centres were oriented towards drug-free living and “reconstructing” the personality of the drug addict (Comissão Parlamentar de Juventude 1992). Projecto VIDA was criticised for being unresponsive to the needs of drug users and in particular for a continued emphasis upon drug-free slogans, poor coordination and an inadequate response to the Portuguese drugs problem (Miguel 1997).

Thus, two key influences upon Portuguese drug policy appear to have been the international pressure to criminalise drug use and trafficking and the ideological objective of a drug-free lifestyle. It appears that the former encouraged the maintenance of criminal penalties, in spite of opposition and that the latter may have discouraged the introduction of drug treatment and harm reduction measures. The development of the new strategy and subsequent decriminalisation thus raises numerous issues for exploration.

In May 1999, the first Portuguese drug strategy developed: National Strategy in the Fight Against Drugs (Estratégia Nacional de Luta Contra a Droga - ENLCD). The ENLCD was built on eight structuring principles including pragmatism and humanism (Resolução do Conselho de Ministros n.º 46/99 de 26 de Maio 1999). It was contended that the main objective was to change from a traditional reactive policy to a more global approach based on science and evidence (Pais 2003). This suggests a shift occurred from ideological to evidence-based policy making. The strategy also included thirteen strategic options, the most notable of which was to decriminalise the acquisition, possession and use of all illicit drugs for personal use. This was followed by the adoption of Law 30/2000 which put into practice the decriminalisation (Lei n.º 30/2000, de 29 de novembro 2000) and then an Action Plan – Horizonte 2004 – detailing 30 objectives, funding of €160 million and an implementation plan until 2004 (Governo de Portugal 2001). The new legislation is distinct from the Dutch de facto decriminalisation because firstly, it is legislated and hence is de jure decriminalisation and secondly it involves sanctions for offenders, through an alternate system of contra-ordenações (public order offences). For the purposes of the
thesis, unless otherwise mentioned, the term “decriminalisation” is utilised to refer to *de jure* decriminalisation.

The adoption of the ENLCD and decriminalisation represented a significant change at least in rhetoric to be evidence-based, proactive, humanistic and comprehensive, and involved considerable funding and political support. Literature on why these changes occurred is very limited. The main study was conducted by Van Het Loo, Van Beusekom and Kahan (2002) between March 1998 and July 2001 prior to the decriminalisation. This attributed the drug strategy developments to the perceived enlargement of the Portuguese drug problem and to the establishment of an expert commission. As they state “the revolutionary step began with the formulation of an elite expert commission to consider what was widely regarded as an increasing drug use problem” (Van Het Loo, Van Beusekom & Kahan 2002, p. 50). This suggests that the window for opportunity may have opened in the problem stream. International researchers have tended to interpret the adoption of the ENLCD and decriminalisation as representing a profound shift from abstinence to harm reduction (MacCoun & Reuter 2002; Van Het Loo, Van Beusekom & Kahan 2002). However, it is questionable whether abstinence has been abandoned.

**Australian drug policy and legislative response**

Similarly, to the development of Portuguese drug laws, Australian illicit drug legislation largely preceded demand or community concern about drug use. The main legislative responsibility of the Commonwealth, in relation to drugs, is for border control (*Customs Act 1901*), and drug trafficking and manufacturing (*Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990*). In 1967 and 1976 possession and consumption of all narcotic drugs and psychotropic substances was prohibited in accordance with the UN Conventions (United Nations 1961, 1971, 1988). The introduction of such legislation has been attributed by many, including Desmond Manderson (1993) to international influences or pressures. Manderson notes the United Nations Conventions were enacted while illicit drug use of in particular marijuana was virtually unknown, and licit prescription of heroin was common. Yet,

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8 This is not to imply that decriminalisation is necessarily deemed a harm reductionist measure, since decriminalisation may enhance harms. See for example MacCoun, R & Reuter, P 2001, *Drug war heresies: Learning from other vices, times, and places*, Cambridge University Press, Cambridge. Nevertheless internationally, decriminalisation has been interpreted as a sign of a major shift in focus.
international pressure led to the ban of *illicit* heroin use. Wodak and Owens (1996, p. 11) have noted that the decision to ban illicit drugs was “arbitrary” but “once written into law, even capricious decisions take on new meanings.”

Given Australia’s federal arrangements drug legislation is complex. While all state and territory jurisdictions retain control over their drug legislation, they are bound by the UN Conventions. Most jurisdictions prohibit use, possession, trafficking, manufacturing and cultivation as criminal offences. Victoria, for example which became a notable state in the development of the IDDI, has similar maximum penalties for use and possession as Portugal. The principle drug legislation in Victoria is the Drugs, Poisons and Controlled Substances Act 1981 which has been amended by the Drugs, Poisons and Controlled Substances (Amendment) Act 2001. This legislation states that the trafficking, cultivation, possession or consumption of substances including heroin, cocaine, cannabis and amphetamines are prohibited as criminal offences. The maximum penalty in Victoria for use or possession of an illicit drug is $500 fine for cannabis or $3,000 fine and/ or 1 year imprisonment for any other drug (*Drugs, Poisons and Controlled Substances Act 1981*). The maximum penalty for major drug trafficking is life imprisonment.

However, the application of criminal penalties is not pursued by all states and territories in Australia. South Australia, ACT, Northern Territory and Western Australia have introduced civil penalties schemes instead of criminal sanctions for use, possession and sometimes the cultivation for personal use of cannabis. Moreover, the law enforcement sector has historically emphasised diversionary responses to youth and minor offences (Morrison & Burdon 2000). In such cases, there has been a preference to use informal or formal cautions and divert offenders away from the traditional criminal justice system. Since Australia’s first drug strategy diversion of user-offenders to treatment has been a stated objective (Department of Health 1985), yet questions have continued as to whether this was in practice implemented (Sutton & James 2000). The introduction of the Illicit Drug Diversion Initiative (IDDI) in April 1999 is a more formal recognition of diversion.

Drug strategies initially developed in Australia at a state jurisdictional level. To coordinate these strategies a National Campaign Against Drug Abuse (NCADA) was devised in 1985 (Department of Health 1985). The NCADA involved a partnership approach between the Commonwealth and the State and Territory Governments. The
The founding principle of the NCADA was harm minimisation which aims to “minimise the harmful effects of drugs on Australian society” (Department of Health 1985, p. 2). Such an objective was described by The Hon Neal Blewett, the then Minister for Health:

Its ambition is thus moderate and circumscribed. No utopian claims to eliminate drugs, or drug abuse, or remove entirely the harmful effects of drugs, merely ‘to minimise’ the effects of the abuse of drugs on a society permeated by drugs. (Blewett 1987, p. 2)

The definition of harm minimisation has since been extended to include a focus upon social, health and economic harms to the individual and community and uses a multifaceted approach to licit and illicit drugs comprising supply reduction, demand reduction and harm reduction (MCDS 2004).

Two key influences upon the development of the NCADA appear to be research and political willpower. Neal Blewett (1987) notes that the campaign was introduced at a time of decreased drug use, but increased societal concern, sparked by drug-related crime and a number of commissions. Seven major inquiries and Royal Commissions were conducted in the 15 years preceding the development of the NCADA, most of which had a harm minimisation focus (Hawks 1988). One of the most significant was a report titled “Drug problems in Australia: an intoxicated society?” that drew attention to the most significant and damaging substances at the time: tobacco and alcohol (Australia Parliament Senate Standing Committee on Social Welfare 1977). The NCADA incorporated much of the recommendations of the prior inquiries, particularly the creation of a comprehensive approach and focus upon licit and illicit drugs.

The presence of political leadership was seen as crucial in creating the national campaign. Prior to the 1984 election the then Labor Prime Minister Bob Hawke wept on television over what was later admitted to be his daughter’s heroin addiction (Hawks 1988; Ryder 1996). This was thought to increase his motivation to address the drug problem. A drugs summit and creation of a National Campaign then became key election promises and upon re-election, a drug summit was called. However, it has been noted that due to lobbying by the tobacco and alcohol industries Bob Hawke initially intended to develop an illicit drug strategy (Hawks 1988). Due to Neal Blewett’s emphasis upon pragmatism, the two most dangerous drugs were included in the NCADA. This suggests that Neal Blewett was a key driver in ensuring that the political opportunity gave rise to a pragmatic strategy.
Since that time the national drug strategy has undergone a number of versions resulting in the current strategy: the National Drug Strategy: Australia’s Integrated Framework 2004-2009 (MCDS 2004). However, it is contentious as to whether the key principles of the original NCADA - harm minimisation, evidence base, consensus decision-making and a balance between supply, demand and harm reduction - are supported today.

There have been two major shifts in recent years: increased politicisation; and increased focus upon abstinence. These include the introduction of Prime Minister John Howard’s “Tough on Drugs” Strategy in 1997 (Commonwealth Department of Health and Ageing 2004b) and a new governance body, the Australian National Council on Drugs (ANCD) in 1999. Such reforms have been heralded with mixed opinions, as will be explored in Chapter Five. At least in rhetoric the “Tough on Drugs” strategy appears to conflict with the objectives of harm minimisation since it focuses upon abstinence-oriented approaches. Further, both the strategy and the ANCD increase the potential for what Fitzgerald (2005b) feared was political control of Australian drug policy.

The emergence of the Illicit Drug Diversion Initiative (IDDI) through “Tough on Drugs” rather than the National Drug Strategy suggests that this reform has emerged through a political window. The concept of drug diversion appears however to conflict with the political philosophy of Tough on Drugs, which takes a zero tolerance approach to drug use. Yet Prime Minister Howard (2002) stated “in no way does it [drug diversion] retreat from our ‘Tough on Drugs’ philosophy, our zero tolerance approach.” This raises questions as to whether the IDDI is in fact an evidence-based reform.

**Conclusions and tensions created**

Studies to date highlight a number of common factors that appear to influence drug policy development: size/nature of the problem; interest groups; political factors; research; and international factors. Incremental development appears to be the norm, no doubt due to the difficulties in obtaining windows of opportunity for reform and impediments to successful atypical reform. Studies of atypical reform suggest the three theoretical frameworks may have applications to the study of drug policy
development, and that they may help clarify how and why atypical reforms emerge. It appears a number of issues remain unresolved.

The first tension is the inter-relationship between drivers of drug policy development. While a number of common factors are noted, the studies highlight considerable conflict, most notably between the roles of politicians and research. Studies have frequently attributed the failure to consider evidence or to adopt pragmatic reform to politicisation. Yet other politicians have shown considerable leadership in adopting pragmatic reforms. It therefore remains unclear how politicians and evidence inter-relate in the adoption of pragmatic reforms and how political imperatives influence the outcomes. Given the obvious conflict between political imperatives and evidence this is a particular quandary in the development of the IDDI.

The second tension is the role of national context. The literature suggests that the trajectory of drug policy is influenced by national characteristics such as the cultural beliefs and the dominance of interest groups. These factors tend to affect the framing of the problem, and contribute towards path dependence, and hence continued differences between national policies of for example Sweden and the Netherlands. Yet atypical reform offers a break from past policies. How therefore do national factors influence atypical reforms? It appears that Portuguese drug policy has historically emphasised drug-free and healthy living and thus reflected an ideological rather than evidence-based approach to policy making. In contrast, in Australia it appears that the NCADA and latter iterations have placed continued emphasis upon evidence rather than ideology. To date, it appears that such key drivers have influenced policy formulation and implementation and in particular the emphasis upon abstinence versus harm minimisation in Portugal and Australian respectively. Questions remain as to how past paradigms influenced the adoption of decriminalisation and the IDDI.

The third tension is the process of development. There are considerable differences between the theories. Will the applicability depend upon the type of factors that emerge and the national context? Are some theories more applicable to particular nations or particular types of reforms? Or is there a common theoretical framework?

The fourth tension is the role of chance or fate in policy development. Researchers to date highlight considerable constraints upon reform including the International Conventions, political opposition and framing of problems. The public policy theories
suggest an element of fate is necessary to overcome these constraints, and the “right” opportunity. It therefore remains unclear as to what extent policy development is controllable, and hence what role policy actors can play in this process.

A fifth tension is how to increase the effectiveness of drug policy making. There is an underlying assumption that greater inclusion of research will facilitate more effective policy making; however political imperatives and ideology appear to counter research. Questions therefore remain as to how evidence can facilitate more effective reform and what role evidence should play.

These five points are investigated throughout this work and as a starting point for the questions developed in the interview schedule, and documentary analysis. The research uses the opportunity of two atypical reforms to examine the atypical factors and mechanisms of influence upon national drug policy development. Cross-national research has highlighted a number of common influences, but the opportunity to compare the development of two analogous developments with completely different political, social, demographic, temporal and religious backgrounds is arguably unique.
Chapter Two highlighted conflict in how factors such as evidence and politicians influence the process of drug policy development and the need for theoretical and practical examination of the policy formulation process. The present chapter outlines the development of a comparative study of drug policy development through the following four sections:

1. Approaches to undertaking cross-national drug policy research
2. The present study
3. Issues of ethics, researcher independence, reliability and validity
4. Justifications and limitations

The first section provides an overview of cross-national approaches and their specific application to drug policy research. It highlights the benefits and limitations of each approach. The second section outlines the current research. It explores a number of logistical and methodological issues concerning the pursuit of comparative, cross-national research and establishment of this research. Specific requirements of undertaking the research are discussed, namely gaining access to the field, funding and methodological and interpretive considerations. It then outlines the data sources and procedures for collection and analysis. As such I locate my work methodologically within the field as a qualitative researcher. The third section examines issues of negotiating researcher independence and establishing reliability and validity. Finally, I discuss the limitations of this particular research and reflect upon the research process.

**Approaches to undertaking cross-national drug policy research**

As the literature review demonstrated, cross-national approaches have been a useful means of examining national drug policy, highlighting in particular national differences and the tendency for path dependence. Hantrais and Mangen (1996) distinguish between three approaches to cross-national research, the choice of which has implications for the objectives, design and conclusions that can be drawn. The three approaches, which are distinguished on the basis of objectives, rather than methodologies, are descriptive, evaluative and/or analytical. The basic distinction is
that a descriptive study aims to highlight similarities and differences, an evaluative study judges the outcomes of policy and an analytical study examines the causes of similarities and differences and formulates, verifies or modifies theoretical propositions.

The following section examines three cross-national studies of drug policy to highlight firstly the differences between a descriptive, evaluative and analytic approach, and secondly the different methodological approaches that cross-national studies can adopt. It should be noted that these studies serve as ideal types of the various approaches to cross-national drug policy research. The studies by Cohen and Kaal (2001) and MacCoun and Reuter (2001) were in fact hybrid approaches to drug policy. They nevertheless illustrate the benefits and limitations of each approach and as a means to justify the particular approach adopted in this thesis the three approaches are outlined.

**Descriptive approach**

One example of a descriptive approach to drug policy was the study undertaken by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) into the patterns of prosecution and non-prosecution for drug users in Europe. It used a mixed methodology involving a questionnaire, narrative reports from a legal representative in each member state and consultations with national experts (EMCDDA 2002a). The study included rich description of the formal and informal practices towards drug users in each of the member states. It concluded that the states displayed considerable consensus that prosecuting drug users for trafficking and property offences was desirable. In contrast, the desirability of prosecution for drug use and possession alone was the subject of far less consensus. The limitation of adopting a descriptive cross-national approach was clearly stated in the report:

> Throughout the study, there has been a temptation to come to some general understanding of – and statement about – the reasons for the various patterns of prosecution and non-prosecution of drug users in the Member States (EMCDDA 2002a, p. 22).

Due to the descriptive approach taken the EMCDDA did not analyse the causes of these similarities and differences. While descriptive studies therefore have benefits of enabling rich contextual descriptions they lack the ability to generalise and/or theorise. Due to these limitations the use of descriptive studies has declined, and such
studies are used predominantly for the initial stages of international comparative research (Hantrais & Mangen 1996).

**Evaluative approach**

In contrast, Cohen and Kaal (2001) used an evaluative approach to compare patterns of cannabis use in three cities: Amsterdam, San Francisco and Bremen. Their research sought to compare a non-criminalising context – Amsterdam – versus criminalising contexts – San Francisco and Bremen – and to evaluate the impact of drug legislation on the prevalence of drug use by experienced cannabis users. This study used general population questionnaires of prevalence and patterns of use to measure city trends and interviews with a sub-group of experienced users in each city. They found similar trends in the timing, length and patterns of cannabis use in the three cities and the title of their paper “The Irrelevance of Drug Policy” pointed to their conclusion; that it appeared policy or at least legislation was not a key influence upon experienced cannabis users. The benefit of an evaluative approach is the ability to draw conclusions about the impacts of policy. The principal problem is that due to the focus upon the outcome rather than the cause, they tend to lead to simplistic conclusions (Berting 1982).

**Analytical approach**

The final study is a cross-national analytical study conducted by MacCoun and Reuter (2001) that examined drug control experiences in ten Western European nations and Australia and extrapolated lessons for the United States. This study used a predominantly quantitative approach to triangulate data sources from different countries, time periods and types of reforms. One component of the study analysed the impact of four legal relaxations upon the prevalence of drug use: the Dutch cannabis regime; repeal of prohibition in the US; decriminalisation of marijuana use in the US and Australia; and depenalisation of all illicit drugs in Italy. They noted that while the Italian data was ambiguous, none of the cases led to an increase in the prevalence of use in the five years following the change. However, they noted that where drug use was commercialised the prevalence of use subsequently increased. By examining the similarities and differences, and analysing the causes of these patterns, they derived eleven lessons or propositions from their research. The two that relate to the component summarised above were that “reductions in criminal sanctioning have little or no effect on the prevalence of drug use,” but that “commercial promotion
leads to a greater expansion in drug use” (MacCoun & Reuter 2001, p. 326). By conducting an analytical approach the authors were able to predict the consequences of regime change in the US, and conclude that the evidence would support regime change.

A major benefit of the analytical approach was the ability to create theoretical propositions on the nature or outcomes of drug policy change. It should be noted that analytical approaches are not restricted to analysing the outcomes, as this study was, but can also examine processes of drug policy development. The major challenge in an analytical approach is grounding the propositions in the relevant context and avoiding simplistic linear relationships.

**Methodological approaches to cross-national research**

Aside from the style of approach it is evident that the studies used different data sources and methodologies. The study by MacCoun and Reuter (2001) used predominantly quantitative data and noted that this decreased the potential reliability of their findings. While quantitative methodologies are often favoured due to their ability to aggregate data, they limit the nature of the research question and therefore the type of findings (Bendikat 1996; Ragin 1987). There are major challenges with the use of statistics in cross-national research that are “definitional, administrative and procedural” (Shelley 1981, p. xxvi). These include the difficulties in gaining access to accurate and equivalent data. As a result of this criticism there has been a shift towards the increased use of qualitative methods in cross-national research (Ungerson 1996).

The EMCDDA study (2002a) on the other hand used more qualitative data and noted the best data was sourced from key informants in each nation. The benefits of qualitative research particularly for the cross-national analyst are significant. Qualitative methods provide holistic rich descriptions and explanations. The main advantage is arguably the ability to generate or revise theoretical frameworks (Bendikat 1996; Miles & Huberman 1994). Furthermore, Ragin (1987) contended that the validity of theoretical propositions is enhanced by qualitative methods, since there is greater potential to search for negative evidence and thus check whether the propositions are justifiable. The major limitation is that particularly for small samples,
the generalisability of findings from qualitative comparative methods can be criticised (Ungerson 1996).

The final approach utilised by cross-national researchers is a mixed methodology. Cohen and Kaal (2001) used a predominantly qualitative approach involving the use of interviews to provide rich description, but supplemented this with quantitative data to increase the generalisability of their research. As was evident in the three cross-national studies cited above triangulation is common. Triangulation of approaches, methodologies or data sources can overcome some of the limitations and enhance the credibility of the cross-national research (Barrett & Cason 1997; Bendikat 1996).

In summary, cross-national research may involve a number of different approaches and methodologies. Each approach has particular strengths and limitations. The choice therefore is dependent upon the research question, expertise of the researcher, time, funding, particular characteristics of the nations of study and the findings that are sought (Hantrais 1999). Ultimately, cross-national research brings huge potential particularly for theory verification and theory generation; however, it also brings considerable challenges. This has led to it being referred to as a “two edged sword” (May 2002, p. 218). The benefits from cross-national research are maximised through flexibility, methodological compromise and triangulation (Mangen 1999; Øyen 1990).

The present study

The current research design has been devised according to predominantly theoretical reasoning. It therefore uses a combined descriptive-analytical approach to study the process of drug policy development in two nations: Portugal and Australia. This enables not only description of the process, but also analysis and identification of similarities and differences. It further facilitates the assessment of the adequacy of fit of the public policy theories for understanding drug policy development. Similarly to the approach adopted by Cohen and Kaal the present research uses a predominantly qualitative approach involving three data sources: interviews with expert policy makers; documents; and statistics. The primary emphasis is upon interviews, to provide rich description of the process and enable theoretical application. The following section overviews the scope of the research, logistical and methodological challenges and the data sources, collection and analysis.
While cross-national researchers are often chastised for selecting nations of study for pragmatic reasons (Hantrais 1999; Øyen 1990), the present thesis was designed to capitalise upon the atypical pragmatic reforms that occurred in 1999-2000 in Portugal and Australia. As previously noted, the reforms were chosen due to their analogous nature, apparent differences in their policy making process and the similar timings of the reforms. The choice was therefore designed to increase knowledge and test the theoretical frameworks.

The scope and time period of data collection focuses upon the atypical change, but also allows examination of the periods preceding the reforms. While the timeframe of this analysis is not restricted, the primary focus of the current research is upon drug policy development between 1994 and 2000. Analysis of the implementation and outcomes of the atypical reforms follows their adoption until July 2006; 1999-2006 in Australia and 2000-2006 in Portugal.

The present research focuses upon one particular area of national drug policy. National drug policy includes several common domains: prevention; treatment; social reintegration; harm reduction; supply reduction; research and training (EMCDDA 2002d). Many of these domains are beyond the scope of this thesis. Given the impetus for the thesis, the focus of this research is the criminal justice and administrative policies and responses to illicit drug users. As such, it specifically excludes responses to licit drug use, since these have not been included in the atypical reforms in either nation.9

9 The IDDI and decriminalisation both recognise that illicit drug use often coincides with licit substance use and as such may respond to licit drug use. However, the primary emphasis of both responses has been to reduce the use or harms of illicit drugs. The IDDI is considering expanding to include diversion for alcohol use.
Setting up the cross-national research
Cross-national research necessitates overcoming two types of challenges: logistical challenges such as funding, support and access to (quality) data within the overseas nations; and methodological challenges (Anderson, R. 1996; Berting 1982; Hantrais & Mangen 1996; Kohn 1989). This section outlines both of these.

Logistical challenges: gaining language skills, access, funding
Key logistical challenges for the research were language skills, gaining access to data in a foreign nation and obtaining funding. The first logistical challenge was language. The primary language spoken in Portugal is Portuguese and thus at the commencement of this PhD I undertook lessons in Portuguese. After two years of study, I had gained proficiency in reading Portuguese texts including legislation, government documents, research and newspaper articles. Spoken skills still proved a challenge and thus necessitated the use of a translator during the data collection, as will be discussed later in the chapter.

The second logistical challenge was obtaining access to policy makers and a link in Portugal. I chose to conduct the current research myself, through the creation of a collaborative arrangement, something Rainbird (1996) notes is common for the single researcher to provide support in the foreign context. As noted by Anderson (1996, p. 105) obtaining support often involves “imagination, perseverence and flexibility”. At the initiation of this PhD letters outlining its purpose and proposed research methodology were sent to a number of experts or institutions in Portugal. Written in Portuguese, the letters requested assistance with the undertaking of the research. Letters sent to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) proved unsuccessful. However, a letter sent to Dr Maria Moreira from the Institute for Drugs and Drug Addiction (Instituto da Droga e da Toxicodependência or IDT) in Portugal was successful. Dr Maria Moreira was the head of the research centre within the IDT (Observatório de Drogas e Toxicodependências), and representative of Portugal in the EMCDDA Reitox network, European Information Network on Drugs and Drug Addiction. This led to the establishment of a collaborative agreement between the IDT and the University of Melbourne.
Access was therefore established with peak bodies in Portugal and subsequently in Australia. The Institute for Drugs and Drug Addiction is a large government body under the Ministry of Health located in Lisbon, Portugal. It deals with the majority of health issues relating to drugs. These include prevention, treatment, education, research and since July 2001 the response to illicit drug use and possession. This institute was crucial in providing a connection with Portugal, gaining access to key informants and documentary resources and providing a base during the research process. Within Australia, I sought the assistance of the Australian National Council on Drugs (ANCD), the peak body of the non-government sector on drugs to nominate a list of suitable people to interview.

The third logistical challenge was funding. Given that cross-national research and qualitative research generally benefits from the ability of the researcher to subsist in the culture of study (Hantrais & Mangen 1996), funding was sought and obtained through the Post-graduate Overseas Research Experience Scheme (PORES) at the University of Melbourne to enable three and a half months in Portugal. Funding was also provided through the University of Melbourne Travel for Research In Post-graduate Studies (TRIPS) enabling documentary research in London, the United Kingdom and Lisbon, Portugal and attendance and presentation at the European Society of Criminology Conference in Amsterdam 25-28 August 2004. It has often been noted that the conditions of funding for cross-national research impact upon the objectives or methodology of research (Rainbird 1996); however these sources had no such conditions. Travel within Australia was self-funded.

I chose to examine the Portuguese context prior to conducting interviews in Australia. This was needed due to the dearth of information on the development of Portuguese drug policy. Overall, I spent a total of five and a half months in Europe between 3 August 2004 and 16 December 2004, of which the period of 30 August to 12 December 2004 was spent in Portugal. Conducting research in Portugal first enabled me to look at the Australian drug policy as an outsider, thus reducing the potential for insider bias which is a potential problem for cross-national research (Hantrais & Mangen 1996).
Methodological challenges to conducting cross-national research

Due to the cross-national design, adjustments needed to be made to the data collection and analysis process. In particular there was a need to recognise that cross-national research is not identical to within-nation research, and necessitates adjustments according to the availability and quality of data, the equivalence of concepts and impacts of translation (Øyen 1990).

A key consideration is the equivalence of terms at the international level and also the chosen conceptualisations within the countries of study (Nießen 1982). There are three major concepts that are referred to in my thesis: national drug policy, incremental and atypical reform. In the current research the national drug strategies from Portugal and Australia are used as the conceptual equivalent of “national drug policy.” This is a common conceptualisation adopted in comparative drug policy research (Bull, McDowell, Norberry, Strang & Wardlaw 1992; EMCDDA 2002d). The focus for incremental reform is the development of previous national strategies, namely Projecto VIDA and the Australian “National Drug Strategic Framework 1998-99-2002-03.” However, the primary focus of analysis is upon the apparently analogous reforms of the Portuguese decriminalisation and IDDI in Australia. Such reforms are deemed analogous since both seek to reduce the involvement of the criminal justice system in responding to drug users, occur at the national level, and relate to all illicit drugs.

It should be noted that there are differences in the role of national government in Portugal and Australia in that the former is unitary and the later is federal. As Australia is a federated nation each state and territory has its own drug strategy. Subsequently there is a certain degree of jurisdictional flexibility in the interpretation and application of the National Drug Strategic Framework. Nevertheless, a national drug policy still has conceptual and practical relevance in Australia (Fitzgerald & Sewards 2002). Furthermore, the IDDI has particular significance as a national reform since it was adopted by all states and territories plus the Commonwealth. On this basis it was believed the conceptualisation of “national drug policy” had enough equivalence within Portugal and Australia to enable comparisons of the processes of national drug policy development.
Throughout the interviews and data collection phase themes emerged which warranted a shift from evaluation and assessment of the transferability of policies to comparison of the process of development. This was due most notably to the scarcity of data and knowledge on the outcomes from reform. As the subsequent section shows there were difficulties obtaining equivalent quantitative data which became a primary reason for this shift and indeed for the use of a predominantly qualitative methodology.

In summary, the overseas component of the research took place between August and December 2004. This involved collaboration with the Institute for Drugs and Drug Addiction in Portugal and was funded by the University of Melbourne through PORES and TRIPS. The thesis adopts a descriptive-analytical approach and uses a primarily qualitative approach to maximise the potential for theoretical insight and application.

**Data sources**
The research uses a number of data sources: semi-structured interviews, documents and statistics. The methods of collecting and analysing data are discussed in the subsequent section.

*Semi-structured interviews*
The primary method of data collection was semi-structured interviews. Semi-structured interviews have a set interview schedule and therefore a standardised format, however they enable researchers to probe and clarify responses (May 2002). Such a technique aids comparability of interviews and is therefore useful for cross-case or cross-national analysis. The interview schedule (see Appendix A and B) differed slightly between Portugal and Australia, but included in common the areas of national drug strategy development, rationale and development of the atypical reforms, implementation and perceived outcomes. In recognition of the difficulty in equivalence in interpreting and responding to interview questions in Portugal and Australia, interview questions were simple and open ended, a strategy adopted by Almond and Verba (1970).

*Documents*
A number of documents were consulted as a means of verifying the accuracy of the interview responses and perspectives. Verification is useful in all qualitative research
however it is particularly useful for cross-national research, when it may be difficult for the reader or the researcher to know whether the interviews are reliable. The documents included the national drug strategies, legislation, Government documents, studies in Portuguese or English on the national drug policies, strategies or analogous law reforms. Such documents were used to verify or question the perspectives and trends garnered through the interview and statistical dat, and are referred to, as appropriate, during the results section.

**Statistics**

Two sources of statistics were sought for this research. The first were national trends on the number of drug offences and trends in drug use and health outcomes. The second were outcomes or trends from the atypical reforms, namely the number of individuals diverted and outcomes from such processes such as successful completion. However, there were considerable difficulties obtaining quality data due to poor data collection or restricted access. This was a particular problem in Australia, due to the delays in establishing and restrictions upon the National Diversion Minimum Dataset (Health Outcomes International Pty Ltd in association with Catherine Spooner Consulting & National Drug and Alcohol Research Centre and Turning Point Alcohol and Drug Centre 2002b). Given the more limited data examination of the outcomes from the IDDI has necessitated greater triangulation in Australia. Nevertheless, trends and impacts from the evaluations were used concerning three types of outcomes:

- Criminal justice response to illicit drugs: Arrests for drug consumption, possession and trafficking
- Alternative response to drug use: diversions/ contra-ordenações (social order offences)
- Health outcomes: prevalence and patterns of use, treatment demand, rates of HIV/AIDS and overdose

The three types of outcomes provide indications on the primary objectives of the reforms: reducing drug use and crime, and improving health outcomes.

**Collection and analysis of the data**

The following section outlines the logistics of data collection – conducting interviews and obtaining statistics – and methods of analysis. In particular it notes the sampling procedure adopted to select key informants and characteristics of the Portuguese and Australian sample. The present study adopted largely a contextual form of data
organisation and analysis, thus data from Portugal were analysed distinct from Australian data. This approach enables the researcher to see and sort the data using a contextually appropriate lens. Mason (2002, p. 166) notes that such a methodology enables the researcher to “make comparisons and build explanations in a distinctive way.” Data analysis drew upon thematic analysis and time series analysis to describe Portuguese and Australian drug policy development.

**Interview sampling**
The research adopted two methods of sampling. The key institutions – Institute for Drugs and Drug Addiction and the Australian National Council on Drugs – were asked to provide a list of key individuals to interview. Subsequently, interviewees were asked to suggest people who ought to be included in the sample. This follows a snowball sampling methodology, a method that is particularly useful for locating interviewees who are “information-rich” (Patton 2002, p. 237). Sampling was also guided by key criteria. In order to get a balanced representation of views, something that was of particular importance given the cross-national methodology, individuals were selected and requested from a number of key areas. This follows a method of stratified purposeful sampling (Patton 2002). Key informants were selected from six key areas: health professionals such as treatment providers; criminal justice officials such as law enforcement officers; non-government such as members of political lobbying groups or non-government treatment organisations; bureaucrats such as members of the Ministry of Health; politicians; and researchers. Requests for interviews were sent to 54 individuals in Portugal and 30 in Australia. Each request contained a letter of introduction, a consent form and a self-addressed and stamped return envelope.

**Sample**
A total of 42 individuals agreed to participate in this research: 26 in Portugal (male=21, female =5) and 16 in Australia (male=14, female=2). Exactly 50% of those to whom letters were sent participated in the research. The majority of key informants are health professionals, academics and criminal justice officials. However, as Table 1 illustrates there was a notable difference in the profile of the Portuguese sample, which included a small number of government officials, but a large number of politicians. In contrast no Australian politicians agreed to participate in this research. That said, it should be noted that many informants had multiple roles, for example as
health professionals and members of non-government organisations and other informants changed roles during the period of study. Accordingly, Table 1 should be viewed as an indication of the spread of key informants. Appendix C contains a full list of, and positions held by, key informants during the period of study. Four key informants have been de-identified in accordance with their wishes.

<table>
<thead>
<tr>
<th>Primary Profession</th>
<th>Portuguese interviewees</th>
<th>Australian interviewees</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Politician</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Bureaucrat</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Health professionals</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Criminal Justice</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Non-Government</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Researcher</td>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>16</td>
<td>42</td>
</tr>
</tbody>
</table>

Throughout this research key informants have been referred to using different titles, according to the most relevant roles. For example, João Goulão has been referred to as a health professional, former head of the SPTT, former member of the expert commission, and current head of the IDT. Given their varied positions, but common objective of advocacy for the reforms key informants will be referred to throughout this research as “policy makers,” a term which is inclusive of policy advocates and policy makers.

*Interviews with key informants*

Interviews in Portugal were conducted between October and December 2004 and in Australia between March and September 2005. All interviews were conducted face to face, predominantly at the workplaces of the key informants. Interviews in Portugal were conducted in Lisbon and Porto. In Australia interviews were conducted in Adelaide, Sydney, Canberra and Melbourne. All key informants in Portugal were given the option of conducting the interview in Portuguese or English. This option was part of the consent form and selected prior to conducting the interview. Eighteen key informants in Portugal chose to partake in English and eight in Portuguese. The latter involved the aid of a translator who had worked for the European Monitoring Centre for Drugs and Drug Addiction and was familiar with the topic of drugs.
Interviews lasted between 36 minutes and 133 minutes, with an average length of 64 minutes. Interviews were on average longer in Portugal than Australia (73 minutes compared to 49 minutes) particularly for those interviews involving the use of translators. All interviews were digitally recorded to enable rapid data transcription and analysis by the researcher. Results from interviews including notes, digital recordings and transcripts were stored in password-protected computer files, or in locked filing cabinets, and are thus available for later access.

Transcription
The digital recordings of the interviews were transcribed manually and in full in the language used in the interview. This process while lengthy enabled the opportunity to build familiarity and reflect upon the data, which is a necessary precursor for thematic analysis. It also enabled clarification and correction by interviewees. Interviewees were sent copies of transcripts of their interviews to review the accuracy of the data and clarify meaning. This is a method recommended to increase the internal validity of interview data (Lincoln & Guba 1985).

Thematic analysis
Thematic analysis was used to identify key themes in the data from Portugal and Australia, to distinguish between the drivers of incremental and atypical reform and examine their influence upon the policy development. Thematic analysis aims to identify themes in the interview data and thus reduce the quantity without detracting from the quality of the data (Patton 2002). Coding of themes is often undertaken in conjunction with memoing, a process whereby thoughts and possible relationships between codes are recorded at the same time to ultimately aid the theoretical development of codes (Bernard 2000; Punch 1998). The present thesis adopted an inductive approach to coding such that the codes emerged from each national dataset of interviews, rather than from the literature. This contrasts with deductive analysis where the codes are imposed from existing theoretical frameworks (Patton 2002). The emerging drivers nevertheless supported that from previous literature.

Despite the frequent use of computer qualitative software packages the decision to not adopt computer analysis was based on firstly the size and complexity of the data, secondly difficulties incorporating non-English text, thirdly the preference of the researcher, and finally the view of Mason (2002) that such software is less useful for
undertaking contextual analysis. Accordingly, thematic coding and memoing was undertaken without the use of computer-aided software.

The first stage of the research involved classifying and coding the data into the drivers of policy development in each nation. Later codes identified the rationale and mechanism of influence upon national drug policy in Portugal and Australia. The aim of thematic coding is to produce a set of categories that are plausible, inclusive, reproducible and credible (Patton 2002). Thus, the process of coding involved modification of the classification scheme until the categories were deemed to meet such criteria.

Through the identification of drivers, this research highlighted that some factors were deemed as having a more direct impact upon the development of the atypical reforms. It was therefore useful to use a heuristic and distinguish between proximal and distal factors. Proximal factors are termed the factors that were deemed as having a more direct impact upon policy development. These factors were more commonly identified by policy makers. Distal factors in contrast had a more indirect impact, and tended to be less identified and less consensual, but were nevertheless important in the developments. Such a distinction was also made by Weatherburn (2001) in his article on the causes of crime. As Weatherburn noted the failure to distinguish between factors that precede criminal behaviour (proximal causes) and those that are more remote (distal causes) has contributed to difficulties in theorising the causes of crime. While the distinction was not absolute, it facilitated the analysis of the reforms and the subsequent application of the public policy theories.

The data were used to identify drivers and provide nuanced interpretations of the process and impacts of drug policy development. Through acknowledging the existence of multiple views this research highlights contests in the interpretation of policy development. Therefore the research will not purport to show the truth in how policies developed but rather provide perspectives. That said, through the use of the policy and non-policy documents, efforts were made to verify the accuracy of perspectives.

Theoretical applications
After conducting thematic and time-series analysis for each nation the data was compiled identifying the key drivers and mechanism of influence. This enabled the
comparison of a number of similarities and differences in the drivers and their roles in incremental and atypical reform. Finally, the similarities and differences in the process of development were highlighted and interpreted in terms of endogenous and exogenous factors. The former are peculiar to a country being studied and the later have a common presence (May 2002). National characteristics are deemed to impact mainly upon endogenous factors, but they may also affect how exogenous factors influence a country (May 2002; Nowak 1977). Thus exogenous or similar characteristics are not necessarily unaffected by national characteristics.

Interpreting similarities and differences between nations can pose challenges for cross-national researchers. Kohn (1989) argues that similarities are easier to interpret than differences. Similarities are unlikely to have resulted from a methodological defect. To the contrary, he argues that differences in the methodology may enhance the robustness of the findings. However, when the researcher detects differences it is more difficult to ensure that that the difference is real or an artifact of differing methodology. Thus Kohn (1989) argues that in the face of differences it is necessary to narrow the scope of interpretation. Differences can however contribute to more powerful interpretations since the researcher is forced to question the reason for such an occurrence.

The similarities and differences from the Portuguese and Australian research were considered in light of existing theoretical models. In particular, the three public policy theories were applied to produce different interpretations of the atypical reforms. This was used to highlight their “fit” and hence the strengths and weaknesses in their application, and areas in need of modification. The strengths and weaknesses were then examined in the light of the findings from other applications of the public policy theories and the existing literature. This was used to identify the theoretical framework that was most applicable in understanding how the reforms evolved.

**Quantitative data – collection and analysis**

A number of different sources were used to obtain the statistics. The timeframe was not equivalent since data were collected on the calendar year in Portugal and the financial year in Australia. Nevertheless, the data provided indications of the trends following the introduction of decriminalisation and the IDDI.
The majority of Portuguese data was obtained through the annual reports from the Institute for Drugs and Drug Addiction (Instituto da Droga e da Toxicodependência). This detailed the numbers of drug offences, overdoses and cases of AIDS between 1996 and 2004 and the number and type of diversions through the Commissions for the Dissuasion of Drug Addiction from 2001 to 2004. Data on the lifetime prevalence of illicit drug use amongst Portuguese school students was obtained through the European School Survey Project on Alcohol and Other Drugs (ESPAD) survey between 1995 and 2003.

Australian data was obtained from three primary sources. Data on the annual number and type of arrests for drug offences were obtained through the Australian Crime Commission for the period 1996-1997 to 2004-2005. Data on the prevalence and patterns of illicit drug use were obtained from the Australian Institute of Health and Welfare from the National Drug Household Survey for the period 1993-2004 and data on the outcomes from diversion were obtained through the Health Outcomes International Evaluation, and the Alcohol and Other Drugs Treatment Survey-National Minimum Data Set between 2001-2002 and 2003-2004. Data on the prevalence of overdoses were obtained from the National Drug and Alcohol Research Centre.

**Statistical analysis**

This thesis aimed to compare annual trends. In practice, due to limitations in the datasets particularly concerning the outcomes from the atypical reforms, analysis was more ad hoc. Nevertheless, where possible the thesis used time series analysis, something that is used to compare trends in two or more data sets and is thought to be particularly useful for conducting cross-national comparisons (Almond & Verba 1970). Such methods have been used by numerous drug policy researchers including MacCoun and Reuter (2001). The thesis adopts the methodology of comparing similarities and difference in the patterns of variables, rather than the absolute values. Annual trends were developed for the number of arrests and number of diversions for drug use and drug possession in Australia. Similar trends were developed in Portugal for the number of presumed drug offenders for use and possession offences, and the number of contra-ordenações through the commissions for the dissuasion of drug addiction. Finally, annual trends were developed for both nations concerning the number of people treated through the diversionary approaches. These figures
highlighted trends in the numbers and proportions of people diverted, arrested and treated prior to and following the introduction of the decriminalisation and the IDDI: 1998-2005.

The statistics were used as a means of highlighting trends in institutional response. Official statistics can be viewed from a number of perspectives, one of which is the institutionalist perspective (May 2002). From this perspective, official statistics are best viewed as institutional measures of priorities and actions rather than as reflecting the true level of crime. The data in this thesis on police arrests and treatment figures were therefore deemed representative of changing institutional responses to drug users, particularly the shift from a criminal justice to a health response, and not as the true level of drug use or drug treatment. The trends in drug offences, prevalence and health outcomes were used to complement observations and critiques made by interviewees and evaluators about the outcomes of these reforms.

**Issues of ethics, research independence, reliability and validity**

*Ethical considerations*

The study was approved by the University of Melbourne’s Human Research Ethic Committee no. 040105. Key informants were approached by letter outlining the nature of the research and interview process (see Appendix D). The letter included a consent form, which was completed prior to undertaking an interview and contained a number of options. Given the sensitive nature of the subject matter, interviewees were offered options regarding the degree of anonymity to be provided in the study. The options were to be completely identifiable or to be referred to by pseudonym. Four key informants opted to be referred to using pseudonyms. As previously noted all data is stored in password protected computer files or in locked filing cabinets to ensure the confidentiality of the data.

*Negotiating researcher independence*

The relationship between the researcher and collaborating body is complex and requires continual adjustment. While data collected in Portugal remained at all times the property of the researcher and thus allowed the confidentiality and anonymity to be maintained, there were tensions between keeping the collaborating body involved versus researcher independence and rights of interviewees. The Institute for Drugs
and Drug Addiction (IDT) was crucial in providing advice and insight into the Portuguese culture and in particular Portuguese drug policy. The process of exchange of ideas proved essential in the first month in Portugal for narrowing the scope of the research, defining key areas for investigation and enhancing knowledge of the paradigms and practices underpinning Portuguese drug policy. It was also essential in establishing lists of contacts for interviews. However, in the process of gathering and analysing interview data the relationship between researcher and collaborating organisation required adjustment to reduce the potential for harm to interviewees. Concerns for the confidentiality and anonymity of interviewees meant observations from interview data were only indirectly discussed with the IDT. The desire to safeguard the rights of interviewees was particularly paramount given that many interviews contained criticism directed at the government or IDT.

After leaving the field and in particular in drafting the findings, the IDT was asked to provide feedback on the findings and interpretations. Such input is useful to both enhance the validity of the findings and to balance the relationship with the collaborating body. Barrett and Cason (1997, p. 121) have noted that “the relationship between the researcher and the researched is often asymmetrical” and thus recommend keeping the collaborating body involved and providing feedback. A final copy of the completed thesis will be sent to the IDT and all key informants who have requested a copy.

**Reliability and Validity**

There is much debate in the field as to whether the goals of quantitative research – validity, reliability and objectivity – apply to qualitative research. Some authors such as Flick (2002) and Silverman (2001) use the traditional quantitative goals. Others such as Lincoln and Guba (1985) and Creswell (1998) have devised alternate terms and goals of qualitative research. For Lincoln and Guba (1985) the ultimate goal of qualitative research is to demonstrate trustworthiness, through credibility, dependability, transferability and confirmability. Huberman and Miles (1994) have compiled both sets of criteria for example reliability/dependability/auditability and internal validity/credibility/authenticity. This is useful as it demonstrates that despite the conflicts in terminology there are commonalities in the ascribed methods of demonstrating the soundness and worth of research.
Following such an approach this research acknowledges the need of qualitative research to meet five key criteria and sought to follow the methods subscribed below. The first is that research is objective and free from researcher bias. Methods to demonstrate this are disclosing any personal or professional information that may have affected data collection, analysis of interpretation (Flick 2002; Patton 2002), making data available for re-analysis, and being explicit in methods and procedures (Miles & Huberman 1994). The second criterion is reliability or dependability and refers to the level of care demonstrated by the researcher in design and undertaking of the research. Methods to demonstrate this are that research design and methods are appropriate for the research question (Flick 2002; Mason 2002; Miles & Huberman 1994), that care is taken in the generation and analysis of data (Mason 2002) and that the process of data collection is transparent (Flick 2002). It is specifically recommended that data are checked for misinformation (Creswell 1998; Miles & Huberman 1994) and that if the researcher uses interviews that they are recorded, transcribed and sent to interviewees for cross-checking (Denzin & Lincoln 2003; Flick 2002; Silverman 2001). By following such methods, it was hoped that the methodological design was appropriate, and that the descriptions made in this research were accurate representations of the data.

It is also important to illustrate that the interpretations in qualitative research are plausible and relate to the phenomena of study. This criterion is called internal validity/credibility/authenticity (Huberman & Miles 1994). Such a quality can be demonstrated through triangulation of data methods to demonstrate convergence in conclusions (Denzin & Lincoln 2003; Miles & Huberman 1994; Patton 2002), use of thick descriptions (Creswell 1998; Huberman & Miles 1994) and consideration of negative evidence or rival explanations (Maxwell 2002; Miles & Huberman 1994; Patton 2002). Ultimately Silverman (2001) argues that internal validity requires the researcher to demonstrate why they chose their particular interpretation and ensure a comprehensive account of the whole dataset is provided.

Finally, there is the issue of generalisability or external validity. This is a key concern for this research since it uses a comparative analytical approach. Use of comparative methods, particularly use of variable sites increases the generalisability of the research (Schofield 2002). Generalisability is therefore dependent upon the sampling procedures and scope of the data (Maxwell 2002; Miles & Huberman 1994;
Silverman 2001). However, Patton (2002) cautions on the need to not over-generalise. MacCoun and Reuter (2002) in particular note the inherent uncertainty in generalising from drug policy research. Therefore the limitations of the current methodology should be acknowledged and the data carefully interpreted.

The main methods used in this research to increase reliability and internal and external validity were careful design and interpretation, recording and transcribing all interviews and sending transcriptions to key informants for cross-checking. To ensure accuracy of the data, quotes were reported highlighting the page number for example [5] from their transcription. Moreover, themes highlighted from interviews were linked with secondary sources and the literature review in efforts to increase the validity of the data and achieve triangulation. Using the recommendations of Patton (2002) perspectives from different groups of key informants, such as politicians versus academics, were also compared in order to reduce bias and distortion. This was thought particularly necessary since there was a heightened political situation in Portugal during the period of data collection. Alternate schemes of classification of the data and/or explanations are also offered in an attempt to increase the rigor and credibility of the research (Patton 2002). In theory generation, a number of means outlined by Huberman and Miles (1994) were adopted to verify the theories. These include triangulation and search for outliers and evidence that negates the theory and getting feedback from key informants. Finally, the theoretical findings from this research were used to re-examine the studies from the literature review.

**Impacts upon reliability and validity**

There were two issues relating to the use of a cross-national research that may have impacted upon the reliability or validity of the research. The first was the equivalence of the interview situation and the second, the use of a translator. Data from interviews in Portugal involved a mixture of Portuguese and English. In recognition that the translation of the Portuguese data is insufficient for interpreting the true meaning of language (Phillips 1970), strict interpretation of the data was avoided. Such a method has been proposed by Almond and Verba (1970) as a means of reducing incompatibilities caused by subtle distinctions in the interview data.

Conducting interviews in Portugal first has undoubtedly impacted upon the comparability of the interview situation in Portugal and Australia. The major impact
to be noted was that the interviews took longer in Portugal since they were less structured. Those conducted in Australia took place after refining the focus of the research. Conducting interviews in Australia prior to going to Portugal may have assisted in narrowing the focus in Portugal; however, such an approach was less desirable as previously explained.

Given that only some interviews involved a translator the reliability of the data collection has no doubt been reduced. The mere presence of a translator impacts upon the interview, particularly when the translator is of the same culture as the interviewee and reduces the involvement between the interviewer and interviewee (Phillips 1970). However as my Portuguese skills progressed, the need for translation was reduced, which enhanced both the speed of the interview and the involvement of the interviewer and interviewee. Concessions were made in data analysis in recognition that this data may not be equivalent.

As noted earlier, despite problems in obtaining access to comparable data, this thesis chose to use statistics on trends and the outcomes of the analogous reforms of decriminalisation and the IDDI. The use of official statistics is problematic for within-nations studies, but creates added complications for cross-national studies. The production of official statistics is affected by definitions and institutional practices. Police statistics are particularly problematic since the level of reported crime is affected by detection, discretionary procedures and police practices for example differential application and enforcement (May 2002). This creates obvious problems for the validity and reliability of the statistics. However, this ought to be less of a problem given the statistics were used to highlight trends in institutional responses, rather than the “truth.”

Justifications and limitations

Scope - breadth versus generalisability

The scope of this cross-national research has implications for the generalisability and depth of the research. The cross-national comparison between two nations as opposed to three or more nations reduced the potential for generalisability of this research. The research therefore acknowledges that the implications of this research for other nations and other cases of national policy development or idiosyncratic change may be limited. Further research to increase the generalisability would be well advised.
However, by narrowing the scope of this research to two nations it enabled more depth of research, which is crucial particularly for qualitative methodologies (Creswell 1998). Furthermore, through reducing the scope it created more opportunity for control over what Bendikat (1996, p. 132) has termed “the frame of comparison.” The research focus upon broad drug policy development and idiosyncratic reform makes this research unique. It is unlikely that a third nation could have been found that fit the criteria of undergoing idiosyncratic change in their national drug policy during a similar time frame.

A key issue concerning the generalisability of the research concerns the small sample size of the Australian drug policy makers. Efforts to maximise sample size through in particular the use of a longer data collection period in Australia came to limited fruition. This has reduced the potential to corroborate views in Australia. Nevertheless, the views represented in the current research are those of highly qualified and esteemed policy makers. Further, many of those were uniquely involved in the development of the IDDI. As is noted throughout the thesis the development of the IDDI occurred through a closed arena, which arguably reduced the capacity to meaningfully enhance the sample pool for the research.

**Issues of non-comparability - Time, unexpected events**

Some limitations could not be avoided due to non-comparability in interview times and situations. Interviews in both Portugal and Australia were conducted prior and during evaluations of key elements of the study, namely the ENLCD in Portugal and the IDDI in Australia. The evaluation received considerably more publicity in Portugal than in Australia. This had unexpected benefits for this research as a number of conferences were held during this period which enabled greater involvement in the Portuguese drug policy environment. The most notable was a two day conference held in Santa Maria de Feira on 24-25 November 2004. This was the inaugural conference of the IDT and enabled a host of speakers to present their impressions and critiques on the Portuguese drug strategy and decriminalisation. Despite this the publicity may have impacted on the type of responses given in the interviews.

The main potential confounding factor was political. During the period of research in Portugal there was considerable hostility towards the conservative government in power which culminated in its dissolution by the President Jorge Sampaio, prior to the
final eight interviews. These events appear to have impacted upon questions of a political nature and may have elevated the level of criticism of the conservative government’s leadership in drug policy. However, this was mainly observed amongst the interviews with politicians. In light of this the various perspectives of key informants were compared to reduce the potential for bias. The most direct impact of this event was that an interview was prevented from occurring with the conservative government. Finally, the sample size in Australia was substantially smaller than that obtained in Portugal.

Reflection
The decision to collaborate with a government body was based upon access to data but also the limitations on the number of options in Portugal. I did however have concerns that perhaps the interview responses were influenced by my collaboration with a Government body. Upon reflection such concerns appear unwarranted given the frequency of criticism directed at the Government. I was fortunate that the IDT was very supportive and enabled considerable logistical support most notably the access to advice and key informants. Barrett and Cason (1997) have noted that the degree of assistance of an affiliation can be variable. The process of living in the field proved a very rewarding experience and I was heartened by the enthusiasm shown by the Portuguese key informants for this research. This may have been aided by the novelty of the research. Portugal had received scarce attention from international scholars. However, another factor that was perhaps crucial not only in obtaining access to the IDT but also to interviewees was a genuine pride in the Portuguese drug policy and openness to research. The pride in the Portuguese drug policy may have created problems of the halo effect (Mangen 1999) if this research was evaluative. Given the nature of the current, analytical research, halo effects were deemed to have minimal negative impact and may indeed have facilitated high participation in this research.

Conclusion
In conclusion, the thesis used a descriptive-analytical approach to examine the process of drug policy development in Portugal and Australia. It used primarily a qualitative approach, involving semi-structured interviews with 42 expert policy makers, and supplemented this with documents and publicly available statistics. The primary
method of data analysis was thematic analysis, which was used as the basis for the following chapters, highlighting the trends and processes of policy development.

The research has been aided by the access to the Institute for Drugs and Drug Addiction and the Australian National Council on Drugs. The use of a cross-national approach has meant that the data sources, collection and analysis is more contextual than for within-nation studies. Accordingly, the reader should recognise the limitations, particularly with understanding the outcomes from the atypical reforms. However, given the primary purpose of this research was to explore the process of development, provide contextual detail, and applicability of the public policy theories the cross-national approach brings the ability to extend current theoretical understandings.
Chapter Two examined theories and literature on public policy and drug policy development. Through doing so it highlighted a number of drivers and processes of policy development. The current chapter examines the process of drug policy development in Portugal in light of this knowledge. It draws upon the experienced, nuanced views of key informants involved in the drug policy making process, views which were supplemented with Portuguese and European literature. The chapter examines the period of drug policy development leading up to the enactment of Law 30/2000, (1994-2000) through four sections:

1. Key influences upon Portuguese drug policy
2. Incremental reform: Development of Projecto VIDA
3. Atypical reform: Development of decriminalisation
4. Framing of decriminalisation

The first section provides an overview of the major influences upon Portuguese drug policy. As noted in Chapter Three, data have been analysed and are reported using the distinction between proximal and distal factors. Proximal factors were the factors found to exhibit the most direct impact upon incremental/atypical reform: crises, research, policy actors and political factors, the roles of which are examined in detail throughout this chapter. Distal factors were found to act through the proximal factors and include past paradigms, international factors, structural arrangements and values.

The second and third sections examine the policy making process particularly through the proximal factors and highlight often contrasting views on how these factors are thought to have contributed to incremental/atypical reform. Due to the complexity of drug policy development Table 2 lists a timeline of key events leading up to the adoption of Law 30/2000. The final section examines how the process of development impacted upon the objectives and mechanism of decriminalisation.
Key influences upon Portuguese drug policy

Proximal factors

Crises
A key factor in the development of Portuguese drug policy was the change in the size and nature of the Portuguese drug problem. In the late 1980s and 1990s drug use in Portugal became increasingly problematic as a significant population of intravenous heroin users developed. Rates of infectious diseases including HIV, AIDS, Tuberculosis, Hepatitis B and C soared creating a public health crisis. For example between 1990 and 1997 the number of drug users with AIDS increased from 47 to 590 and peaked at 635 in 1999 (Instituto da Drogad e da Toxicodependência 2004c).

The crisis grew as drug use became increasingly visible through the creation of open air drug markets, the most infamous of which was called Casal Ventoso. Casal Ventoso was a slum, characterised by extreme poverty and social exclusion amongst a predominantly migrant population (Chaves 1999; Flores 1993) and was located at the outskirts of the capital city of Lisbon, in Santo Condestável. Over a period of about twenty-five years Casal Ventoso developed into a metropolis of drug use and criminality and ultimately the biggest drug market in Europe (Miguel 1997). It attracted large numbers of drug users, with up to 5,000 visiting daily to obtain drugs, predominantly heroin. Casal Ventoso became a site of the most problematic drug use and infectious diseases in Portugal with 60% of drug users HIV positive (Gabinete de Apoio ao Toxicodependente 2003) and 74% HCV positive (Valle & Coutinho 2001). Furthermore, 800 hardcore drug addicts ended up homeless, residing in Casal Ventoso in temporary accommodation:

Casal Ventoso was a quarter, the big supermarket for drugs, where 5000 people go there everyday to buy drugs. But these people some of them become degenerated and then they stay there.

Rodrigo Coutinho – Health Professional – [15]

The public health and social crisis exemplified by Casal Ventoso is reflected in the following images. The temporary accommodation that was established at the foot of Casal Ventoso, the homes to many drug users and drug dependent persons, is depicted in Figure 3. Figure 4 illustrates some of the drug users in front of the Social Centre of Casal Ventoso. A key driver in Portuguese drug policy development was thus the increasingly problematic nature of the drug problem.
Figure 3: Panoramic of Casal Ventoso with temporary/slum housing in the foreground

Source: Câmara Municipal de Lisboa – Arquivo Fotográfico

Figure 4: Drug users and residents in Casal Ventoso following demolition of sections of Rua Costa Pimenta

Source: Câmara Municipal de Lisboa – Arquivo Fotográfico
Two sources of research played key roles in the development of the Portuguese drug policy: local and European research. Local research increased during the 1980s and 1990s. That said, it must be acknowledged that research into the Portuguese drug problem was of a limited nature. Indeed the first national survey of drug use was not conducted until 2001 (Balsa et al. 2004). Nevertheless, research by Portuguese universities and drug research centres was important to highlight the size and nature of the drug problem in Portugal (Miguel 1997; Ribeiro 1999). This drew attention to the problematic nature of heroin addiction in Portugal and the public health and social problems highlighted above.

The effectiveness of the traditional criminal justice approach to the drug problem became another focus of attention. The first parliamentary commission into drugs recognised the difficulty in fighting drug trafficking in Portugal— a transit country— due to two reasons. Policing drug trafficking was very inefficient and of questionable worth (Comissão Parlamentar de Juventude 1992). The parliamentary commission noted that the primary policing body— the Judicial Police— apprehended only about 5-10% of all drugs going through Portugal. This provoked questions as to the desirability of strengthening the “war on drugs.” For example, Rodrigues Almeida (1997) asserted that such an approach contributed towards drug adulteration, overdoses, human degradation, corruption and ultimately more crime and hence was a dangerous pathway. He therefore asserted that Portuguese drug policy needed to reconsider the desirability of the “war on drugs” particularly for drug users. Moreover, Pedroso (1997, p. 94) concluded that the deterrent effect of prohibition on consumption, “isn’t much effected by the penal law and consequently by police or judiciary.”

This led to the conclusion that there were no moral, ethical, juridical, economic or political reasons for why prohibition should be maintained.

In the mid to late 1990s politicians established two expert bodies into the Portuguese drug problem. The first of these was a parliamentary committee that was established in November 1995 with the intention of examining the current state of knowledge on drug addiction and trafficking. The parliamentary committee ran until July 1999 under

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10 Translation of “não deve ser efectuada pela via da lei penal e consequentemente pela via policial ou judicial.”
the leadership of António Filipe Rodrigues and produced a parliamentary report that noted:

- Systems and structures of coordination were inadequate
- Drug use had spread throughout the country, with heroin and cocaine constituting the major problems
- Waiting lists for treatment and social reintegration were extensive and there were insufficient resources for combating drug trafficking
- Drug use in prison had become an increasingly prevalent occurrence, with a prison population of 14,052 in 1997 of whom 68% were estimated to consume drugs and 20% to be HIV positive. Given the primary option provided by prisons was for drug users to attend drug-free units, the report highlighted the need for vaccination, condoms, syringes and expanded methadone treatment (Niza 1998).

The parliamentary committee identified problems in all major areas of the Portuguese drug policy: prevention; treatment; reintegration; and supply reduction; Moreover, it concluded that since 1976 and the introduction of the first structure for managing drug problems in Portugal – the Drug Fighting Coordinating Office (Gabinete Coordenador de Combate à Droga - GCCD) – the drug problem had gotten considerably worse:

The irrefutable truth is that the consumption of drugs has not only increased but that new drugs have invaded the market – designer drugs – and drug users have become younger (Niza 1998, p. 239). 12

This provoked the damning conclusion that the period from 1976 – 1996 constituted twenty years of failure. The Portuguese response to the drug problem was therefore painted as woefully inadequate.

The second expert body was established by José Sócrates with the express purpose of proposing a national drug strategy for Portugal. The Commission for a National Drug

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11 While methadone substitution was available in Portuguese prisons in 1998 there were stringent criteria, one of which was that the offender must have been enrolled in a methadone program before entering prison.

12 Translation of “A verdade irrefutável é a de que o consumo de drogas não só aumentou, como novo drogas – as “design drugs” – invadiram o mercado da oferta e despertaram a procura das camadas mais jovens.”
Strategy (CNDS) ran between February and October 1998 and comprised nine experts from health, law enforcement and academic fields. The final report concluded that:

> The war on drugs is a paradigm of battle whose actors, dominated by emotions, think they can win without thought. Consequently: [the dominant actors] neither remove the phenomenon of drugs nor the fundamental source of desire (Comissão para a Estratégia Nacional de Combate à Droga 1998, p. 6).\(^{13}\)

It listed 63 recommendations in the areas of prevention, treatment, training, coordination and legislative frameworks, including recommendation 3.2.6 - decriminalisation of drug consumption and possession for personal use (Comissão para a Estratégia Nacional de Combate à Droga 1998).

The European Union played an increasing influence, through demonstrating European trends in drug policies and situating the Portuguese drug problem in the European context. Research of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) was particularly important. The European Union agency was established in 1993 in Lisbon, and produced its first reports in 1995. In the late 1990s the annual and thematic reports highlighted a number of important European drug trends.

In particular, the EMCDDA highlighted two key trends. First, drug-related arrests increased in most EU nations, particularly for use-related offences. Between 1985 and 1997 drug-related offences increased fourfold in a number of countries including Portugal, Spain and the UK (EMCDDA 1998). Moreover, this trend continued steadily until 2003 (EMCDDA 2005a). Second, towards the mid 1990s there was increasing recognition of the need to consider alternative responses to use and possession and thus moderate the expanding criminal justice system. Accordingly, EU nations increasingly refrained from repressive responses to drug users. While consumption and possession continued to be prohibited few drug users received criminal prosecution or convictions (EMCDDA 1999). The trend therefore was towards *de facto* decriminalisation.

Further, the EMCDDA highlighted that, compared to other European nations, the Portuguese drug situation was increasingly problematic. While the EMCDDA reports (1999) showed Portugal continued to maintain a very low prevalence of lifetime illicit

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\(^{13}\) Translation of “A "guerra da droga" é o paradigma daqueles combates cujos actores, dominados pelas emoções, crêem poder vencer sem pensar. Resultado: nem o fenómeno das drogas foi vencido nem dele dispomos de conhecimento tão solidamente fundado como desejáriamos.”
drug use – about 5% throughout the 1990s – they demonstrated that the nature of drug use was problematic. The reports indicated that in most European nations the rate of drug-related deaths and AIDS peaked in 1994-1995, yet the rates were still increasing in Portugal (EMCDDA 1998). The increasing public health crisis meant that by 1999 Portugal had the highest rate of AIDS amongst injecting drug users in the European Union (EMCDDA 2000). These reports thus concurred with the Portuguese research demonstrating the need for a more adequate response.

Policy actors
Prior to the development of the national drug strategy and decriminalisation Portuguese drug policy was coordinated by the High Commissioner or head of Projecto VIDA and a series of inter-ministerial bodies: the National Council, the Inter-ministerial Council and the National Commission (Lei n.º 45/96, de 3 de setembro 1996). These governance structures essentially consisted of Government Ministers and bureaucrats who coordinated the dominant policy of the time: Projecto VIDA.14 Drug strategy coordination shifted significantly during the period of study. For the purposes of this research, the major change identified as relevant by key informants was the creation of the Portuguese Institute for Drugs and Drug Addiction (Instituto Portugues da Droga e da Toxicodependencia - IPDT), which replaced the Drug Fighting Coordination and Planning Office (GPCCD – formerly known as the GCCD). This occurred between 1998 and May 2000 (Decreto-Lei 90/2000, de 16 de maio 2000).

The main interest groups involved in contemporary Portuguese drug policy were the health and law enforcement sectors and the political lobbying group Abraço which

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14 The head body was the National Council for the Prevention of Drug Addiction (O Conselho Nacional de Prevenção da Toxicodependência). Membership was wide including representatives from the judicial system and public prosecution, regional government and non-government sectors such as therapeutic communities. The main executive body was an inter-ministerial council (Comissão interministerial) presided over by the Prime Minister and involving all relevant Ministries (defence, education, justice, health, internal administration, employment and social security). The second executive body was called the National Coordinating Commission (A Comissão Coordenadora Nacional) which was a bureaucratic body consisting of representatives from within the above stated ministries and was responsible for the coordination and implementation of Life Project. The final executive body was the High Commissioner for Life Project (O Alto-Comissário para o Projecto VIDA) who was appointed by the Prime Minister and whose staff had a mission to run day to day issues, promote knowledge and debate on drug issues and act as international spokespersons on Portuguese drug policy.
promotes more effective responses to HIV/AIDS. The key representative of the health sector was the Drug Addiction Treatment and Prevention Service (SPTT), which was established in 1994, to supervise the drug treatment centres (CATs). The law enforcement sector included three national police services. Of these the Criminal Police (Policia Judiciária - PJ) focused upon drug traffickers. In contrast, drug users were the major focus of the other two police services: the National Republican Guard (Guarda Nacional Republicana – GNR); and the Public Security Police (Polícia de Segurança Pública – PSP) (GPCCD 1997).

A number of key individuals played entrepreneurial roles in the development of Portuguese drug policy. These included the President of the Republic, Jorge Sampaio, Socialist politicians – José Sócrates and Alexandre Rosa – and treatment professionals including Nuno Miguel, João Goulão, Luís Patrício and Rodrigo Coutinho. Following the election of the Socialist Party in 1995 a number of these individuals gained roles of increasing importance. Notable changes included the appointments of João Goulão and José Sócrates in 1997 to the respective roles as head of SPTT and Prime Minister Adjunct and Drug Strategy Coordinator.15 Subsequently Alexandre Rosa was appointed as National Coordinator and High Commissioner of Projecto VIDA.

**Political factors**
The Portuguese political system consists of eleven political parties. The parties of greatest relevance to contemporary drug policy making included two right of centre parties and four left of centre parties. The former included the Social Democratic Party (PSD) and the People’s Party, formerly known as the Party of the Democratic and Social Centre (CDS-PP). The latter included the Socialist Party (PS), the Portuguese Communist Party (PCP), the Green Party (PEV) and Left Bloc (BE). The Social Democratic and Socialist Parties have dominated in recent years, under the governance of Social Democrat Prime Minister Covaco Silva (1985-1995) and Socialist Prime Minister António Guterres (1995-2001) (Comissão Nacional de

15 The term “Drug Strategy Coordinator” will be used to refer to the Government Minister responsible for the drug portfolio. This position is delegated by the Prime Minister to any member of his Government, who then appoints a “National Coordinator.” In Portuguese drug policy, the National Coordinator traditionally has the leading role in policy making. However, during the development of decriminalisation the Drug Strategy Coordinator had unusually high involvement in drug policy formulation.
The National Drug Strategy and decriminalisation were introduced during the latter period, under the Socialist Party.

The Portuguese government paid increasing attention to the drug problem, following the election of the Socialist Party. The drugs issue was included in their election campaign, which was a first for Portugal. Moreover, the Governance Program 1995-1999 of the Socialists included specific objectives to expand treatment and increase penalties for drug trafficking and allocate more resources to the drugs area (Presidência do Conselho de Ministros 1995). Subsequent events included the establishment of the parliamentary committee into drugs, holding of D Day – a national drugs awareness day involving politicians and the President – and establishment of the CNDS. The leading individuals responsible for the drugs portfolio during the development of decriminalisation were the Drug Strategy Coordinators José Sócrates (1995-1999) and Vitalino Canas (1999-2001). National Coordinators during this period were Alexandre Rosa (1998-1999) and Elza Pais (1999-2001).

**Distal factors**

**Past paradigms**

As outlined in Chapter Two the first national drugs campaign was created in 1987 and called Projecto VIDA (Life Project). Projecto VIDA aimed to promote healthy lifestyles and had two key objectives: supply reduction and prevention. (*Resolução do Conselho de Ministros n.º 23/87, de 21 de Abril 1987*). In particular it sought to publicly condemn drug traffickers and therefore supported a “war on drugs” approach (Gabinete do Ministro da Juventude 1989).

There was considerable debate regarding the extent to which drug legislation in Portugal criminalised drug users. Drug consumption was not criminalised in Portugal until 1970 and the ratification of the UN Conventions (*Decreto-Lei n.º 420/70, de 3 de setembro 1970*). There was debate as to whether the ratification had a rhetorical or practical impact. On the one hand it was argued that drug laws took a quasi-symbolic approach to drug consumers (Fonseca & Quintas 1997). In this vein drug legislation emphasised the need to provide opportunities for treatment and rehabilitation of drug users. On the other hand punishment of drug users arguably continued as a consequence of the fight against drug trafficking.
Figures on drug use and trafficking show that the number of presumed drug law offenders almost doubled between 1995 and 1999. During this period the total number of presumed offenders increased from 6,380 to 13,020 (Instituto Português da Droga e da Toxicodependência 2000). The major increase concerned charges for drug use which increased from 47% to 62%, in 1995 and 1999 respectively. This was not however mirrored by a clear trend in convictions for consumers. While the number of convictions for drug law offences also increased, the percentage of consumers convicted fluctuated between 32% and 48%. Moreover the majority of drug users convicted for consumer offences received fines. The number of people in prison for drug law offences also increased during this period to a total of 44% of all convicted prisoners in 1999; however most were convicted of crimes related to drug trafficking.

*International influences*

Portugal joined the European Union in 1986 and following that time has been increasingly influenced by European bodies. European action towards drugs increased through the 1990s and included the adoption of European Action Plans on drugs in 1995-1999 and 2000-2004 (EMCDDA 1997, 2002b). The actions plans recognised that Europe was an international market and that removing borders increased the ease of drug trafficking. They increasingly recognised the need for pragmatic and evidence-based responses, and expressed support for harm reduction activities, and alternatives to the strict use of the criminal justice system in responding to drug users. The twentieth special session of the United Nations General Assembly held in July 1998 also called upon all signatories to introduce national drug strategies. Furthermore it recognised demand reduction as an “indispensable pillar in the global approach to countering the world drug problem” (United Nations 1998, paragraph 17) and set two significant dates. The first date, 2003, was the target date for new or enhanced demand reduction strategies; and the second date, 2008, was the target for significant and measurable results in demand reduction (United Nations, 1998).

International bodies and conventions had particular influence upon the development of decriminalisation in Portugal. The international legal framework on drugs is established through the three UN Conventions on drugs to which Portugal is a signatory. These are the 1961 Single Convention on Narcotic Drugs, as amended by the 1972 protocol, the 1971 Convention on Psychotropic Substances and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. The
1961 and 1971 Conventions require parties to limit all activities related to narcotic drugs or psychotropic substances, including the manufacture, preparation, distribution, sale and possession, to medical and scientific purposes (United Nations 1961, Article 36; 1971, Article 20). Signatories to the 1988 Convention are required to implement measures to reduce trafficking through criminalising the financing, facilitating or organising of drug-related activities (United Nations 1988, Article 3, paragraph 1) and made the following ruling regarding personal drug use:

Subject to its constitutional principles and the basic concepts of its legal system, each Party shall adopt such measures as may be necessary to establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention (United Nations 1988, Article 3, paragraph 2).

There is debate as to whether this mandates all signatory bodies to criminalise drug possession for personal use, but this is the view adopted by the International Narcotics Control Board (INCB). Other international organisations including the EMCDDA (2004) take the view that countries have the right to decriminalise drug possession, an approach taken by Italy and Spain, in accordance with their constitutional and legal principles:

It is the right of the country to prohibit drug use, but to apply the sanction, penal or administrative, that they want to. So a country is absolutely free to criminalise drug consumption, consumption or use, or prohibiting but applying administrative sanctions.

Danilo Ballotta – EMCDDA – [3]

Nevertheless, Portugal received international criticism following the adoption of the national strategy and option to decriminalise, and again in 2001 following the enactment of Law 30/2000:

In April 1999, a draft law was approved in Portugal stipulating that drug users will face fines rather than jail sentences. Under the new law, the abuse and possession of drugs for personal use will no longer be criminal offences but only administrative offences. As the Board has stated repeatedly, this is not in line with the international drug control treaties (International Narcotics Control Board 1999, section 449).

**Structural arrangements**

Portugal is a parliamentary republic, which means it has a President, in addition to a government and parliament. Under President Jorge Sampaio (1996-2006), the role of the President became of particular importance in the development of Portuguese drug policy. While the primary role of the Portuguese President is to oversee government and to promulgate and veto all proposed laws and decree-laws, the President also has
the power to call for public referenda or to dismiss government (Assembleia da República 1997, artigos 133-136).

The mechanism of legislative development was also an important issue in the development of decriminalisation. Portuguese legislation can be devised through Parliament (laws) or through Government (decree-laws). However, the major power is with parliament which has exclusive rights in a number of areas, particularly on crimes and can inspect every decree-law devised by Government (Assembleia da República 1997, artigo 165.1.d). In theory, this therefore gives foremost control over legislative formulation to Parliament (Leston-Bandeira 2004). However, such a process will be shown to have been voided in the development of Law 30/2000.

Related issues were that legislative proposals must be discussed with the independent islands of the Medeira and Açores archipelagos if they are to be enacted in both Portugal and the independent regions. Medeira and the Açores are autonomous regions and therefore have their own governments and legislative systems (Assembleia da República 1997, artigo 112.4). Between 1996 and 2004, there was a Socialist Government in Açores under Prime Minister Carlos César but a Social Democratic Government in Madeira under Prime Minister Alberto João Jardim. The structural arrangements therefore created multiple opportunities to advocate for or oppose Law 30/2000.

Values/frameworks

The Portuguese Constitution and national values were of importance in the development of decriminalisation. Following the liberation of Portugal from dictatorship in 1974, the Portuguese Constitution and laws put considerable emphasis on human rights:

The liberation of Portugal from dictatorship, oppression and colonialism represented a revolutionary change and an historic new beginning in Portuguese society. The Revolution restored fundamental rights and freedoms to the people of Portugal. (Assembleia da República 1997)

The Portuguese Constitution not only supports, but guarantees human rights and freedom, including the right to safeguarding of health and guaranteed access to health care. The most relevant article of the Portuguese Constitution is article 64 on health care which states the Government has a duty, “to guarantee access by every citizen, regardless of his economic situation, to preventive, curative and rehabilitative medical care” (Assembleia da República 1997, artigo 64.3.a). While the Constitution does not
guarantee the right to take drugs, it does guarantee to provide treatment for drug users. The Portuguese Constitution also emphasises proportionality in punishment. It states that prosecution must be in the public interest and that punishment must not be onerous or disproportionate (Assembleia da República 1997).

In recognition of these principles, the Portuguese legal system uses the criminal law as a last resort. It traditionally distinguishes between the seriousness of offences: criminal acts; administrative acts; and contraventions (contra-ordenações) (Machado 1999). The latter were developed in 1982 in response to the increasing levels of state regulation of health, education and social matters and are defined as breaches of statutory laws or social order offences (Decreto-Lei n.º 433/82 de 27 de Outobro: Institui o ilícito de mera ordenação social e o respectivo processo 1982). Thus, many minor Portuguese infractions are dealt with through the contravention system rather than through the criminal law, thereby effectively decriminalising certain acts.

Finally, there has been a long history in Portugal of support for either decriminalisation or legalisation. Prominent Portuguese advocates for the legalisation of marijuana and/or illicit drugs included Almeida Santos, Cardona Ferreira, Figueiredo Dias, Victor Cunha Rego, João Menezes Ferreira and Carlos Rodrigues Almeida (Resolução do Conselho de Ministros n.º 46/99 de 26 de Maio 1999). Perhaps the most notable was the Minister for Justice Almeida Santos who proposed to decriminalise drugs in 1976 (Poiares 2003). Policy makers reinforced the importance of this belief, arguing that decriminalisation was inevitable:

So everyone was practically agreed that decriminalisation should arrive one day, that it was a better strategy and policy.


The following section examines how these factors impacted upon incremental and atypical reform.
Incremental reform: Development of Projecto VIDA

In 1998 the Portuguese Parliamentary Committee came to the infamous conclusion that Portuguese drug policy had been the story of twenty years of failure (Niza 1998). The majority of policy makers concurred; following the introduction of Projecto VIDA Portuguese drug policy had undergone limited and insufficient change. Incremental reform was attributed to a number of factors: the low political priority; the dominance of psychiatrists with partisan views; silos; and a lack of research.

Low political priority
Prior to 1995 Portuguese drug policy was perceived as an issue of low political importance. It was therefore largely seen as removed from the macro-political agenda. Most political interventions including the introduction of Projecto VIDA in 1987 were perceived as symbolic and deemed to have limited impact upon the ground:

*The Government created a special body which was called Projecto VIDA, which was mainly at the county level – locally – but this special body was created mainly to give the public the idea that it was doing something.*


Furthermore, coordination of drug policy shifted in central control, between the Ministry of Justice and the Ministry of Health, without apparent reason:

*The intervention to control drug addicts’ problems in Portugal has been a lack of quest and if you want, a lack of persistence.*

José Castanheira – Health Professional – [2]

*The political level… they made many noise, but they made very little [impact].*

Rodrigo Coutinho – Health Professional – [12]

Some policy makers asserted that incremental reform was aided by successive Social Democratic governments between 1985 and 1995:

*The Socialists are more aware of this kind of problem in Portugal than the Social Democrats. Even if they are not so different in their ideology, in certain policies they are different and this is one of them; the Socialists are more aware.*


Indeed Carlos Costa, who undertook doctoral research into Portuguese drug policy making from 1974-2000, argued that there was a shifting of responsibility during this era:

*Between 1985 and 1995 during the Cavaco Silva Government there was a politics of ping-pong, so this is not my problem, this is your problem.*

Magalhães (2003) similarly contended that the period of Cavaco Silva’s reign was characterised by technocratic governance. However, Carlos Costa also stated that with the exception of the Portuguese Communist Party drug policy was essentially a low priority for all political parties:

The sole party that has had a very consistent and objective speech about this problem has been the Communist Party in the period from 1988 to 2000.


A number of politicians noted that many politicians took closed or moralistic views on drug users, which constrained opportunities for reform:

I think that some politicians have closed visions about this problem.


Closed visions, or what many policy makers referred to as “dogma” reduced opportunities for discussion and facilitated the low political priority of the drugs issue. Due to the frequency with which key informants referred to dogma – defined as “closed minds” or fixed beliefs – such a term will similarly be utilised in this research.

Policy makers contended that due to the low political priority, the governance structure was the major determinant of policy direction and opportunities for reform. The introduction of Projecto VIDA sought to counter-balance the myopic focus upon drug trafficking (war on drugs) through a three-pronged approach involving education, treatment and combating drug trafficking. The new inter-ministerial governance arrangements sought to mesh the operations by the health and law enforcement sectors (Presidência do Conselho de Ministros 1996). It thus aimed to reduce silos, encouraging sectors to operate in a coordinated fashion, rather than independently. However, policy makers asserted that poor coordination and the presence of differing objectives – supply reduction and demand reduction – meant silos remained:

The entities which were in charge of the different sides of the problem were scattered. This contributed to a certain dispersion of objectives and goals.


I would say it is a cultural problem in Portugal. We can have a very good law regarding all matters but when it turns to practice it tends to be very different. Because there is no… There is no communication. That is a big problem. There is no communication between the different systems. So the justice system doesn’t communicate with the health system with the education system and so on.

Maria José Campos – Member of AIDS Non-Government Organisation – [10]
The CNDS (1998) concurred that communication between the sectors was impeded. Accordingly, this may have encouraged the maintenance of dual and sometimes conflicting objectives of punishment and treatment for drug users.

Further, due to the predominance of bureaucrats and Ministers, the Governance structure reduced potential input of new ideas. This was a particular issue of concern raised by the CNDS (1998). The major decisions were made by the law enforcement and health sectors, the latter of which was dominated until the late 1990s by a group of psychiatrists advocating drug-free treatment. This contributed to considerable frustration, but minimal opportunity to challenge or change the direction (Miguel 1997).

**Dominance of the drug-free supporters**

Policy makers argued that the greatest constraint upon Portuguese drug policy was not the policy making structure or the silos per se, but the dominance of psychiatrists with drug-free ideologies. Most notably the head of the Drug Addiction Treatment and Prevention Service (SPTT) Dr José Castanheira who was appointed in 1994 was openly anti-methadone. As he summed up, harm reduction would encourage drug use:

> So this type of method is very common in Europe, and in my perspective they are part of the problem and not part of the solution.

José Castanheira – Health Professional – [6]

Efforts by other health professionals and researchers to challenge or change such ideas, and in particular to introduce low threshold methadone maintenance, met considerable opposition. Since low threshold methadone maintenance was designed to stabilise rather than treat addiction - though reducing the entry criteria for drug users - it was strongly opposed by the drug-free supporters. As the subsequent head of the SPTT, Dr João Goulão, said the introduction of low threshold methadone was not possible during this era, due to “the technical and ideological position we were fighting” [5]. In other words, the opportunities and impetus for change were reduced through the dominance of the ideological aim for a drug-free society:

> So in a very preoccupied way the psychiatrists that were working in the drug/health network were against everything related with harm reduction. What do I mean by that? Even syringe exchange they never had that in their policy and also against methadone. They worked against any adoption of legal methadone since 1972.

Maria José Campos – Member of AIDS Non-Government Organisation – [3]

Due to the dominance of the drug-free supporters, there was minimal opportunity to challenge the direction of Portuguese drug policy. This facilitated policy making in
pre-determined directions. In this environment, the closed governance structure reduced the potential to advocate for reform. A further constraint was that Portugal lacked drug user organisations. This reduced the potential to advocate for the rights of drug users. As Maria José Campos notes, this was a defining distinction and key impediment to reform in Portugal:

There is no association of drug users. Never. Never. Never. So we never had the movements that you can find in England, Netherlands or even in France. France is also very peculiar because France has the biggest prohibition of all but it has a very impressive harm reduction movement. But in Portugal we never had that. So the drug users were not involved in this discussion, were not involved in this situation.

Maria José Campos – Member of AIDS Non-Government Organisation – [2]

**Lack of research**

The final constraint upon Portuguese drug policy highlighted by policy makers was the scarcity of research. In particular, policy makers including Elza Pais noted that research into the prevalence or nature of the drug problem did not commence until the 1980s: “before that there were no studies” [3]. This was supported by Miguel (1997) who argued that the lack of knowledge, particularly concerning the prevalence of drug dependence, contributed to sensational prevention approaches.

An alternate view was that while there was limited understanding of the size of the problem, research critiquing the desirability of the status quo was increasing. A number of reports and outspoken advocates questioned the desirability of continuing with a traditional criminal justice response to drug users (Comissão Parlamentar de Juventude 1992). Crucially, however these reports recognised that evidence was but one factor to consider in any reform. In 1994 a debate was held on the merits of liberalising drug laws at which it was argued that while evidence for reform was important, such a decision was first and foremost a political and ethical decision (Fundação da Juventude 1994). The debate concluded that in that era both the requisite evidence and political support were absent. This suggests that perhaps it was not only a lack of evidence, but that due to the dominance of the drug-free supporters, evidence alone was insufficient to spur reform:

I can remember the problem of adopting or not adopting Methadone for treatment. People who were in favor or against Methadone were not for scientific reasons. These are irrational reasons, “I agree with that, I don’t agree with that” and never based on scientific reasons.

Graça Poças – Corrections Official - [10]
Ideological decision making thus dominated. This encouraged the continuation of drug-free policies towards drug users, including the use of drug-free clinics and drug education campaigns and slogans. Such campaigns were exemplified by the final Projecto VIDA (1999) campaign depicted in Figure 5, that contained a picture of a puppet and said “don’t be manipulated, ecstasy isn’t innocent.”

Figure 5: Projecto VIDA Campaign: Ecstasy isn't innocent

Source: Projecto VIDA 1999

Conclusion
It would appear that incremental policy reforms were encouraged in Portugal through the policy making process: policy making through policy communities, through a small circle of policy actors who were poorly coordinated. The most important factor was however the dominance of ideological beliefs. In this context, it appears the promotion of research, advocacy for reform and to address the needs of drug users had limited impact. These factors combined to maintain a criminal response to drug problems characterised by abstinence-oriented policies and slogans.
Atypical reform: Development of decriminalisation

The following section examines the development of atypical reform – decriminalisation – through the primary drivers of crises, research, policy actors and political factors. In contrast to the period of incremental reform, key factors driving the atypical reform included a public health and human rights crisis epitomised by Casal Ventoso, increased role of experts and evidence, concerted advocacy by multiple interest groups and political recognition of the drug issue. In the development of decriminalisation, two phases were important. The first phase was the adoption of the strategic option to decriminalise illicit drug use, possession and acquisition. This occurred as part of the adoption of the National Strategy in the Fight Against Drugs (Estratégia Nacional de Luta Contra a Droga – ENLCD) in May 1999. The second phase was the adoption of Law 30/2000 and the model of decriminalisation involving sanctioning through the Commissions for the Dissuasion of Drug Addiction (CDTs). This occurred in November 2000.

**Crises**

Policy makers asserted that the catastrophic drug situation in Portugal created a policy window for reform. In the lead up to decriminalisation the rates of injecting drug use, heroin addiction, HIV, AIDS, Tuberculosis, Hepatitis and homelessness soared, particularly within the mega-drug market of Casal Ventoso. The public health and social crisis became an instigator for atypical reform:

> [It was] due to the seriousness of the addiction problem, that had reached the highest points in those years. The problem of Casal Ventoso was very well known all over Europe.

Nuno Miguel – Health professional – [6]

In the development of decriminalisation policy makers asserted that Casal Ventoso played a pivotal role. Not only was it the site of the most problematic use in Portugal, but it played critical roles in setting the agenda and framing the problem. Moreover, it was used as a tool to challenge dominant views and demonstrate the desirability of a new direction.

Through demonstrating the seriousness of the drug problem, Casal Ventoso created an agenda setting opportunity. The location of Casal Ventoso in central Lisbon, and the nature of the market, namely as an open drug scene and slum environ increased recognition of the Portuguese drug problem. The visibility was aided by the
liberalisation of television in 1992 which gave rise to new public television stations (Fugas 2001). Television and newspaper coverage increased considerably during 1997 and 1998, and as a consequence, the problem could no longer be ignored:

You could see them everywhere so it was a very present situation. Nobody could say they don’t exist. Nobody. It was impossible to deny something that was on the street, thousands of people on the street that concentrate in certain neighbourhoods and that were using. It was a very, very present situation: everyday on the newspapers; everyday on the television. So there was a big buzz around it.

Maria José Campos – Member of AIDS Non-Government Organisation – [1]

Public anxiety about the drugs issue increased particularly between 1994 and 1998 (Assembleia Municipal de Lisboa 2000; Fundação da Juventude 1994; Niza 1998), which culminated in the drugs issue becoming the “number one concern” of Portuguese society. Casal Ventoso came to symbolise the failure of the prohibitionist response and the need for an urgent re-think of the government response.

Moreover, Casal Ventoso became a turning point for many individuals, particularly health professionals such as Rodrigo Coutinho. Through meshing the problems of social marginalisation, drug use/trafficking and a public health crisis, it provoked attention to the rights of drug users, or rather the neglect of their basic human rights:

These people live there for two, three, four years in degradation. So their minds, they were human beings but their bodies, they were like animals. It was terrible because the goal of these people was only to survive. Many of them live here, they die there, not by overdose, but by destruction…. They die by degradation.

Rodrigo Coutinho – Health Professional – [15]

The “humanitarian emergency” illustrated that drug use was not merely a health or criminal issue (Canas 2002, p. 20). This contributed towards a paradigmatic shift in the conceptualisation of drug users – to see drug users as citizens who were sick – not criminals. Traditional law enforcement or indeed traditional treatment responses were therefore inadequate responses.

This led to the realisation that complex solutions were needed to resolve the problem. However, as noted by Rodrigo Coutinho a big question remained “What are we going to do?” [16] In this regard the provision of mobile needle syringe programs in 1996, food, bathing, clothing and medical support in 1997 and low threshold methadone in 1998 through Casal Ventoso became critical to see whether new ideas and new responses could be more effective:

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At the end of the 1990s we understood that even with the opportunity advances there were people that were not coming to treatment and then we began to start the risk reduction, the harm reduction advances, trying to get more and more people who were not able, or did not want, or were not in condition to start treatment. Then we went to the street, faced with more and more people. And I think that was a turning point.

João Goulão – Health professional – [1]

These programs demonstrated that that new responses – harm reduction and social responses – could get more people into treatment and social services than the traditional responses. Ultimately, therefore the mega-drug market created the window of opportunity to reform Portuguese drug policy:

That was the greatest [advantage]…..One of things that helped to change opinion about drug addiction was to see that people were very ill. It was important….. It was a pity that we must go so extreme to have something good, but I think Casal Ventoso had a role in this.

Rodrigo Coutinho – Health professional – [17]

A number of reports and researchers similarly identified Casal Ventoso as the protagonist of a paradigm shift in the perceptions of drug users (Assembleia Municipal de Lisboa 2000; Chaves 1999; Fugas 2001; Jornal de Notícias 1998a; Presidência do Conselho de Ministros 1996).

However, some individuals argued that the response was not a function of need. It was instead the result of a political opportunity provided by a change in government and a financial boom.

The evolution of the response at the level of demand reduction, was not a function of needs, but was a function of political and economic and structural possibilities, arrangements.

Joaquim Rodrigues – Bureaucrat – [1-2]

The roles of such factors will shortly be examined.
Research

Research played three main roles in the development of the National Drug Strategy/decriminalisation. Policy makers asserted that a key reason for the decriminalisation was the accumulation of evidence on the prevalence and nature of the problem. The international research, particularly that of the EMCDDA, was deemed important since it revealed the seriousness of the Portuguese drug problem:

We at the time released data on problematic HIV infection among drug users. Here in Portugal we released data that compared Portugal with the other countries as one of the highest prevalence for heroin users.

Danillo Ballotta – EMCDDA – [1-2]

Research was also vital in confronting the dogma. Policy makers contended that in the lead up to decriminalisation two types of dogma needed to be challenged. This included ideological beliefs – that a drug-free society was the only direction – or non-ideological beliefs, that past approaches and directions were effective. While ideological beliefs necessitated concerted advocacy within the health sector, the belief in the status quo was an issue that needed to be confronted throughout society: within political circles, the health and criminal justice sectors and the broader community.

Research was seen to play a particular role in confronting such beliefs through questioning the effectiveness of prior responses and the desirability of the criminalisation of drug use. The increasing research throughout the late 1990s by not only academics but also treatment and criminal justice professionals – experts from the field – increased the persuasiveness of the arguments. The law enforcement sector increasingly recognised the strong relationship between drugs and crime and the limits of their ability to stop drug trafficking (Nascimento Rocha 1997; Polícia Judiciária 2000). The parliamentary committee provided influential support for this argument with its conclusion that past responses had failed (Niza 1998). Such research was vital in confronting the dogma throughout society and increasing the political willpower to adopt an alternate and atypical reform:

We only knew about the past and in the past the policies were not positive, were not good. Past policies were not solving the problems, and were in some instances, in some areas, counterproductive.

Vitalino Canas – Former Drug Strategy Coordinator – [1]

Research therefore increasingly demonstrated the severity of the drug problem and that the traditional criminal justice response was ineffective and counter-productive.
The most important role played by researchers and experts was in policy formulation, and will therefore be discussed subsequently.

**Policy actors**
In the lead up to decriminalisation, there was a notable expansion in advocacy for decriminalisation or reform. Three key sectors were of note: health professionals; criminal justice officials; and political lobbying groups. The most important advocates were a number of entrepreneurs from health and political fields.

**Health professionals**
While the Portuguese health sector was historically dominated by psychiatrists supporting a drug-free approach, such views became increasingly unpopular in the late 1990s. Miguel (1997) noted growing disquiet among health professionals over the naïve emphasis upon fast and unrealistic solutions. The counter-view was led by a number of directors of Lisbon-based CATS (drug treatment centres): João Goulão, Luís Patrício and Rodrigo Coutinho and a clinical director Nuno Miguel. The health professionals did not directly advocate for decriminalisation, but were strong advocates of the need for a paradigmatic shift: to treat drug users as citizens who needed assistance, not criminals who need punishment.

Harm reduction had been supported in Portugal by a minority of health professionals for many years. Most notably Portugal signed the Lisbon Declaration in 1992 at an international conference on drug addiction hosted by Luís Patrício, Director of CAT Taipas. The Lisbon Declaration was signed by 22 nations and attested that drug users were citizens, with a temporary illness, and therefore deserved the rights afforded other sick people (‘Declaração de Lisboa, elaborada e adoptada pelos delegados ao Congresso Internacional de Toxicodependência’ 1992). Rights of particular note included the rights to healthcare, social services and opportunities to work.

In the years preceding decriminalisation key proponents for harm reduction and a more humane response to drug users became increasingly vocal. There were three key changes in the lead up to decriminalisation. In March 1997, João Goulão was appointed head of the SPTT. Subsequently health professionals became increasingly active in Casal Ventoso. Those involve contended that Casal Ventoso facilitated advocacy against the drug-free direction, and spurred concerted advocacy through the media and political avenues. Consequently, conflict between advocates of abstinence
and harm reduction increased. Finally, advocacy for and attainment of the right to use low threshold methadone in June 1998 was a symbolic and practical shift, in the increasing power of the harm reduction coalition.

For some health professionals, involvement in Casal Ventoso was a turning point. As noted by Rodrigo Coutinho, the director of CAT Xabregas, going to the field led to a change in his beliefs and increased his willingness to support harm reduction. His involvement in the operations in Casal Ventoso illustrated that thousands of drug users were not receiving treatment and hence were “out” of the system:

Most of the workers who work in the field are here … they are not in the street. I have the privilege to be in the street since in 1998, was one operation Casal Ventoso. And it was after that I could have the perception that I have developed since now. Because it was there, in 1998 (and I worked in this field since 1985), it was in 1998 that I had the perception that it was thousands, thousand of them, I never… thousands, and this is not an expression, … there are thousands of them that are out … These numbers indicate that 50% of drug addicts are not in treatment.

Rodrigo Coutinho – Health Professional – [10-11]

This led to the realisation that traditional treatment responses were insufficient and that new responses, particularly street teams providing harm reduction measures, were needed. This in turn spurred advocacy for the rights of drug users, for harm reduction and particularly the need for low threshold methadone.

The push for methadone became a symbolic and practical battle, in overcoming the dominance of the abstinence supporters. Health professionals organised conferences, including debates in February and April 1998 called “Drugs – methadone as an alternative,” and “Substitution programs and risk reduction,” to raise awareness of the benefits of and need for methadone. João Goulão, the new President of SPTT, asserted that from 1997 health professionals were increasingly open towards harm reduction:

I was talking about substitution treatment in Portugal and I think in the 1980s it would be impossible. This would be like a failure. But in 1997-1998 there was the technology and ,the conditions, and even though the mentality of the technicians was much related to abstinence, they were already changing. In the technical field [substitution treatment] was very well accepted.


However, Alexandre Rosa, one of the politicians involved in negotiating the introduction of low threshold methadone, indicates that such a decision was far from consensual. He noted the opposition by the health professionals (doctors) to the political push for methadone:
I had a meeting at night at the SPTT headquarters, with the psychiatrists and the psychologists … And I was speaking with to them and said “OK the problem exists, this is the way, how can we help this process and so on and so on. We need methadone, without methadone how can we put the people inside [mainstream treatment programs], and to take them in the program?” And the doctors said “No. Methadone is not something that you can use like that. It’s the politicians who always want something to let them off [the hook].”

Alexandre Rosa – Former National Coordinator – [6]

Indeed, methadone was adopted by José Sócrates in spite of the views of the majority of the health professionals:

It is interesting that now we have 30,000 people who contact heroin, methadone programs and we have a needle exchange but it was imposed more or less from the top. It was the Government, it was Sócrates, who against the will of the health professionals that methadone was available.


The introduction of methadone in June 1998 suggests that while the context of the public health crisis facilitated the adoption of methadone, that such a response was not supported by the majority of health professionals. From this point of view methadone would not have been adopted were it not for the leadership by a number of key people including, João Goulão, the Lisbon Mayor João Soares and José Sócrates. In particular, the appointment of João Goulão, a long time advocate of harm reduction, as director of the SPTT in March 1997 increased the political leverage to advocate for harm reduction measures.

Following this trial it appeared that opposition towards harm reduction decreased within the health sector. The former director of the SPTT, Prof José Castanheira, attested to this change:

When I was in the national director of the SPTT almost all the therapists were totally against methadone. There was a small group that considered that methadone was an option for a very specific group. Psychiatrists and psychologists and so forth were in favour of programs free of drugs and so they were against programs of substitution. Nowadays, as far as I know the number of people in favour of substitutions programs is increasing …. I guess that it is much more of a fashion, than any kind of academic knowledge on the treatment.

José Castanheira – Health Professional – [4]

The years preceding decriminalisation were therefore years of critical change within the health sector, as minority views gained increasing leverage. Shifting from an ideological to a more evidence-based approach was critical to increase receptivity to decriminalisation. Advocacy by health professionals to treat drug users humanely, and treat them as citizens subsequently became the driving force behind decriminalisation:
If we blind our minds with the consumption … we don’t dignify our human beings. We recognise that globalisation will be something very bad if we penalise the effects and not the source of drug consumption.

Luís Patrício – Health Professional – [9]

The actions and advocacy of health professionals appeared, in turn, to spur public and political advocacy for a humane response.

**Criminal justice officials**

Throughout the 1990s, the Portuguese criminal justice system increasingly supported the principle of decriminalisation. As noted by the head of the Criminal Police, José Braz, decriminalisation was not a controversial response to drug users:

> From the point of view of the law, it is a good invention for the consumers.

José Braz – Head of Criminal Police – PJ – [5]

The criminal justice officials took the view that the criminal law itself was the problem. This was a profoundly different view to that expressed by criminal justice officials in many other nations.

The opposition to criminalising drug users developed due to a number of reasons. The first argument raised by the criminal justice sector concerned the effectiveness and efficiency of applying criminal penalties, particularly the imprisonment of drug users. The application of criminal penalties for drug users was not reducing the problem. To the contrary, the drug problem was increasing. Moreover, the criminal justice system had insufficient resources to deal with it:

> If all the consumption is criminalised we don’t have sufficient means to do that.


Such a view was supported by the Criminal Police reports (Polícia Judiciária 2000) due primarily because Portugal was a major transit country; its position in Europe and proximity to Africa meant that it was subject to considerable drug trafficking.

The increasing opposition to the criminalisation of drug users occurred in the context of prison overcrowding, which was largely attributed to drug-related offenders:

> Our prisons were and still are full with a high percentage of people who were convicted for drug-related crimes.


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17 Translation of “Do ponto vista da lei é uma boa invenção para os consumidores.”
The Ministry of Justice (2004) argued that the number of drug users and drug-related offenders within prison increased exponentially following the introduction of Decree-Law 15/93 in 1993 due to two reasons. The new legislation increased the length of sentences for drug offences and failed to distinguish between minor and major drug trafficking. Moreover there was an increase in drug-related crime, something which Pedroso (1997) contended was the major problem in the lead up to decriminalisation. Both factors contributed to significant numbers of illicit drug users in prison. For example, it was estimated that in 1999 up to 75% prisoners were daily heroin users (Polícia Judiciária 2000). As noted by Graça Poças from the Portuguese prison services, the prisons were ill-equipped to respond to the rapid change in prisoner characteristics, and increasing drug-related problems:

The prison system already integrated services for healthcare for normal people arriving in prisons, but was not prepared to receive these people, specifically related to drugs and health care conditions relating to drug consumption and HIV.

Graça Poças – Head of Prison Services – [7]

Indeed the drug trade flourished within the Portuguese prison system:

The reality for us, it is much worse, much worse to go the prison because there is consumption of everything. They have no answers to this problem.

Rodrigo Coutinho – Health Professional – [7]

This was supported by reports from the European Council:

The delegation was told that a veritable marketplace of drugs was apparently part of the daily routine. Every morning, immediately following the opening of cells, prisoners advertised the excellence of the products which they had for sale and the going price. Cell windows facing the outdoor exercise areas were used as counters for transactions between adjacent wings. Certain of the prisoners interviewed by the delegation stated that the quality of the drugs they acquired in the prison was better, and the prices lower, than outside. It was alleged that these circumstances, together with the proximity of the vendors, made it very difficult to resist the temptation to acquire and take drugs; a number of inmates claimed that they had started to take drugs for the first time (or gone back to consuming drugs) after their arrival in the prison. The information provided by prison staff tended fully to support these accounts. (Council of Europe 2001)

Increasingly such factors pointed to the inability of the criminal justice system to stop drug use and trafficking and the need for a more efficient and effective response. As clearly summed up by the former Drug Strategy Coordinator Vitalino Canas criminalisation was seen as part of the problem, not the solution:
We were one of the countries that had a criminal penalty for the drug use since the 1970s. Since then the figures were showing that the use of drugs was increasing, that many people were caught using drugs, and were jailed. But to send those people to jail didn’t solve the problem. So, when they came out they were using drugs in the same way, sometimes in a much more problematic way. Hence to send these people to jail was not good, courts were spending much time and money without any positive outcomes. Police and judges were saying it was no use to arrest these kinds of people, because they were not really criminals. Some of them were just sick people; they required help, medical help, not to be jailed.

Vitalino Canas – Former Drug Strategy Coordinator – [1-2]

The second issue was that after years of applying criminal measures the criminal justice sector shifted to see drug use as a health and social issue, not a criminal justice issue. They therefore questioned the desirability of the use of criminal penalties:

Before the decriminalisation in most of the cases police didn’t present hard drug users to the court because they know that they are addicts. They in some way, they already understood that they are sick people and there is no improvement in keeping them in jail because they were really sick.

José Braz – Law Enforcement Officer – PJ – [5]

We must think that some of the consumers are sick people so we need to treat them.

Law Enforcement Officer – GNR – [5]

Increasingly the criminal justice professionals rebelled against the laws and implemented a de facto decriminalisation whereby they chose to ignore the criminal penalties, particularly the penal sanctions attached to drug use and possession. This led to what Victor Feytor Pinto (1997), former head of Projecto VIDA, called “tacit depenalisation.” This was seen by many policy makers as leading to a hypocritical situation:

They had a law and we know that in the last 10 years or 20 years the judges don’t apply the law. Usually, the judges don’t put to prison but the law is to put in the prison you know. They don’t put but they don’t…. They close their eyes.

Almeida Santos – CDT – [5]

Thus, the criminal justice sector increasingly supported the need for reform for two reasons: belief in the improbability of ever stopping the drug trade in Portugal and belief that drug users would be better assisted through the health and social system.

It appears that criminal justice advocacy for a more health-oriented response increased in 1997 following increased public dissatisfaction with the criminal justice system. This spurred numerous conferences and public events including a Conference by the Union Association of Portuguese Judges in 1997 which explicitly advocated for the decriminalisation of drug consumption (Partido Socialista 2000b). Subsequently Almeida Santos, the then President of the Portuguese Parliament, advocated depenalising drug consumption due to the loss of confidence in the criminal justice
system. He asserted that the loss of confidence, insecurity and criminality resulted from inefficiency, increased laws and the existence of unjust laws (Santos 1997). At the time however, his proposal to depenalise drugs – remove all criminal penalties – was opposed by the health professionals.

In the development of decriminalisation the criminal justice professionals did not appear the most vocal advocates, a position held by health professionals. Nevertheless, the support of the criminal justice system was critical to the adoption of the reform. Politicians such as the National Strategy Coordinator Vitalino Canas frequently referred to their advocacy, rather than the arguments by the health sector:

The police and the magistrates – from the Public and Justice Ministries – the prison guards and therapists respond and think daily about the effectiveness and justice of the law which criminalises illicit consumption of drugs. And they are the first to seek new instruments, new solutions and new visions (Partido Socialista 2000b). 18

**Drug law reform groups**
Throughout the 1990s, political lobbying groups SOMA and Abraço increased in size. These groups mobilised a broad cross-section of society and advocated the need for drug law reform and the provision of harm reduction. This was seen as particularly important in encouraging political involvement and recognition of the problem:

We had very high professional defiance. We had psychiatrists, to economists, to statisticians, to lawyers, to judges, to people from the police, professors from health, public health, criminology and so on trying to agree… how can I say, higher defiance by people who believe in drug reform.


Another advocate for drug law reform was the National Association for Intervention with Drug Addiction (Associação Nacional de Intervenientes em Toxicodependencia - ANIT Portugal) which was established in 1992 after the signing of the Lisbon Declaration on the rights of drug users. ANIT similarly advocated the need to address the rights of drug users and, following February 1997, was particularly involved in interventions in Casal Ventoso.

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18 “Os policies, os magistrados – do ministério público e judiciais -, os executores das penas, os terapeutas dão todos os dias respostas sobre o que pensam da eficácia e da justeza da lei que criminaliza o consumo ilícito de drogas. E são eles os primeiros a pedir novos instrumentos, novas soluções e uma nova visão.”
Charismatic individuals
Policy makers asserted that the most important policy actors in the development of
decriminalisation were a group of entrepreneurs who consisted of health professionals
and politicians. The health professionals of Nuno Miguel, João Goulão, Luís Patrício
and Rodrigo Coutinho cultivated links with politicians, particularly Socialist
Politician Alexandre Rosa and advocated for change. Alexandre Rosa was the then
National Coordinator and High Commissioner of Projecto VIDA, and was seen as an
intermediary who channeled the advocacy for a more humane response into the
political arena:

I think Alexandre Rosa, he and the technicians who worked Nuno Miguel, me and Luís
Patricio, the other technicians …. I think it was a taskforce that could, we were five or
six, but he talked with us… he saw the reality. And this thing it went also to the
Government men because he was a political man and he could make the link between the
field and the political level.

Rodrigo Coutinho – Health professional - [18]

The charismatic individuals led the advocacy for change and increasingly mobilised
support for reform. It was contended that the health professionals had a particularly
persuasive influence because, through their involvement in Casal Ventoso, they had
been forced to “open their minds” to the scale and true nature of the drug problem and
to the undesirability of the status quo. In doing so, they encouraged other politicians,
including José Sócrates and the Portuguese President Jorge Sampaio to similarly
consider the need for alternative positions:

The President of the Republic, the Minister Jose Sócrates, Jorge Quail, João Goulão,
(Nuno) Miguel, (Rodrigo) Coutinho and so on….. These people are the openers of the
minds… They opened up their own minds and willed the process of opened minds.

Alexandre Rosa – Former National Coordinator – [12]

Through challenging dogmatic beliefs, entrepreneurs thus challenged political
reticence and opened the way for atypical reform.

At the same time, there was widespread belief that the President of Portugal, Jorge
Sampaio, took a very active and public role in the development of the new strategy
and decriminalisation. Policy makers asserted that he used his position to appeal to the
public and politicians and encourage the search for new solutions to the drug problem.
Most importantly, he encouraged the need for a non-dogmatic approach:

Our President of the Republic was a key person in this because he organised some
campaigns on his behalf in order to make clear that everything could be discussed, no
dogma. The first fight was against the dogma, dogmatism.

Alexandre Rosa – Former National Coordinator – [5]
In particular, Danillo Ballotta asserted that a public forum held by President Sampaio in June 1997 was instrumental. The forum was titled “Drugs: Current and New Strategies” and was attended by representatives from 15 EU states.

In 1997 one of the external signs that triggered, that might have triggered this event, was a conference organised by the President of the Republic, Mr. Sampaio…. The tone of the conference, and the people invited there were all scientists and doctors, was this tendency to present drug users not as criminals but as sick persons who needed some kind of support for their current situation. The proceedings of the conference led to the view that there is not much use in criminalising drug use and putting drug users in jail. Such a view may have influenced Government thinking and created the conditions for a new regard.

Danillo Ballotta – EMCDDA - [2]

At the opening of the forum President Sampaio (1997) drew attention to the humanity of drug users. He increasingly pushed for non-dogmatic, pragmatic approach and that politicians listen to the advice of the experts: the health professionals. Such a message was advocated through numerous events, including the opening of the III International Conference on Drug Abuse, and launch of the 1997 EMCDDA Annual Report on the State of Drug Addiction in the European Union (Ashton 1997). Moreover he used his 1998 new year address to the nation to call attention to the drugs issue (Jornal de Notícias 1998b), and played a critical role in 2000 in the lead up to the adoption of decriminalisation (see Figure 6). In such a way President Sampaio used his role to promote public awareness and debate on the drugs issue and encourage a pragmatic attitude.

Figure 6: President Jorge Sampaio in Casal Ventoso – July 2000

In summary, in the lead up to decriminalisation political lobby groups and criminal justice professionals increasingly advocated for more a humane and effective response. The most important change was within the health sector, where health
professionals challenged the dominance of drug-free beliefs, and enabled new voices and ideas to be heard. It is therefore notable that in the lead up to decriminalisation that the entrepreneurs were from the health and political sectors, the sectors that policy makers asserted had great levels dogmatism. The distinguishing feature of the advocacy preceding atypical reform was the concerted nature from multiple venues, most notable of which was the distinct role played by President Sampaio. Moreover, it was complementary advocacy – that traditional prohibitionist responses were ineffective, inefficient and inhumane – and that new responses – decriminalisation – could be more effective.

**Political factors**
Policy makers asserted that politicians had an instrumental role in the adoption of decriminalisation. However, there was considerable conflict as to their roles and impacts upon the development of decriminalisation. The roles and impact are examined through three periods. The first period was the development of the ENLCD and strategic option to decriminalise drug consumption and possession which was adopted in May 1999. The second period was the development of Law 30/2000 – the decriminalisation legislation – which was adopted in November 2000 and the final period was the political response to international pressure.

**Development of the strategic option to decriminalise**
Since the Portuguese drug problem tended to be an issue of low political priority, policy makers contended that in the development of the strategy and decriminalisation, counteracting this trend was the first challenge. The drugs issue became a higher priority following the election of the Socialist Party in 1995 as was exemplified through the inclusion of the drugs issue in the Socialist Party election campaign, the establishment of the parliamentary committee to investigate drugs and the holding of D Day, a public day of debate on drugs issues:

> Something very different happened in the next years between 1995 and 2000. We had the Guterres Government from Socialist Party. For the first time the political power feels that this is a problem.


Drugs therefore became a macro-political issue.

The second and arguably greatest challenge was confronting the political belief that past policies were effective. Many policy makers contended that while the election of
the Socialist Party increased the government’s willingness to reform drug policy
decriminalisation would not have occurred without a challenge to dogmatic beliefs. In
particular, the development of the ENLCD and decriminalisation required a
substantial challenge to the political mindset concerning “effective” drug policies.
This necessitated challenging the dominant belief that Projecto VIDA and
criminalisation of drug use and possession were desirable. While there were differing
views within parties, the dominant belief particularly between 1995 and 1997,
supported the continuation of the status quo. This was exemplified by the initiatives
undertaken by the Socialist Party in their first years of office. These included
increased penalties for drug trafficking (Lei n.° 45/96, de 3 de setembro 1996) and
overhauls to Projecto VIDA coordination (Decreto-Lei n.° 193/96, de 15 de outubro
1996). In short, early initiatives continued in the vein of past approaches and
objectives.

Policy makers contended that the years 1995-1998 were a period of confronting
political dogma, particularly that of key stakeholders such as José Sócrates. Events
including the parliamentary discussions and D day facilitated attention to evidence,
new ideas and provided a means to challenge to dominant beliefs. This encouraged
the “opening of political minds” and new ways of looking at and responding to the
drug problem:

It started with Day D, not literally, but it started the Government to open our minds, and
we could face the problem, we could look to the problem in a different way.
Alexandre Rosa – Former National Coordinator – [5]

I think was about 1995, 1997 there was a huge discussion in the parliament and there was
a big event and I think this conviction felt by the people, all the parties, they agree – left
or right – I think it was a good circumstance to do something in a different way.

It was also noted that change particularly to key stakeholder views did not occur
quickly.

Two events have been noted as turning points in the attitudes and responses of José
Sócrates. The first was a discussion in February 1998 held by José Sócrates with a
number of health professionals including João Goulão, the head of the SPTT. During
this discussion, it was clear that José Sócrates believed that the provision of low-
threshold methadone would be the solution – the magic bullet – for the Portuguese
drug problem. Through the actions of experts, he was persuaded of the need for a
more complex solution. This led to the appointment of the expert commission, the CNDS:

He began discussing with some specialists and he understood that is my reading of it that it was quite different from what he was thinking…. He had some ideas he wanted to put in the field then he understood that things were not so easy. He thought that substitution treatment would solve the problem. Need psychiatrists, we need social workers working on it and we need methadone and we will lower the problem. I think that he understood that this was not so simple. So he decided to establish the Commission.

João Goulão – Health Professional – [3]

The establishment of the CNDS in February 1998 and involvement of what were seen as the primary experts in Portugal was seen as a significant shift from ideological decision making:

I think that the team of professors and professionals that was collected to elaborate the strategy was integrated with very competent people. Some were more related to the research field, others were more related to the professional field but in any case I think the different personalities that were chosen were most knowledgeable of the drug situation and the solutions that could be elaborated in order to control the most negative consequences in our society.

Jorge Negreiros – Academic – [1]

Many policy makers viewed the establishment as evidence that the dogma had been overcome, but two months prior to the release of the CNDS report José Sócrates again re-formulated Projecto VIDA (Decreto-Lei n.º 266/98 de 20 de Agosto 1998). Then, in the months following the release of the CNDS report, José Sócrates asserted that there was no need for the government to follow the Commission’s recommendations. Such events suggest that at that time there was no intention or perceived need to radically change the direction of Portuguese drug policy, despite what the PCP said was strong support for many of the CNDS recommendations, including the extinguishment of Projecto VIDA (Filipe 1998; Gonçalves 1998; Partido Comunista Português 1998).19

The second and equally important event was the pilot provision of methadone in Casal Ventoso. As Rodrigo Coutinho stated, the involvement of health professionals and politicians on the ground following June 1998 helped to shift political views that piecemeal approaches within the current paradigm would solve the problem. In particular it demonstrated that the provision of methadone was but part of the solution, and that the humanitarian and social crisis was far from solved:

19 Strong support for the extinguishment of Projecto VIDA emerged towards 1999-2000 and resulted in a merge of Projecto VIDA staff into the Institute for Drugs and Drug Addiction in 2001.
When they made this program in Casal Ventoso, most of the people said “well now drug addiction, our problem is resolved.” No our program was for those people who were there, and the supermarket was spreading. Most of the 5,000 who went there everyday they spread and they went to other places that sell drugs. So, what the people said was “the only thing they have done is spread the problem.” It was not good, the first impression. Then in the political level they understand because we talk to them and they saw what we did, they go there and they saw. But in public opinion and in the paper it was not very understood. Anyway, it was very important to us to know, to begin to see the reality and also to have some experience to go to another measure that we were afraid to do.

Rodrigo Coutinho – Health Professional – [16]

This suggested that involvement of politicians on the ground was vital in provoking change. Firsthand experience with the issues and problems in Casal Ventoso showed that the dominant beliefs were part of the problem.

By January 1999, it was evident that resistance to change was diminishing. Prime Minister António Guterres (1999) asserted that the biggest threat to the nation was dogma and the ignorance of problems, particularly problems concerning drugs, unemployment and social marginalisation. Indeed overcoming dogmatic beliefs was deemed one of the main achievements in the lead up to the national drug strategy (Resolução do Conselho de Ministros n.o 46/99 de 26 de Maio 1999).

The evidence-based approach to policy making and forming of the “marriage”, or alliance between politicians and experts, mobilised political support:

Our politicians adopt to invite persons from political, professional, scientific etcetera persons to prepare the strategy, the report, so that mobilised politicians and professionals, and this is a good thing.

Joaquim Rodrigues – Former Minister for Justice and member of the CNDS – [6]

I used to say the secret to this approach was the very nice balance between the political approach and the technical approach. We have done a very nice marriage.

Alexandre Rosa – Former National Coordinator – [12]

One of the CNDS recommendations was decriminalisation, which reflected pragmatic and humanistic principles, to see drug users as citizens. As noted by the former head of the CNDS the decision to propose decriminalisation of possession was controversial and two members opposed the decision.20 Nevertheless, the idea of humanism was essential to the process of policy development:

I got the feeling that even though they didn’t always agree they always had pre-eminent in their way of looking at the drugs issue, the idea that drug addicts are not criminals, that they are people, probably closer to being patients than being criminals. This was something that was pervasive through the whole team.

20 Two members opposed decriminalisation of possession on the grounds that it could send the wrong message. There was unanimous support however for decriminalisation of drug use.
The CNDS recommendations were then widely discussed and debated within parliament, government and society. This was a highly unusual process of policy making in Portugal, but one deemed very impressive.

Was one of the most pragmatic experiences and the most impressive experiences, logistically, of bringing people together: some from the Left party; some from the Right-wing party.


The inclusive policy making process contributed to a strong consensus and commitment to the new evidence-based direction – a new paradigm - involving a more humane response to drug users: This became critical in engendering commitment to the proposed recommendations. Almost all the CNDS recommendations were adopted, including the proposal to decriminalise drug consumption and possession. As noted by the former head of the CNDS, this was a significant achievement:

To my surprise most of what we recommended if not everything that we recommended was adopted and that was pretty amazing because other countries had gone through similar exercises with different results. We had this in England and in France they had committees who looked at the strategy and then what I was led to understand was they get them to produce a report and then it was put into a drawer and nothing happened. So I was half expecting that after this very interesting work – for me very interesting, very enlightening – that the report would simply be put into a drawer and forgotten. So the fact that it came out as a Governmental strategy was quite amazing.

Alexander Quintanilha – Head of CNDS – [8]

The EMCDDA noted many European nations at the time of the Portuguese decriminalisation came to similar conclusions that traditional criminal justice responses to drug users were ineffective:

Countries are trying the criminal aspect and now they are trying to integrate the health aspect because they are realising that locking people up isn’t helping the problem, that it is a health problem, this idea that sanctioning people is fundamentally unhelpful.

However, the EMCDDA also noted that Portugal was the first nation to formally adopt these changes through the introduction of decriminalisation. This was a move that many nations were deemed unwilling to take:

In this case I think it involved the parliament so I think you have this significance of the fact that it is taken at a higher level. In practice what the drug users see I don’t know if there is a difference. I think it more to do at the level of a signal, so you have some countries that don’t want to take that step and haven’t…. I can only repeat that it is a different political step, I mean it is almost… considering Portugal has done it, it seems strange that a country like The Netherlands hasn’t.


The key factors that enabled Portugal to formally adopt decriminalisation were adherence to the advice of the expert commission – the CNDS – and political and societal support for a new, more humane response. As noted by Alexandre Rosa societal support was evident prior to the proposal:

That is why I say the consensus in Portuguese society was indeed very big. Even before this commission… The society was in fact prepared to change this idea. Sometimes we develop laws that are not very popular and we don’t open the way of the law.

Alexandre Rosa – Former National Coordinator – [9]

The Former National Strategy Coordinator Vitalino Canas (2004b) concurred that societal and scientific support were essential to the adoption of decriminalisation. The expert and societal support facilitated, in turn, substantial financial and organisational commitment by the Portuguese Government. Funds devoted to the drugs issue were doubled (from PTE 15,006 million in 1998 to PTE 32,000 million in 2004) and the coordination of the strategy was placed directly under the Prime Minister (Resolução do Conselho de Ministros n.° 46/99 de 26 de Maio 1999).

Thus, the years preceding the atypical reform were characterised by the accumulation of evidence, discussions and debates, and advocacy to challenge dominant political beliefs and increase receptivity to the advocacy by experts. As events and activities coalesced towards 1997-1998 this enabled Portugal to undertake a decision that other nations were unwilling to take.

**Development of Law 30/2000**

Policy makers asserted that the factors that led to the adoption of decriminalisation – pragmatism and bipartisan policy making – were difficult to sustain in the 18 months leading up to the development of Law 30/2000. Two key changes were noted: increased partisanship and increased ideology. The following section highlights such
changes and conflict as to their cause, in particular whether this stemmed from ideological beliefs of political parties or from the policy making process.

The first such change was the break down of political consensus. In particular, this period was marked by a divide between the left and right-wing parties. The second and related change was the emergence of ideological debates between criminalisation and decriminalisation:

On the left people were in favour of liberalisation and on the right criminalisation.


Consequently, many policy makers asserted that Law 30/2000 would not have been adopted were it not for a left-wing majority, especially the vocal support of the Socialists:

In fact the decriminalisation would not have been approved without the Socialists in power.

Elza Pais – Former National Coordinator – [12]

It has been implemented as a political decision of the Government.

Carlos Costa – Law Enforcement Officer – [10]

The decision to enact Law 30/2000 was therefore a non-consensual decision, one that was very different to the adoption of the strategy. Policy makers attributed this shift to two possible causes: long-term ideological beliefs or the process of policy making.

The majority of policy makers attributed the break down of consensus to ideological positioning by the right-wing parties, particularly strong opposition by the Popular Party (PP) towards decriminalisation:

At the beginning it was very difficult to change the idea, because the right-wing they did, they did like a taboo. They didn’t want to talk about it. They said only that drugs are a problem, a criminal problem so all drug users should go to jail.

André Beja – Left Bloc Politician – [2]

The leader of the PP had a position against the decriminalisation. He said that Portugal would be a paradise: drug paradise.

Professor Poiares – Academic – [6]

This led to the majority belief that consensual adoption of decriminalisation was not possible due to fundamental differences in the beliefs of the right-wing and left-wing parties.

From the alternate view, the ideological phase was not a reflection of beliefs on the desirability of decriminalisation. In particular, Carlos Costa noted that a relatively bipartisan and non-ideological approach existed up until 2000:
In year 2000 started what we may call the ideological phase….. Until the year 2000 there was no such thing as a right-wing view and a left-wing view.

Carlos Costa – Law Enforcement Officer – PJ – [5-6]

Instead the “ideological phase” was a response to the process through which decriminalisation was adopted. A crucial change in 2000 was that the Socialist Government rejected parliamentary calls for a public referendum on decriminalisation:

It is only after the year 2000 because of the problem of the referendum that we view that the parties have radicalised into different fields.

Carlos Costa – Law Enforcement Officer – PJ – [5-6]

The legislative proposals preceding Law 30/2000 confirm that a left/right divide did not exist prior to the referendum. In the lead up to 21 June 1999, the date of a parliamentary debate concerning decriminalisation, the major parties issued proposals concerning the legislative framework including an anti-project or proposed outline of the decriminalisation legislation (Conselho Superior do Ministério Público 2000). Proposals during this period demonstrate that the far right and far left parties, the Left Bloc and the Popular Party, had concerns over decriminalisation, and displayed quite different responses. In particular, the Left Bloc contended that decriminalisation was insufficient and hence proposed to legalise cannabis (Projecto de Resolução n.º 52/VIII, de 10 de maio 2000). In contrast, the Popular Party were more reticent about decriminalisation and requested a public referendum on decriminalisation (Projecto de Resolução n.º 59/VIII 2000). At the same time a number of leading Social Democratic members, Nuno Freitas and Vieira de Castro, supported decriminalisation on the proviso that Commissions for the Dissuasion of Drug Addiction were introduced (Proposta de Lei n.º 31/VIII 2000). This illustrates that opinions within the left and right-wing parties were mixed. This was in fact recognised by the former Drug Strategy Coordinator, Vitalino Canas.:

So our first opponents were these two parties who opposed themselves to the decriminalisation of the law. The PSD had a mixed position: some of the most influential people were in favour, but the official decision was that although this might be a good initiative we should make a referendum.

The parliamentary response to the lack of consensus was to formally request a public referendum on two questions:

1. that soft drugs (cannabis and derivatives) be depenalised\textsuperscript{21} and
2. that hard drugs remain criminalised but therapeutic administration of these be permitted as necessary (Projecto do Resolução n.º 63/VII 2000).

However, the Government response was to reject such a call.

The decision to bypass a referendum gave rise to heated debate which culminated in the enactment of a motion of censure by the Populist Party (Moção de censura n.º 1/VIII 2000). Such a move could have given rise to the collapse of the government, were it not for the support of the other left-wing parties.

Following the motion of censure President Sampaio used his period of open presidency, a period in which to highlight the issues of greatest importance to the President, to draw attention to the drug problem and call for an end to political games and dogmatism:

Our President of the Republic actually made it one of the areas of his own campaign, the so-called open Presidency that he discussed.

Alexander Quintanilha – Former head of CNDS – [8]

Such calls were made in July 2000 (following the motion of censure) from the grounds of Casal Ventoso (Partido Socialista 2000d). His timely intervention appeared to reduce the conflict. Vitalino Canas (2002) noted his actions were critical to maintain the strength to enact Law 30/2000.

Subsequently Law 30/2000 was approved by the left-wing parties from Government: the Socialist Party, Portuguese Communist Party, Left Bloc and the Greens (Partido Socialista 2000c, 2000e). To further complicate matters, the initial law approved by Government was vetoed by President Sampaio as an unconstitutional legislative proposal for failing to consult with the parliamentarians from the autonomous regions (Partido Socialista 2000a). Nevertheless, Law 30/2000 was subsequently adopted in November 2000. This therefore suggested that the process itself contributed to the emergence of a partisan and left-right divide.

\textsuperscript{21} Depenalisation implied the removal of all criminal penalties, without necessarily applying new administrative penalties. It was therefore a different model to that later adopted.
The Socialists contended that the decision to bypass a referendum was essential to enact decriminalisation, since public support was not forthcoming, nor was parliament:

The society was quite divided. I would say there was a half/half division. Half of the people were for decriminalisation and half of the people were against decriminalisation. If we had made a referendum I am not sure about the final outcome of the referendum.

Vitalino Canas – Former Drug Strategy Coordinator – [2-3]

In the framework of the parliamentary committee we couldn’t conclude anything about the decriminalisation because we hadn’t consensus about that decision. But when we had a left majority in the Parliament it was possible to decide as we decided.

António Filipe Rodrigues – Former head of Parliamentary Committee – [3]

In the lead up to the adoption of Law 30/2000, international pressure and criticism by opposition parties increased which arguably decreased the likelihood of obtaining bipartisan support. From such an argument, decriminalisation would not have been enacted without the strong political willpower of the Socialist Party and by Vitalino Canas:

It is not easy for a political party, which wants to maintain power, to stay in Government, to make such a radical move. Knowing that people were divided, and knowing that the consequences were not foreseeable there was some risk of loosing the election..... I would say that this reform required a very strong political will. Without strong political will this reform was not possible.


It appeared that the strong political will might have been aided by a shift in leadership, in October 1999 following the re-election of the Socialist Party, and appointment of Vitalino Canas as new Drug Strategy Coordinator. At the time of data collection Vitalino Canas was known for being a drug law reformer. He was and remains at the time of writing a member of the Senlis Foundation and the Committee des Sages and through these is trying to promote drug law reform and the legalisation of drug use. Such an ideology no doubt facilitated his willingness to undertake reform:

The fight against drugs, misery, exclusion and the sickness of consumers must be fought not in fear of innovation but with boldness, courage and reforms to the international system. (Canas 2004a)

Through the process of adopting Law 30/2000, decriminalisation arguably shifted from a bipartisan strategy, to the political flagship of the Socialists:

It was the Government who took this as a priority you know, who took every political decision necessary to involve everyone in the strategy, so it was I would say it was a political flag, a flagship.

Comparisons of the Government programs during the Socialist and subsequent Social Democratic reign illustrated the former were much more supportive of the drugs issue and decriminalisation (Presidência do Conselho de Ministros 1999, 2002, 2005).

Regardless of the cause, policy makers strongly asserted that the loss of consensus and rise in ideology reduced the role of evidence in the development of Law 30/2000. Indeed many asserted that no research was considered. This has given rise to the belief by policy makers and some reviewers that Portugal did not consider experiences of other nations. For example Van Het Loo et al. (2002, p. 50) stated that decriminalisation “did not consider the experiences of Spain or other countries.” This appeared an exaggeration.

Certainly, the model for the Commissions for the Dissuasion of Drug Addiction (CDTs) was not developed by a committee of experts such as the CNDS. However, it involved some expert input. Vitalino Canas visited Spain and Italy to examine their models of administrative responses to drug users and Professor Poiares developed the therapeutic jurisprudence approach:

Since it was the last country to implement this kind of solution, the fact that they studied the Spanish and Italian experiences, and they thought it was better to introduce other specialists in the field, not only policeman, and so they decided to put psychologists and sociologists in the commissions, and that is the big difference. And that is one consequence of all the criticism they had about the way people were dealing with the problem in the other countries.

Elza Pais – Former head of SPTT – [4-5]

My role was to revoke the law (Decree-Law 15/93) and to help create an alternative view that could include both the social perspective and the psychological perspective.

Professor Poiares – Academic – [1]

The introduction of Law 30/2000 was thus considered less consensual and more ideological. Conflict remains as to whether such a proposal would have been adopted were the Socialist Party to have conducted a referendum and/or waited for political consensus. Vitalino Canas asserted that given the uncertainty, reform may not have been achieved without bypassing such ideals.

Response to international pressure

The proposal to decriminalise drug consumption and possession followed expert advice, that suggested Portugal would not contravene international guidelines through decriminalising drug use and possession:
We asked an expert in international law to give us an opinion about whether if Portugal decriminalised, whether that would put Portugal in a very difficult position internationally, and it was felt by the expert that the answer was no.

Alexander Quintanilha – Former head of the CNDS – [3]

However, in the lead up to and following the adoption of decriminalisation there was a considerable level of pressure exerted by the INCB and some European nations who did not support the adoption of decriminalisation. Key informants noted various responses to this pressure ranging from near submission to strong defiance. Professor Poiares noted that the first Drug Strategy Coordinator José Sócrates almost chose to re-criminalise the law following international criticism:

Sócrates wanted to recommend the decriminalisation. But after he called me and wanted to go back on the law. He said that the other European countries criticised them very much.

Professor Poiares – Academic – [2]

On the other hand, the second Drug Strategy Coordinator Vitalino Canas showed strong defiance and invited the INCB to inspect the Portuguese proposal:

We had some warnings from the INCB, the International Narcotics Control Board. I invited them here to show what we were going to do. We weren’t able to convince them that we were complying with the international regulations, but I believe that we respected the UN Conventions or at least a certain interpretation of the Conventions.


Both Vitalino Canas and President Sampaio took leading roles in discussing and informing international audiences on the meaning of the adopted law particularly in the UK (Roberts, A. 2001; Tremlett 2001). For example, Vitalino Canas was quoted in The Guardian following the enactment of decriminalisation:

Why not be clear about this, and change the law to recognise that consuming drugs can be an illness or the route to illness? America has spent billions on enforcement but it has got nowhere. We view drug users as people who need help and care. (Tremlett 2001, p. 20)

Strong defiance was seen as instrumental in reducing opposition to this reform:

It was quite difficult at the top level of the Government if we didn’t have the strong support of the President – Jorge Sampaio – and even with some leaders of the opposition, it would very difficult to take, because Portugal was officially warned by the United Nations that we were going in the wrong direction.


Thus, Portuguese politicians and the President helped defuse the criticism through their open approach. Political involvement in Portuguese drug policy was seen in the main as very positive, but in the development of the Law 30/2000, a less consensual process emerged. Arguably, such battles were inevitable in the context of increased
international scrutiny, and thus political will appeared essential to have not only obtained, but also retained decriminalisation in the face of international criticism.

Conclusion
The development of the atypical reform of decriminalisation resulted from an accumulation of evidence, and advocacy by the criminal justice sector of the inefficiency and ineffectiveness of the traditional criminal justice response, and by the health professionals of the need to see drug users as citizens with rights. Such arguments were carried by the policy entrepreneurs into the political arena, but also into society where they challenged the prevailing dogma and mobilised support for a new response. The factor of greatest relevance for this reform was the humanitarian and public crisis in Casal Ventoso. From a humanist perspective, the perceived increasing depravity of the drug users who frequented Casal Ventoso proved crucial in providing an impetus for change, in challenging the views of health professionals and in illustrating the need for a new paradigm involving decriminalisation. The public health crisis, research and policy advocacy led politicians to produce a strategy and premise of decriminalisation derived from evidence and consensual support. While, the development of Law 30/2000 was less consensual, it appeared to be nevertheless influenced by expert opinion. Furthermore, the Socialist Politicians ensured that decriminalisation was adopted in spite of international and domestic criticism.
Framing of decriminalisation

Decriminalisation heralded a new paradigm, whereby drug use, acquisition and possession were deemed contraventions (public-order offences) rather than criminal offences. Decriminalisation was a legislated reform whereby drug users were diverted by the law enforcement sector through the Commissions for the Dissuasion of Drug Addiction (CDTs). The CDTs sought to deter drug consumers and provide treatment for drug addicts (Lei n.º 30/2000, de 29 de novembro 2000). Further, decriminalisation was seen as having an important symbolic role; facilitating a paradigmatic change in the perceptions towards drug users. This role was argued to have been the key reason for undertaking the reform. The following section examines the objectives of the decriminalisation. Policy makers asserted that there was a difference between the theoretical objectives of decriminalisation, as stated through the strategy, and the final model of decriminalisation through the CDTs. Accordingly, the following section compares the objectives and explores the reason for the development of the final model of decriminalisation.

Objectives of decriminalisation
Policy makers asserted that there were three major objectives of decriminalisation: to change perceptions, to introduce proportional punishment and to increase the effectiveness of the response.

The first and most important objective was to introduce a paradigmatic change in the response to drug users; to change perceptions of drug users. Decriminalisation distinguished the act of drug use from the drug user, as exemplified through the key message, that drug users were people not criminals, and suggested a more constructive means of looking at the drug user:

I think that decriminalisation was very, very important. It was a very important issue in the national strategy. Why? Most people moralise, but because with this decision we give one signal to society, to the justice, to the police “Hey they are not committing a crime.”

Alexandre Rosa – Former National Coordinator – [14]

Decriminalisation therefore aimed to achieve a paradigm change and open the way to a new means of responding to drug users. Under the new paradigm drug users were

22 Law 30/2000 doesn’t explicitly list the objectives of decriminalisation.
people with rights, requiring education and treatment, help not punishment. In this regard, there was a high consensus among policy makers that decriminalisation needed to be a legislative change, in order to transmit the message throughout the whole of society and maximise the potential for change:

To change the law was a way of changing the social views about drug use and drug addiction. If the law says that to use drugs is a crime, of course the approach of common people to drug users would be negative. If we start to say that to use drugs is not a crime, but a problematic thing, a health problem, then the problem might change.


Pereira (2003) confirmed that the primary aim of decriminalisation was to initiate a paradigm change, particularly in the institutional rationality towards drug users and addicts.

The second objective was to introduce a proportionate response to drug users and address the perceived injustice of criminalisation. The most important reason was stopping the application of criminal penalties, whether it was prison or fines, and removing the labelling and stigma associating drug users as criminals:

We had a political decision – very important – that was to finish with the imprisonment for people who only consume drugs. The jail must be for traffic dealers, not for other things like the people who consume. I think that the recognition of this difference and the end of the criminalisation of drug consumption were very important measures


The final objective was to increase the effectiveness in the response to drug use. In particular, it was argued that it would be easier to educate, treat and socially reintegrate drug users without the use of criminal sanctions:

What I think that we have helped to achieve is changing the penal framework that in the past chased away people, drug addicts, making them out, forcing them out of the treatment system and what this decriminalisation law helped to achieve was to help bring them closer to the treatment system.

Bruno Dias – PCP Politician – [3]

With this change, was a paradigmatic change, the social inclusion of the drug addict, it will come better.

Elza Pais – Former National Coordinator – [14]

Ultimately, therefore decriminalisation was seen as derived from the humanistic principle as was characterised in the strategy:

It essentially considers the drug addict to be someone who is ill, and demands guaranteed access to forms of treatment for all drug addicts who seek treatment, including those who may for any reason be in prison. It is also implies the promotion of conditions for effective social reintegration, as well as the adoption of an appropriate, fair and balanced, legal framework, respecting the humanistic principles on which our legal system is grounded. (Resolução do Conselho de Ministros n.º 46/99 de 26 de Maio 1999, pp. 3-4).
Objectives of Law 30/2000 - CDTs

Law 30/2000 did not specify formal objectives for decriminalisation. Policy makers, particularly politicians, and news from the period suggest that Law 30/2000 supported the objectives above, but was more practically oriented. In accordance with the proportionate response, decriminalisation distinguished between drug users and drug addicts, favouring non-pecuniary penalties for the latter. This was an important distinction since it was deemed drug addicts should be offered treatment rather than fined. Further, it emphasised the desire to facilitate the implementation of the strategy and to provide a constructive response to drug users.

Law 30/2000 was promoted as a component of the strategy. Thus, decriminalisation was not promoted as an end in itself, but as a means of increasing the access to harm reduction, education, treatment and reintegration. From such an argument, it was contended that having de facto decriminalisation led to a hypocritical situation, and made it harder to assist drug users. In contrast, de jure decriminalisation would enable a more consistent approach, and facilitate the implementation and effectiveness of the strategy:

Decriminalising and having a good strategy, because we not just decriminalise, we decriminalised but we also defined the strategy and so in the implementation of these two political decisions combined was thought to be a good sign and a good political option.


Further, Law 30/2000 was promoted as a means of providing a constructive response to drug users. It did not therefore reflect radical principles of non-intervention for drug users, as in the Netherlands. Instead, a different type of intervention was deemed essential to enhance the effectiveness of responses to drug users:

Decriminalisation is not legalisation; it is different. So I think it is in the middle, some kind of punishment and some kind of information and help if you want to be helped.


To decriminalise cannot mean to close the eyes and to say nothing about the drug problem. The drug addicts must not to be jailed, but they need help to leave the drugs.


This therefore sent the signal that drug use remained prohibited. As the IPDT Annual Report (2000, p. 68) stated “this is not a decriminalisation by omission but rather a constructive decriminalisation project.” In particular, it was argued that the criminal justice system could help solve the problem through funnelling drug users into the
health system. Decriminalisation, it was argued, would widen the net of drug users who were put in contact with the health and social services:

I would say one of the aims, perhaps one of the top aims of this reform was to get these people and to integrate these people in a health care system.


In doing so, the CDTs were promoted as essential to achieve positive outcomes from decriminalisation:

The goal of the CDTs was to find, to stress a different vision on the phenomenon and to promote a constructive view on decriminalisation.

Poiares – Developer of model of CDTs - [1]

If we haven’t the commissions, the positive effects of decriminalisation don’t work and the situation remains [the same as before].


The CDTs were promoted as a means to stop drug use through the dissuasion of occasional drug users and treatment of dependent drug users. This was a core message promoted by politicians in the lead up to and following the decriminalisation. As Vitalino Canas (2004b) asserted “a reform must be served by a clear message. A message that both makes a difference and affirms change, that comforts people’s conservative tendencies and calms their fears…. ” The message of the Portuguese decriminalisation was clear, namely that it offered a more humane and effective response. Drug traffickers deserved to be punished but, drug users were sick, not criminals. Moreover, whereas prohibition perpetuated the problem, treatment could reduce the problem; the new regime offered a better response to the drug problem.

**Mechanism of decriminalisation - CDTs**

Most policy makers saw the CDTs as reflective of primarily political objectives and as a political marketing strategy for the new legislative framework. The resounding contention was that the CDTs were poorly thought-through. This was attributed to the limited expert input into their development. From this perspective, the key challenge with the introduction of Law 30/2000 was to avoid the perception of condoning drug use. In this vein, the official framing emphasised that decriminalisation offered a more constructive response.

According to the policy makers, the CDTs served primarily symbolic purposes: they showed that drug users were sent somewhere, and thus their actions were still censured:
The Government was afraid of being accused of facilitating drug consumption. [So] when it decided to push the strategy it created the CDTs. So this creation was more of a political one than motivated by other reasons.

Nuno Miguel – Health Professional – [7]

The model of CDTs it was discussed in a later period with the Socialist Government. When I first saw the legal project of the CDTs, I thought it was too complicated and it was over-proportional to the need, services in all the capitals of the districts, you know? I thought it was too much and I was asked to give my opinion and I gave that to the general administration at the time. Looking at it now I think I was right.


The CDTs therefore served as a means of responding to or preventing international and domestic criticism.

Finally, decriminalisation and the CDTs retained the objective of achieving abstinence, something that was clearly emphasised through the term “dissuasion.” Thus, while some policy makers and critics contended that Portuguese drug policy heralded a new era of harm reduction – symbolised by harm reduction and decriminalisation – (Canas 2002; Van Beusekom, Van Het Loo & Kahan 2002) as summed up by Alexandre Rosa, abstinence remained the central objective of Portuguese drug policy:

In Portugal we also want that is the direction is recuperation, the recuperation from treatment, but if it is not possible to stop drug addiction, at least, there is always something that we can do. This is the harm reduction approach.

Alexandre Rosa – Former National Coordinator – [7]

This is quite distinct from the more traditional objective of harm reduction that is reflected in nations such as Australia whereby the reduction of harm is the objective, not abstinence. Harm reduction in Portugal therefore remains a tool to facilitate change, not a goal. While the entrance of harm reduction and indeed decriminalisation is therefore significant it reflects the emphasis of previous eras of a drug-free society. This is arguably a key reason why the Portuguese decriminalisation did not raise enduring criticism: decriminalisation was not framed as a radical shift towards depenalisation or harm reduction.

Instead, it was framed as a more humanistic approach that would retain sanctions, and increase the net on drug users. In this manner, CDTs were seen as providing the means to widen the net and increase the number of drug users who were counselled by the health and educational system. Ultimately, therefore decriminalisation was promoted as a means of facilitating the vision of a drug-free society.
We always have a very strict, I would say Catholic idea, that someone who is a drug user who is a sinner, and ... who has to be saved and needs redemption. And so it, they never understood, they never understood the philosophy of harm reduction. They never understood that in our point of view.

Maria José Campos – Member of AIDS Non-Government Organisation – [4]

Decriminalisation therefore represented a significant shift in the conceptualisation of drug users, yet it retained ties to the past emphasis upon abstinence.

**Conclusion**

In conclusion, incremental policy development was encouraged in Portugal due to the limited political attention to the drugs issue, a paucity of evidence and ideological beliefs amongst psychiatrists on the necessity of a drug-free society. In 1998, circumstances increasingly produced an opportunity for atypical reform, due principally to the presence of an extremely problematic and visible drug supermarket in Casal Ventoso. This had an instrumental role in provoking recognition of the drugs problem, challenging alternate views amongst psychiatrists and most importantly in challenging political dogma that past policies were effective. Casal Ventoso was used as a tool to overcome the dominance of the drug-free supporters and advocate for a more humane and pragmatic response to drug users.

This encouraged the primary objective of decriminalisation, namely humanising the drug user and instilling a paradigmatic change. Entrepreneurs from the health and political sectors drove the advocacy. Paradigmatic change was unlikely without such actors, given in particular the need to challenge dogma and ideology. Through challenging the dominant beliefs, establishing an alliance between politicians and experts and mobilising society, decriminalisation emerged through an evidence-based approach. The pragmatic approach and strong community support facilitated the adoption of the recommendations. Though embracing a more humane and pragmatic approach the decision to decriminalise was seen as the epitome of Portuguese drug policy.

While the strategy was seen as developing from the evidence-base and through consensus-decision making, thus a significant departure to prior drug policy making, the development of Law 30/2000 marked a return to more closed decision-making. This arguably led to the introduction of a more political model of decriminalisation. The mechanism and objectives of the CDTs reflected the desire to not just change
societal views, but to widen the net, and increase the potential for abstinence. Such was seen to reflect primarily political objectives – of deferring criticism of being liberal – and dissuading drug users. The development of the atypical reform – decriminalisation – reflected the culmination of years of advocacy for change, and a more humanistic response that developed in spite of the political and international constraints.
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>1994</td>
<td>Drug Addiction Treatment and Prevention Service (SPTT) created. Director José Castanheira.</td>
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<td>1995 (Oct)</td>
<td>Socialist Party elected - PM António Guterres</td>
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<td>1995 (Nov)</td>
<td>Parliamentary Committee created to assess and evaluate drug consumption and drug trafficking</td>
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<td>1996 (Jan)</td>
<td>Guterres gave 17 billion escudos to rehabilitate Casal Ventoso</td>
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<td>1996 (Sep)</td>
<td>Law 45/96- increased min and max penalties for drug trafficking</td>
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<tr>
<td>1996 (Oct)</td>
<td>Overhaul of Projecto VIDA coordination and demolition of 6 Casal Ventoso houses</td>
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<tr>
<td>1997 (Jan)</td>
<td>D Day – 28 Jan 1997 - drug abuse “public enemy number one”</td>
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<td>1997 (Jan)</td>
<td>European Commission: AIDS stabilising except Spain, Italy + Portugal</td>
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<td>1997 (Mar)</td>
<td>José Castanheira replaced by João Goulão as head of SPTT</td>
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<td>1997 (Jun)</td>
<td>Debate held by President Sampaio ‘Drugs: context &amp; new directions’</td>
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<tr>
<td>1997 (Nov)</td>
<td>President of Parliament – Almeida Santos proposed to depenalise consumption of drugs. Opposed by medical field.</td>
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<tr>
<td>1997 (Nov)</td>
<td>5th Congress of Portuguese Judges – Recognised problems in CJS, lack of public support and need for reform.</td>
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<td>1997 (Dec)</td>
<td>José Sócrates became Adjunct Minister to the Prime Minister and was appointed Drug Strategy Coordinator.</td>
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<td>1998 (Feb)</td>
<td>Relocation of residents of Casal Ventoso began.</td>
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<td>1998 (May)</td>
<td>National Strategy in the Fight Against Drugs (ENLCD) approved – with strategic option to decriminalise</td>
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<td>1998 (Jul)</td>
<td>Low threshold methadone started in Casal Ventoso</td>
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<td>1998 (Aug)</td>
<td>Change to coordination of Projecto VIDA</td>
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<tr>
<td>1998 (Oct)</td>
<td>CNDS completed report.</td>
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<tr>
<td>1999 (Jan)</td>
<td>Relocation of residents of Casal Ventoso began.</td>
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</tr>
<tr>
<td>1999 (Jul)</td>
<td>Closure of Parliamentary committee into drug addiction</td>
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<tr>
<td>1999 (Oct)</td>
<td>Socialist Party re-elected</td>
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<tr>
<td>1999 (Nov)</td>
<td>EMCDDA Annual Report: Portugal had 2nd highest incidence of AIDS</td>
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<tr>
<td>2000 (May)</td>
<td>Left Block – proposed to legalise cannabis</td>
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<td>2000 (Jun)</td>
<td>People’s Party (CDS-PP) called for a referendum on decriminalisation and PSD members proposed decriminalisation with CDTs</td>
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<td>2000 (Jun)</td>
<td>Decriminalisation debated in Parliament on 21 June 2000 - requested that the President hold a public referendum</td>
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<tr>
<td>2000 (Jun)</td>
<td>CDS-PP issued a motion of censure for failure to hold referendum</td>
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<td>2000 (Oct)</td>
<td>EMCDDA Annual Report: Portugal had highest drug-related AIDS in the EU</td>
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<tr>
<td>2000 (Oct)</td>
<td>PSD members called for the President to block application of decriminalisation to Azores and Madeira</td>
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<tr>
<td>2000 (Nov)</td>
<td>Law 30/2000 adopted - decriminalisation of possession and consumption</td>
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Chapter Four demonstrated that decriminalisation arose through a shift from ideology to pragmatic policy making. In the development of decriminalisation, many of the historic constraints upon atypical reform were overcome, through the concerted advocacy for a humanistic and evidence-based approach, mobilisation of public and political support and challenge to ideology and dogmatic beliefs. The following chapter turns to examine Australian drug policy development, to explore the drivers and processes underpinning reform in a different national context. It examines the process of national illicit drug policy development in the lead up to the adoption of the Illicit Drug Diversion Initiative (1994-1999) through four sections:

1. Key influences upon Australian drug policy
2. Incremental reform: Development of the NDSF
3. Atypical reform: Development of the Illicit Drug Diversion Initiative
4. Framing of the Illicit Drug Diversion Initiative

Chapter Five draws upon the privileged views of Australian drug policy makers and verifies where possible these views through publicly available literature and accounts. The first section uses the same heuristic from Chapter Four to identify the major influences upon Australian drug policy. It overviews the proximal factors: crises, research, policy actors and political factors; and distal factors: past paradigms, international factors, structural arrangements and values. The second and third sections examine the development of the 1998-99 to 2002-03 National Drug Strategic Framework (NDSF) and the Illicit Drug Diversion Initiative (IDDI) respectively, through the gaze of the proximal factors. The final section examines the objectives and mechanism of the IDDI and thus the framing of the adopted reform. A timeline has once again been developed to highlight key events leading up to the adoption of the IDDI (see Table 3).
Key influences upon Australian drug policy

Proximal factors

Crises
During the period of study, Australian drug policy was influenced by a number of crises concerning public health, drug-related crime and criminal justice cost and effectiveness. The first crisis concerned the increasing prevalence of heroin overdose which escalated during the 1990s and led to a peak of 958 fatal overdoses in 1999 (Topp, Kaye, Bruno, Longo, Williams, O'Reilly, Fry, Rose & Darke 2002). This represented a rate of 112.5 per million persons and meant heroin overdose was the third greatest cause of death in Australia amongst 25-35 year olds (Warner-Smith, Lynskey, Darke & Hall 2000).

The escalating deaths spurred considerable media attention, most notably during 1998 and 1999, with frequent articles about the tragedy and prevalence of overdose. Most notably the Herald Sun newspaper in Victoria ran a “heroin toll” documenting the daily tragedy and in December 1998, as non-fatal overdoses in Melbourne climbed to 190 per month, Melbourne – the capital city of Victoria – was dubbed the “heroin city” (Anderson, P. 1998, p. 1). In addition, fierce debate contested the best means of responding, the most topical of which concerned the provision of naltrexone, heroin trials, safe injecting facilities and zero tolerance.23

A second issue of public concern was the relationship between drug use and offending. While the level of property crime remained relatively unchanged between 1983 and 1999 (Australian Institute of Criminology 2001), the link between drug use and crime became more documented (Trimboli & Coumarelos 1998; Weatherburn & Lind 1999). Up to 70% of crime and 80% of property offences was reported as drug-related (Harris 1998) and became an increasing public and political concern (Howard 1998). This spurred a guest chapter in the 1997-98 Australian Illicit Drug Report devoted to drugs and crime. Written by Makkai (1999) the chapter indicated wide variation in the self-reported rate of drug-related crime, with between 27% to 70% drug users reporting property offences in the preceding month. However, Makkai

(1999) also noted that a minority of such offending (41%) was attributable to illicit drug use per se. Nevertheless, this indicated that the drugs-crime nexus was a considerable issue for many property offenders. Accordingly, drug-related crime, rather than drug use, was a major contributor in Australia to community concern (Spooner, Hall & Mattick 2000).

A further and related issue was the increasing cost of responding to crime and in particular illicit drug use. Collins and Lapsley (2002) estimated that the total cost of crime attributable to illicit drugs – illicit drug offences and drug-related offences – was $2.5 billion in 1998-99. A more recent study estimated that in Australia crime amounted to $19 billion per annum, of which $5.6 billion (29%) was attributable to drug-related crime (Mayhew 2003). Thus, by the late 1990s there were considerable demands to reduce the public health, social and economic costs of illicit drug use.

**Policy actors**

Multiple policy actors can influence drug policy making in Australia: governments; bureaucracies; criminal justice, health and education sectors; academia/research; and the non-government sector. The Drug Policy Modelling Program identified over 100 organisations involved in creating Australian illicit drug policy, most of which are involved at the level of issue identification, advocacy and consultation (McDonald, Bammer & Breen 2005). One key organisation in Australian drug policy, and indeed in the development of the IDDI, was the Alcohol and other Drugs Council of Australia (ADCA). ADCA is the peak non-government body, which has advocated for evidence-based policies since 1967. During the period of study, ADCA was chaired by Professor Ian Webster (1993-2002).

Given the federal system, governance of Australian drug policy is shared between the Commonwealth, state and territories. Prior to 1998 governance was split between two bodies: the Ministerial Council on Drug Strategy (MCDS); and the Inter-Governmental Committee on Drugs (IGCD). The MCDS (2004) comprised health and law enforcement ministers from the Commonwealth, State and Territory Governments, and was intended to be the “peak policy and decision-making body in relation to licit and illicit drugs in Australia.” The MCDS was supported by the IGCD comprised of senior government officials representing health and law enforcement agencies from New Zealand and each Australian jurisdiction.
In 1998, following the introduction of the Australian National Council on Drugs (ANCD) by Prime Minister John Howard, there has been an additional advisory body. The ANCD includes a wide range of experts from treatment, rehabilitation, law enforcement, research and community organisations. Until late 2005 the ANCD was chaired by Major Brian Watters of the Salvation Army. As noted in Chapter Two the reason for the introduction of the ANCD is somewhat controversial. While the Federal Coalition says it was introduced to represent the voice of the non-government sector (Howard 1998), others including Fitzgerald (2005a) have seen it as a means to increase political control over drug policy. That aside, as of 1998 the ANCD assumed an interesting position in the governance structure. While it reported to the MCDS, it also had direct access to the Prime Minister, something that was outside the powers of either the IGCD or MCDS. Governance in the new era of Australian drug control therefore created opportunities for more non-government input but also conflict between governance bodies.

As noted above health and law enforcement sectors are key drivers of Australian drug policy and operate, at least in principle, under the common objective of harm minimisation. Unlike the health sector in Portugal, health professionals in Australia have driven the emphasis upon evidence-based policy making, and harm reduction policies and practices (Wodak 2005). While law enforcement has similarly supported harm minimisation, there has been continued conflict between the need to enforce laws and minimise harms for drug users. This has led to difficulty in the application of harm minimisation “on the ground.” By 1999 there was somewhat of a watershed through the recognition that the traditional law enforcement response was inadequate, and in need of greater flexibility and collaboration. This was exemplified by the comments of the Australia Federal Police Commissioner Mick Palmer (1999) one month prior to the introduction of the IDDI:

> Law enforcement is only a small – albeit significant – part of the approach to dealing with the issue of illicit drugs. The traditional “arrest and prosecute” response to drug-related crime is too rigid and restrictive when dealing with low level use and possession.
> (Palmer 1999)

At the same time, there was evidence of a growing drug law reform movement and pressure for increased use of harm reduction measures, including heroin trials, safe injecting facilities and decriminalisation. Much of this led to heated political battles, which will be examined in the following section.
**Political factors**

Since the introduction of the National Campaign Against Drug Abuse (NCADA) politicians have tended to play limited role in Australian drug policy. However, the development of the IDDI arose in a context of increasing political involvement and conflict between the federal and state and territory governments.

The political system in Australia comprises two major parties, the Australian Labor Party and the Liberal Party, which are centre-left and centre-right respectively. In addition there are a number of minor parties including the Nationals, Democrats and Greens. Similar parties operate federally and at the state and territory level. As outlined in Chapter Two the NCADA was introduced in 1985 by Labor Prime Minister Bob Hawke. Federal Labor governments remained in power until 1996 when the Federal Coalition, comprising the Liberal and National parties, were elected under John Howard (1996-current). In 1997 an ACT heroin trial was supported by all state, territory and Commonwealth health ministers, but then blocked by Prime Minister John Howard (Wodak 1997). The trial could therefore not proceed since it required Commonwealth importation of heroin. Following this time there have been a number of political changes, at both the federal and state level, which impacted upon developments during the period of study.

First, the Federal Coalition introduced a number of new initiatives including the “Tough on Drugs” National Illicit Drug Strategy in 1997, and the Australian National Council on Drugs in 1998. “Tough on Drugs” was a coalition strategy, not a bipartisan strategy like the NCADA and its later versions, the National Drug Strategy. Despite this, policies of the major federal parties consisted mainly of rhetorical differences. Key elements of “Tough on Drugs” included stronger law enforcement, particularly protecting borders and anti-drug education and treatment to encourage people to “kick the habit” (Liberal Party of Australia & National Party of Australia 1999, p. 9). The Australian Labor Party’s (1999) “10 point plan” on drugs essentially supported a “Tough on Drugs” approach: increased funding and focus upon border control, but also the provision of education and rehabilitation. Neither major party supports drug law reform. In contrast, the minor parties of Greens and Democrats were more supportive of harm reduction measures and drug law reform, as exemplified through their positions in the 2004 federal election (Families and Friends for Drug Law Reform (ACT) Inc 2004).
Second, following the blocked heroin trial there was some evidence of increasing conflict between the federal and state and territory governments. Three state and territories Governments stood out in the development of the IDDI, due to their vocal stances for evidence-based drug policy reform: the ACT, NSW and Victoria. The Australian Capital Territory had been the site of the proposed heroin trial in 1997. Despite its failure the ACT Chief Minister Kate Carnell (1995-2000) again advocated in 1999 for heroin trials and a supervised injecting facility (Carnell 1999). NSW Labor Premier Bob Carr (1995-2005) introduced the first Australian drug court in NSW in February 1999 and shortly after the adoption of the IDDI held a NSW Drug Summit which led to the adoption of Australia’s sole Medically Supervised Injecting Room (NSW Government 1999). Finally, the Victorian Liberal Premier Jeff Kennett (1992-1999) became a key proponent for a Victorian heroin trial, particularly in the period preceding the adoption of the IDDI. In March 1999 he held a premiers meeting involving the NSW, SA and WA Premiers and the ACT chief minister to obtain inter-state support for his proposed trial. This meeting was held one month prior to the Council of the Australian Government’s (COAG) meeting on 9 April 1999, at which the IDDI was developed. Thus, during the late 1990s while there were trends towards a more partisan and “tough on drugs” approach at the federal level, a number of state and territories actively promoted more liberal, evidence-based measures.

Research
In the 1990s, academics and researchers contested the effectiveness of drug law enforcement versus treatment and pointed to the benefits of non-criminal justice responses. Questions have long been asked in Australia about the effectiveness of drug law enforcement and its impacts upon drug users (see for example Australian Parliamentary Joint Committee on the National Crime Authority 1989). Such questions expanded in the 1990s with the demonstration that despite the rhetoric of targeting the “Mr Bigs” of the drug field, minor drug offenders constituted the major focus of drug law enforcement activity (Green, P. & Purnell 1996; Sutton & James 1996). It was increasingly demonstrated that drug-law enforcement could have counter-productive impacts upon drug users, through encouraging unsafe using practices such as needle sharing (Fitzgerald, Broad & Dare 1999; Maher et al. 1998). At the same time studies established that drug law enforcement may encourage drug users to enter treatment (Weatherburn & Lind 1997).
Arguably, the pinnacle of such research was in January 1998 with the release of the 1996-97 National Illicit Drug Report (Australian Bureau of Criminal Intelligence 1998), which not only called into question the effectiveness of supply reduction and drug law enforcement, but concurred with the need for alternative responses to minor drug users. This report was followed by an unprecedented response by the law enforcement sector as police admitted they were losing the drug war (Snell 1998).

At the same time increasing state, territory and Commonwealth inquiries called for non-criminal justice responses to drug users. Most notable was the report from the Penington Drug Advisory Committee (1996, p. 112) in Victoria, which concluded that “some existing laws have created harms and costs greater than those that result from the drugs themselves,” and recommended cannabis decriminalisation and diversion of drug users from the criminal justice system. The evaluation of the National Drug Strategy by Single and Rohl (1997) further recommended increased emphasis upon trafficking rather than possession offences. As they noted:

> The enforcement of criminal law against nondependent, infrequent users of a drug should be tempered by consideration of whether the benefits (which consist mainly of deterrence) of applying criminal sanctions are outweighed by the negative impacts. (Single & Rohl 1997, p. 47)

They therefore recommended the provision and use of diversionary options.

Other researchers increasingly examined drug diversion, particularly the benefits and challenges to their expansion. Drug diversion was deemed to have considerable benefits: the avoidance of a disproportionate response to drug users; increased partnerships between health and law enforcement sectors; increased consistency and accountability of law enforcement response; and the provision of a more cost-efficient, humane and potentially effective response (ADCA 1996; Hall 1997; Morrison & Burdon 2000; Spooner, Hall & Mattick 2000, 2001). In particular it was noted that drug treatment offered much better returns for investment, with estimates that $1 invested in drug treatment was equivalent to $7 invested in supply reduction (Rydell & Everingham 1994). Further, drug diversion offered the potential to decrease use or harmful drug use, increase individual and public health and reduce

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24 It should be noted that the estimate of returns for investment has been subject to some dispute, due primarily to the methodology used by Rydell and Everingham. See for example Manski, CF, Pepper, JV & Petrie, CV (eds) 2001, Informing America's policy on illegal drugs: What we don't know keeps hurting us, National Academy Press, Washington DC. Nevertheless, such research contributed towards acceptance of the benefits of alternate responses.
drug-related crime (ADCA 1996; Howells & Day 1999). In short, studies contended that drug diversion could provide a more effective response.

However, due to the lack of systematic assessment and evaluation on the outcomes from drug diversion, there was considerable debate as to the extent to which drug diversion would lead to the above mentioned public health and criminal justice benefits. Hall (1996; 1997) and Makkai (1998) urged the need for realistic expectations, and cautioned against seeing drug diversion or drug courts as a panacea, and in particular as seeing drug diversion as a crime control measure. Reductions in crime were seen as unrealistic, but decreased court congestion and criminal justice agency satisfaction were seen as realistic outcomes. Similarly, reductions in the level of harm were suggested as more realistic than reductions in use.

A further issue was the need to ensure that drug diversion was not utilised to produce more onerous outcomes. As noted by Polk (1987) while destructuring initiatives such as diversion have often been introduced to reduce the potential for stigma, and counter-productive impacts of criminal justice intervention, the destructuring initiatives themselves often produce net-widening, whereby social control and intervention is increased rather than decreased. This may increase the number of individuals receiving criminal justice contact, or the degree of intervention with offenders, and is often attributed to the belief that alternate interventions are less onerous than the traditional criminal justice intervention (Roberts, L. & Indermaur forthcoming). It was therefore recommended that drug diversion programs focus on repeat offenders rather than first-time offenders (ADCA 1996; Makkai 1998; Spooner, Hall & Mattick 2000).

A particularly notable study of drug diversion commenced in 1994 by the Alcohol and other Drugs Council of Australia (ADCA) which was funded through the Commonwealth National Drug Crime Prevention Fund. ADCA (1996) held a National Diversion Forum in 1996 involving fifty stakeholders from law enforcement, health and attorney generals departments and representatives from drug diversion programs. This contributed to the identification of benefits and barriers to diversion and principles of best practice. ADCA (1996) best practice principles included:
• shared philosophical basis of harm reduction, and in particular that “diversion should be seen as initiating the process of social change, rather than simply treating ‘drug problems’ ” (ADCA 1996, p. 21)
• broad range of diversion options according to need or offence seriousness
• access and equity for offenders regardless of age, gender, cultural background, substance type
• provision of a client charter and follow up for clients that need additional support
• that the outcome should not be more onerous that the imposition of the traditional criminal justice penalty
• inclusion of major stakeholders in all stages of planning/review
• clear and ongoing communication between stakeholders
• clear definition of roles, particularly for law enforcement personnel
• ongoing training for people administering programs
• evaluation and monitoring according to agreed outcome measures

ADCA (1996, p. 28) noted that key challenges to obtaining drug diversion were that it was less marketable than punishment and control, and fell into a “funding wilderness” between health and justice sectors. They further highlighted that agreement between the major stakeholders on what constituted satisfactory outcomes would be essential, to obtain funding and political support and hence to expand drug diversion.

Evaluations from drug diversion trials, particularly those commenced following the ADCA workshop, constituted another key source of evidence. The first such program was a Victoria Police Cannabis Cautioning Trial which commenced in July 1997. During the five month trial 97 people were cautioned, of whom 19 (20%) re-offended (Ditchburn 1999). This trial led Victoria Police to conclude that cautioning was a significant deterrent to first time offenders and a means of saving police time and resources. The program was extended state-wide in January 1998. This was followed by another Victoria Police pilot – the Illicit Drug Diversion Pilot – and a court-based pilot – the Court Referral and Evaluation for Drug Intervention and Treatment (CREDIT) – both of which were introduced in late 1998. The evaluation of the Drug
Diversion Pilot indicated support from all key stakeholders and that it was a significant and necessary shift:

The program is viewed as one means of turning the policy rhetoric into reality: it is a practical and strategic response to an often intractable problem (McLeod Nelson and Associates Pty Ltd 1999, p. 17).

Further, it was a success according to the ADCA principles of best practice.

Distal factors

Past paradigms
Contemporary Australian drug policy stems from the National Campaign Against Drug Abuse (NCADA) and the national objective of harm minimisation. As noted in Chapter Two harm minimisation emphasises the belief that society can never get rid of drug use and thus avoids utopian objectives of a drug-free society. The NCADA, which was renamed the National Drug Strategy in 1993, embraced the objectives of supply, demand and harm reduction and key principles including pragmatism, partnerships and a whole of government approach (National Drug Strategy Committee for the Ministerial Council on Drug Strategy 1993).

The objective of Australian drug policy appears less clear following the introduction of “Tough on Drugs.” The National Illicit Drug Strategy has a somewhat different emphasis to the National Drug Strategy, most notably the support for an abstinence-based approach. Subsequently the 1998-99 to 2002-03 National Drug Strategic Framework was produced (MCDS 1998). Harm minimisation in the new strategy explicitly included abstinence-based policies, something that as noted above was not a part of the original NCADA definition.

As noted in Chapter Two, drug use and possession is criminalised in most states and territories. Cannabis use and possession is however decriminalised in South Australia, Northern Territory, Australian Capital Territory and Western Australia. Despite, this there has been a historical emphasis upon diversion by the law enforcement sector, for many minor offences, including drug use and possession (Morrison & Burdon 2000). This has tended to occur through informal mechanisms.
International influences

International influences included United Nations guidelines and trends from other countries including the United States and Europe. Australia is signatory to the three UN Conventions on drugs (United Nations 1961, 1971, 1988). The International Narcotics Control Board (INCB) (1999) has long criticised the adoption of harm reduction as a policy objective unless the purpose is to reduce demand. It has therefore opposed the traditional objective of Australian drug policy. Further it criticised Australia for establishing a supervised injecting room in Kings Cross, New South Wales (International Narcotics Control Board 2001, 2002). In contrast, the INCB (1999, p. 67) supported the introduction of Tough on Drugs “in order to reverse the negative trends in the 1990s.” No reference was made by the INCB to the introduction of the IDDI.

Unlike Portugal, Australia is an isolated continent, having no shared borders. The main nation to influence Australian drug policy has been the United States. Yet, while United States drug courts received considerable interest in Australia, it has been noted that police and court-based responses “have grown more naturally from Australia’s system of justice and its experiences” (Hamilton 2001, p. 106). Thus, the diversionary model that emerged in Australia was quite distinct from drug courts, which may reflect the doubts expressed by researchers including Makkai (1998) and bureaucrats over the mass introduction of drug courts in Australia. Accordingly, the development of the IDDI has been seen as the result of limited international influence.

Structural arrangements

A number of structural factors influenced the drug policy development including Australia’s federated structure, consisting of eight states and territories. Blewett (1987) has asserted that the establishment of the NCADA in 1985 was a considerable achievement in the face of inter-state bickering, and it enabled a single and agreed direction for all the states and territories and resource maximisation. State and territory jurisdictions have retained considerable flexibility in responding to their own issues, and have retained control over drug laws, law enforcement and treatment provision. The federal government has provided funding for establishing initiatives under the National Drug Strategy, but these have in the main been cost-shared between the federal and state/territory governments. The federal structure means that national drug policies require agreement between the eight governments through the
Council Of Australian Governments (COAG). COAG is the peak intergovernmental forum involving all state, territory and federal leaders. It meets on average once per year to propose or adopt policy reforms of national significance (Council Of Australian Government 2006). Australia’s federated structure therefore creates multiple venues from which to initiate policy development.

Values
Australia is a liberal democracy which has long led to conflict in the drug policy arena. The liberal ideals recognise the rights and liberties of individuals and encourage restrictions on government intervention, something that encourages harm reduction and decriminalisation (Parkin 1998). On the other hand, democratic ideals emphasise collective and public decision making and the need for law and order responses. However, due to the controversy of the drugs issue, Crosbie (2000) and Parkin (1998) have noted the difficulty of obtaining a rational debate that epitomises liberal democracies. This has meant that while Australia has progressive liberal ideals on drugs such as injecting rooms and decriminalisation of marijuana, these are often blocked by democratic concerns.
Incremental reform: Development of the NDSF

Policy makers contended incremental reform has been facilitated in Australia due to three main reasons: the policy making structure; emphasis upon evidence-base; and support for the direction of harm minimisation. A number of changes occurred in the lead up to the development of the 1998-99 to 2002-03 National Drug Strategic Framework (NDSF) and indeed the IDDI which have been seen as threats to either the direction of Australian drug policy or the policy making process. The introduction of “Tough on Drugs” and introduction of the Australian National Council on Drugs (ANCD) arguably increased the potential for atypical reform, and more ideological, abstinence-based reform. The following section outlines the primary drivers of incremental reform, the newly emerging and potentially conflicting drivers and how both sets of drivers impacted upon the emergence of the NDSF.

Governance mechanism
A particular driver of incremental reform was the policy making process, namely bureaucratic and ministerial control, emphasis upon consensus-making and restricted input. The governance process has been conducted in the main by bureaucrats and Ministers. Decision-making through the MCDS and IGCD reduced the potential for political decision making and politically-led atypical reform. As Fitzgerald and Sewards (2002, p. 26) stated Australian drug policy involved “the deliberate avoidance of electoral politics and public conflict.” Policy makers contended that limited political involvement has been aided by the presence of a bipartisan political position towards the drug problem, something which has been seen existing until 1997 with the entrance of the Coalition “Tough on Drugs” strategy and the ANCD:

For the vast majority, about 20 years it wasn’t a political football. Both sides of government agree it is a no-go zone.


However, the policy making structure has also constrained opportunities to input new ideas and proposals, and thus facilitate more evidence-based atypical reform. In particular, the Australian governance process has been critiqued for being overly bureaucratic, leading to a closed-shop approach to policy making and reducing the potential for policy input from outside the bureaucracy. The Single and Rohl (1997) evaluation pinpointed the managerial structure of the NDS as the biggest threat to the future of the strategy. This was due to two reasons: ministers met very infrequently,
necessitating a focus upon short-term issues; and the process excluded voices and input from the non-government sector. Crosbie (2000) concurred and noted another problem namely that policy making was conducted behind closed doors.

Finally, the governance process operated by consensus decision-making. This reduced the potential for rash or one-sided decision-making but also for atypical reform. Due to the need for agreement between eight governments, the process of consensus decision-making was seen as a particular constraint upon atypical reform in Australia:

It is often not the decision that the heroes and the champions want because it is watered down, it is consensus.

For Australian drug policy we get what I call lowest common denominator drug policy that all the jurisdictions can sign off on and what makes them able to sign off on it is that it requires minimal change.
David Crosbie – Non-Government Treatment Professional – [1]

Consensus decision-making was seen by many policy actors as a source of frustration. That said, the major benefit was that it reduced the power of one individual government, and in particular of the federal government. This meant that states and territories were not dictated to by the Commonwealth:

Even though the states and territories have their own idiosyncrasies we get an overall collaborative view, so this is part of the success. There is no imposition of here is the way we are going to do it, because the states would just walk away. So probably it can be very frustrating, but I think it is a strength.

In Australian you don’t have major changes in drug policy. They talk about checks and balances, even though it sometimes seems like a slow, monolithic thing to change but in a way that is better than a landscape that changes dramatically.

**Research**

Policy makers contended that the commitment to evidence-based policy making, establishment of research centres, and the monitoring of trends and evaluating progress, were driving forces of Australian drug policy. Research in turn facilitated non-ideological policies:

So that investment in the evidence-base has put us in good stead to move forward with developing robust policies that will stand up to examination rather than taking a view that some other major countries that base theirs on moralistic interpretations.

Evidence of positive impacts from the NDS, and of continued support, facilitated the continuation of similar policies. Success has been seen in particular through declines
in the prevalence of smoking and increases in responsible drinking (Fitzgerald & Seward 2002; Single & Rohl 1997; Success Works 2003). The most touted success was the reduction in number of cases of HIV amongst intravenous drug users, which was attributed to Australia’s early adoption and support for needle syringe programs. Such evidence was seen by most policy makers as indicating that atypical and dramatic change is neither necessary nor desirable:

I think we are still basically world leaders and that’s mirrored by our HIV rates, our Hep C is going up but it is still comparable or a lot less than other places in the world so I think the evidence is probably in that we have done a good job. So we just need to keep it on track and keep developing it.

Stephen Vaughan – Senior Health Bureaucrat – [2]

This view was supported by the five major evaluations conducted since the inception of the NCADA. The evaluations recommended primarily incremental adjustments of a conceptual and practical nature (Commonwealth Department of Community Services and Health 1989; MCDS 1988, 1992; Single & Rohl 1997; Success Works 2003). Policy makers thus contended that the evidence-base facilitated Australian drug policy, but that it had not necessarily encouraged dramatic change. While some policy makers wanted greater attention to evidence suggesting more major reform, others contended that the evidence-base also reduced the potential for radical, non-pragmatic change:

Those are the things that make this thing enduring, why it has lasted 20 years, why it is difficult to dismantle which some people have tried to do. …… There have been people who have tried to dismantle the whole process because they actually don’t agree with the process. But quality improvement is difficult to dismantle because there is the evidence-base to say that this is actually working or it is getting better.


**Support for policy direction**

The final and perhaps more important reason for incremental reform in Australian drug policy was that most policy makers supported the objective of harm minimisation, and core principles established under the NCADA. Consequently, radical change was seen by most as undesirable:

I think going right back to the beginning they got it pretty right in the first one, so it hasn’t had to have a major re-work or turn it on its head.

PC – Member of Non Government Organisation – [3]

Even some staunch advocates of “Tough on Drugs” were not opposed to the overall direction of harm minimisation:
It [Australian drug policy] is a simple terminology that we use in Australia: the “tough on drugs strategy.” We’ve got a current policy which has been going for seven years under the Howard Government and fundamentally it is a pragmatic approach which has as its underpinnings a very humane basis to people with drugs problem and it is also aware of the importance of law enforcement…. It rests on three major platforms; harm reduction, supply reduction and demand reduction.

Brian Watters – Former head of ANCD – [1]

Despite the presence of different beliefs, harm minimisation facilitated the bringing together of individuals. As Single and Rohl (1997, p. 49) summed up, harm minimisation provided a “middle ground” where individuals could work together. This facilitated the desire to modify and adapt policy to changing circumstances while retaining the core premises:

There will always be small disputes, and you get off track occasionally but if you get back to the central track of harm minimisation…. I think your policy is the right way.

Stephen Vaughan – Senior Health Bureaucrat – [1]

The policy making process, commitment to evidence-base and support for harm minimisation thus encouraged an emphasis upon the pragmatic and humane policy established in 1985. There has been minimal change, but unlike the policy in Portugal, the policy was supported in the main by policy makers and the evidence-base.

Conflicting drivers?
Most policy makers deemed that the introduction of “Tough on Drugs” and the ANCD enhanced the potential for ideological and politically-led policy making, most notably to reflect the political desire for more abstinence-based approaches:

With the entrance of the current Federal Coalition Government there was a clear political desire to change the nature of Australia’s overarching conceptualisation of its’ drug policy to a more non-drug use approach.


Moreover, the introduction of the ANCD increased the potential for partisanship and Prime Ministerial control over Australian drug policy making. Such a view was supported by Fitzgerald (2005b, p. 259) who argued that the introduction of the ANCD was a “shift from consensus decision making through a policy community approach to centralized executive decision making through the prime minister’s office.” In some respects, this was supported by the view by the Prime Minister and his advisors, that “Tough on Drugs” was and is the National Drug Strategy:

I call it Tough on Drugs as a policy direction. When the bureaucrats write about it they call it a National Drug Strategic Framework.

John Perrin – Prime Minister’s Office - [8]
Impact upon the NDSF

There was conflict as to whether either change had an impact upon the policy making process or the direction of Australian drug policy. Indeed, most policy makers saw the ANCD not as a means of Machiavellian control, but as a necessary means of increasing input of new ideas into policy making:

In some ways it [the ANCD] is a counter or a balance to the ascendancy of the bureaucracy, a pragmatic, practical coalface awareness of some of the issues.

The Australian National Council on Drugs was the inside voice for people who have historically been outside.

The development of the NDSF resulted in the broadening of the definition of harm minimisation to include abstinence-based approaches:

It has now become part of the mantra harm minimisation holds dear to its heart abstinence from drugs.

The broader definition was in clear opposition with the original definition of harm minimisation: reducing harm without necessarily reducing use (Blewett 1987). From one perspective, this was facilitated by the political landscape and in particular the expansion of the governance process. Major Brian Watters, the then head of the ANCD, notes he was a key proponent for including and enhancing the emphasis upon abstinence:

I was very keen to make sure that the non-use of illicit drugs was seen as part of the strategy, not simply reducing the harms which is worthy in itself, but the best means of reducing harm is by not using.
Major Brian Watters –Former head of the ANCD – [4]

That said, the development of the NDSF was conducted primarily by the MCDS and IGCD, since the draft document was produced prior to the emergence of the ANCD. ANCD input into the development of the NDSF was therefore minimal.

From another perspective, the broader definition of harm minimisation was a reflection of the research. The evaluators of the National Drug Strategy, Single and Rohl (1997), noted that the original definition of harm minimisation was not supported by all sectors. This led to their recommendation that while the narrow definition provided greater strategic direction, a “more general, catholic definition of harm minimisation” was necessary to facilitate the inclusion of all sectors, particularly law enforcement and abstinence-oriented providers (Single & Rohl 1997, p. 45).
could therefore be argued that the broader definition was driven by the evaluators and research, not the ANCD. Needless to say, while the broader definition has bore the brunt of conflicting opinions, the mainstay of prior strategies remained.

Perhaps most importantly policy makers contended that in the development of the NDSF the policy making process was driven primarily by the core drivers identified above, namely the emphasis upon consensus-making, attention to the evidence and support for harm minimisation. Policy makers noted that while there was debate and some pressure to scrap the objective of harm minimisation, this was thrashed out “until we got a compromise” [DC – 3]. Consequently, harm minimisation was retained as the objective of the NDSF, albeit with a broader definition. The core drivers therefore facilitated minimal change.

In summary, incremental reform was encouraged by the policy making structure, the evidence-base and widespread support for the direction of Australian drug policy. Decision making by the sub-systems reduced the potential for electoral policy making but also constrained opportunities for policy input. In the emergence of the NDSF, policy makers suggested that the more ideological and political landscape influenced the policy making process, but had minimal impact upon either the process or the policy direction. It is unclear whether this was facilitated by the more limited role of the ANCD or politicians in this development, but it appeared that the core drivers, at least in the development of the NDSF, facilitated the continuation of prior, albeit modified, policies.
Atypical reform: Development of the Illicit Drug Diversion Initiative

The following section examines the development of an atypical reform, the Illicit Drug Diversion Initiative (IDDI). It highlights the development of the Council Of Australian Government (COAG) agreement to adopt diversion and the national diversion framework, which occurred in April and November 1999 respectively. Policy makers contended a number of factors contributed towards the development of the IDDI including the expansion of the circle of policy actors, concerted advocacy, venue shifting and the accumulation of evidence. The following section highlights the process of development through the four major drivers: crises, research, policy actors and politicians. The subsequent section will examine the framing of the initiative and therefore examine who, or what, ultimately framed the reform.

In contrast to the Portuguese decriminalisation which was a highly public development, the IDDI evolved away from the public gaze, arguably due to the birth of the IDDI through a political window. As a consequence, there has been limited opportunity to support or verify the perspectives of those involved in this development. Nevertheless, the following section uses publicly available accounts to support, where possible, the expert views from the Australian drug policy arena.

**Crises**

Policy makers identified three crises as contributing towards the development of the IDDI. In contrast to the development of decriminalisation, it appeared crises were not the major driver of the reform. Nevertheless, they played considerable roles in focusing attention, facilitating advocacy and increasing receptivity to proposals. The public health crisis concerning heroin overdose was noted as an important driver in the development of the IDDI:

> It was a crisis, we were losing 1,200 or 1,300 kids a year and drug use was expanding and people were worried, a horrible fear of the knock on the door late at night to say…
> 
> Brian Watters – Former ANCD Chair – [12]

Its’ primary role was to focus political minds on the “drug problem”:

> It didn’t change the policy of drugs, what it did do was it focused politicians’ and governments’ minds on we need to do something about this, 1000 people dying, this can’t continue.
> 
As noted previously the heroin overdose crisis sparked calls for heroin trials and safe injecting facilities (Ferguson, Mitchell & Cusworth 1999; Hawes, Nason & Le Grand 1999; Walker 1999; Williams 1999) which contributed to the pressure for a political response to the drug problem.

Policy makers contended that pressure for change was also driven by increasing community concern over property crime, and the burgeoning demand upon the criminal justice system. The pragmatic realities of increased cost and demands on time and resources appeared to focus the attention of the law enforcement sector:

You will find that the large numbers of people going through for low-level drug offences has expanded the criminal justice system so what we are trying to do is streamline it......

As a prosecutor I remember I prosecuted in Prahran 140 briefs before court, in court one on one day. That is what police do everyday of the week. That is the sort of volume that we see in court, the system doesn’t cope with that. There has to be a better way.

K - Victoria Police – [9]

I think there are just practical, pragmatic things; too many people in jail, too much time that cops spend on minor non-problematic drug issues.

PC – Member of Non Government Organisation – [8]

The crises therefore appeared critical in increase receptivity to new ideas and most importantly the political willingness to undertake reform.

**Research**

Research was deemed to play a considerable role in the development of the IDDI. It highlighted problems with the existing approach, and particularly the harms and apparent futility with the traditional criminal justice response. Policy makers contended this contributed to a shift in law enforcement attitudes:

We were to arrest people for small amounts of cannabis, they went into the criminal justice system, they would get virtually no penalty but it would be a harm maximisation of the system because they couldn’t travel, they couldn’t get jobs, there were a range of harms associated with that. We weren’t breaking the cycle of drugs.


The same Victoria Police member contended that the increasing knowledge assisted the maturation of the police force [5].

Importantly research also highlighted the strengths, weaknesses and technical feasibility of non-criminal justice responses. The former CEO of ADCA, David Crosbie, contended that reports particularly by ADCA (1996) on the benefits of diversion, including the potential to introduce a more humane response to drug users and reduce drug use, crime and costs had considerable influence:
The bottom line is studies have shown it is a good way of spending money, you will actually reduce crime, you will actually reduce drug use, the community will actually be safer and there will be less people dying.

David Crosbie – Non-Government Treatment Professional – [9]

Following the ADCA study and forum, drug diversion was placed onto the MCDS agenda in 1997 and filtered through to the Prime Minister’s Office. The proposal was not enacted at that time. While evidence was not seen as a catalyst for the IDDI, it played an increasing role in subsequent political events.

Evidence of technical feasibility of drug diversion pilots appeared to strengthen the political receptivity to the evidence. This was particularly through the evaluation from the Victoria Police Cannabis Cautioning Pilot:

Well we had the tool, we’d already done it and we’d already done an in-house evaluation to say it worked. So we had something on the table to offer.


This demonstrated a model of drug diversion, and perhaps more importantly considerable support by the Victoria Police.

Research was deemed to play a considerable role in highlighting problems with a traditional criminal justice response, encouraging shifts in the law enforcement sector and increasing political receptivity to drug diversion. However, there was conflict as the quality of evidence that was amassed prior to the development of the IDDI:

The documentation that has come out that I have seen doesn’t provide any clue that this was based on a rigorous academic study of what works and what doesn’t work.

Alex Wodak – Health Professional – [7]

Policy actors
The development of the IDDI involved a complex group of policy actors. By necessity, the development involved a large number of Government and bureaucratic personnel from the Commonwealth, State and Territory Governments. One key factor that emerged as distinguishing this reform from the development of the NDSF was the enlargement of the circle of policy actors beyond the traditional bureaucracy. Indeed, it was argued that the breadth of the policy actors involved in this initiative was highly unusual:

They actually involved a wider group of people in developing that. They involved the Australian National Council on Drugs and people outside of government in developing those processes, people who were actually involved in treatment and research, areas like that actually had input into what happened with that money which had never happened before.

David Crosbie – Non-Government Treatment Professional – [10]
The following section examines the roles played by the key policy actors and advocacy preceding the adoption of the IDDI. It examines the role of the two main interest groups that advocated for the IDDI: the law enforcement sector and non-government organisations. The roles of the more peripheral groups – the health sector and the drug law reform movement – are examined subsequently.

The first interest group was the law enforcement sector. It was contended that in the lead-up to the development of the IDDI, law enforcement officials suggested a need to fundamentally change the business of responding to drug users. This gave rise to concerted advocacy to shift traditional policing practice – from a traditional law enforcement role to a more collaborative response – one where police acted as gateways to education and treatment:

It was actually driven by the police and courts who wanted some other way of dealing with offenders with drug problems.

Marion Simmonds – Bureaucrat – [3]

We should channel that person into timely and accessible treatment because what is coming out of that the benefit to the community and the individual and law enforcement is tenfold.


Following the trial of Cannabis Cautioning in 1997 the law enforcement sector in Victoria were key proponents of the need for a national diversion framework. Principally it was argued the trials and evaluations of the Victorian Police Cannabis Cautioning Program and the Drug Diversion Pilot provided impetus and direction for the IDDI:

Based upon those two programs and there was a little bit happening in Sydney at the time around Drug Courts I think we were able to steer this and drive this in such a way that it gained a lot of momentum


The timely release of these evaluations meant that both were sent to the Victorian Premier Jeff Kennett and the Prime Minister’s Office just prior to the COAG meeting in early 1999. These evaluations demonstrated that drug diversion could work and provided a model of how to implement diversion. As Superintendent Paul Ditchburn said “we had something on the table to offer” [5].
In both cases, the evaluations were positively received:

What happened was I received a phone call just prior to that COAG meeting in 1999, two phone calls, and I was sworn to secrecy. I had to send our program to our Premier here at the time Jeff Kennett. . . . Now what happened in that meeting in 1999 the Premier got the paper work and was fairly excited about it. I also received a phone call from Canberra, I remember standing at the fax machine thinking “here we go” but I actually faxed it to Canberra as well so it went to the Prime Minister’s Office. At that meeting in April they both came together and said “this is the best program since sliced bread, this is good, this is something we should commit to” and that was a couple of days before the meeting and I got a phone call saying you’ve got $110 million funding plus.

K – Victoria Police – [3]

In some respects, this was supported by the literature and media since the launch of the Illicit Drug Diversion Pilot in July 1998 was seen as very bold and innovative. It was also counter to the political climate of the time and therefore sparked some criticism of the Victoria Police. This move saw Victoria Police Commissioner Neil Comrie portrayed as a “reluctant drug reformer”:

He [Police Commissioner Neil Comrie] is the driving force behind the most radical realignment in drug policing yet to be attempted in this country – a pilot scheme to caution, rather than prosecute, heroin and other hard drug users. That it is the police, not politicians, who are setting the pace speaks volumes. Since John Howard toppled the controversial ACT heroin trial . . . the issue has disappeared from the political agenda. (Walker 1998, p. 23)

This suggested that that the federal climate was opposed to law enforcement reforms and that Victoria created a possible venue to trial alternative responses. The introduction of the Victorian diversion programs was followed by considerable criticism from other premiers who deemed the move a liberalisation of drug laws. As criticism decreased a number of other states and territories introduced their own drug diversion programs or drug courts.

However, there was disagreement as to what drove law enforcement advocacy for drug diversion. Law enforcement policy makers suggested it was the result of law enforcement initiative and innovation, particularly by the Australian Police Commissioners. Such a view was supported by Success Works (2003) who praised the proactive role taken by Australian Police Commissioners in shifting law enforcement practice from a traditional enforcement approach to encompass demand and harm reduction. However, not all law enforcement individuals believed the IDDI was thought up by the police:

[I am not sure where it came from. It may not have been an initiative of the police

Moreover, the leadership of the Police Commissioners ought to be viewed in the context of the questioning of the traditional drug law enforcement response, and thus perhaps drug diversion became a means of embracing change in a controlled way. For example, the Victoria Police pilot followed the recommendations of the PDAC report for decriminalisation, something which sparked the search for an alternate response that fit within the criminal law:

You had Penington talking about, we knew that out of his 72 recommendations he was talking about decriminalising cannabis….. So I think that was good and bad. What it did was made us have a look internally and what it enabled us to do was look at it and come up with a better solution.


Perhaps therefore as noted by Paul Ditchburn, in his conference presentation, an important message from the Victoria Police pilot was that the diversion represented a strategic, non-radical, change:

This program [Cannabis Cautioning] is an example of our commitment to developing the best practice projects and [to] explore alternative sanctions. It demonstrates our willingness to embrace change in a controlled and strategic way (Ditchburn 1999).

The second key sector advocating for diversion was the non-government sector, led initially by the Alcohol and other Drugs Council of Australia (ADCA). The former President of ADCA, Professor Ian Webster, noted that in the early 1990s there was a belief that illicit drug policy had lost momentum and slipped off the political agenda.

This was partly due to the belief that there was nothing that could be done with drug users:

There was a feeling among people connected with that organisation, that in many ways the government had “hit the glass ceiling” about drugs. It had lost momentum around illicit drugs….. going back to the idea of diversion, ADCA convened a national workshop around diversion and it effectively set the new agenda for diversion.

Ian Webster – Former President of ADCA – [4]

Hall (1997) concurred that unrealistic expectations around the purpose of early diversion approaches led to a loss of faith in diversion and the belief that treatment could not work. ADCA therefore initiated and held a diversion forum in October 1996. In addition to gathering evidence of the strengths and barriers to diversion, the ADCA forum initiated advocacy and designed strategies to enhance the political receptivity to drug diversion. In particular, the forum suggested that the despondency over treatment could be overcome, and ADCA outlined a proposal to get diversion onto the political agenda. This specified the need for goal clarification and clear advocacy of the benefits of diversion, including the potential for a more effective and
humane approach to drug users. It identified that due to the reduced marketability of drug diversion political support was another challenge. However, due to the inadequacy of the status quo the ADCA diversion report argued that if advocacy could be made more strategic, political support was virtually inevitable:

The view was expressed repeatedly that the status quo, the present criminal justice system, generally deals so poorly with the problems of drug offenders that the obvious advantage of diversion programs should be readily accepted. The main barrier to this occurring is the failure of current diversion programs and researchers to clearly articulate the aims of diversion programs, the outcomes that are achieved, and the possibilities for future action. (ADCA 1996, p. 30)

The diversion forum was used to initiate efforts to push diversion onto the political agenda. Much of the discussions on behalf of ADCA were undertaken by David Crosbie, the then CEO of ADCA. He became the leading proponent and entrepreneur pushing for drug diversion. Much of the advocacy was conducted with the Prime Minister’s Office:

There was a concerted advocacy around how this was going to be a, we tried to market it as a win for everybody, politics 101 there are no losers here, this is a win for everybody, it may cost a bit but in the longer term it actually saves money. I have to say the Prime Minister was receptive and so were people in his office.

David Crosbie – Former CEO of ADCA – [8]

Equally importantly, ADCA initiated a grass-roots campaign in 1997 – “treatment works” – to address the major barrier to diversion:

It hinged on a number of key assumptions that we needed to enforce: one is that treatment works, it actually reduces crime and drug use. To support that we agreed out of the 1995 conference to run a treatment works week, got the Prime Minister to support that and arranged as part of that week that agencies invite their local politicians to come and visit. So we started a grass-roots campaign about the effectiveness of treatment because our own discussions showed that that was the major barrier to diversion.

David Crosbie – Former CEO of ADCA – [8]

The treatment works campaign and other advocacy by ADCA appeared to have influenced the bureaucracy. For example, treatment works campaigns have been held annually by ADCA, and have been singled out by the Commonwealth Department of Health and Ageing as examples of positive advocacy (Treloar, Abelson, Cao, Brener, Kippax, Schultz, Schultz & Bath 2004). More importantly, diversion shifted onto the MCDS agenda in 1997. While drug diversion was not adopted in 1997, diversion was an option that could be utilised when an appropriate political opportunity arose. ADCA appeared critical in increasing Federal government, bureaucratic and public knowledge of the benefits of drug diversion.
Increased receptivity to the proposal was argued to have hinged upon entrepreneurial advocacy by in particular David Crosbie. His role appeared poorly recognised by most interviewees, but was seen as critical by the Prime Minister’s Office. It appeared that this link was strengthened following the appointment of John Perrin in 1997 as the “principal drugs advisor” to the Prime Minister. John Perrin was briefed at the time by David Crosbie on the “important things in drug policy” [5]. David Crosbie contended he used this link to increase receptivity to the ideas of treatment and drug diversion. As John Perrin noted, “his view and my own strong conviction is that treatment does work” [5]. This supported David Crosbie’s argument that his main role was in advocating for diversion, specifically in persuading the Prime Minister’s Office of the benefits to drug diversion, and need for federal funding:

Tens of people if not hundreds were involved in developing different models and putting them forward about how this money could be rolled out. My role was more in getting the money.

David Crosbie – Non-Government Treatment Professional – [9]

The limited recognition of his role by other policy makers suggested that either such negotiations were conducted behind the scenes, or they were perhaps less important than asserted in the development of the IDDI.

The non-government sector was also influential through the Australian National Council on Drugs (ANCD). As noted earlier, following the introduction of the ANCD governance arrangements shifted to enable greater input by non-government organisations into drug policy making. It was argued that the ANCD had three impacts upon the development of the Illicit Drug Diversion Initiative: first, it broadened the circle of voices in policy making; second, it increased the public gaze on proceedings; and third it increased the potential to counter potentially doctrinal proposals. The impacts of both ADCA and the ANCD are explored in the following section; however, it was suggested that in the development of the IDDI the enlargement of the policy arena increased opportunities to influence policy formulation.

While the law enforcement and non-government sectors were seen as major proponents in the development of the IDDI, two other sectors were also noted: health and the drug law reform movement. There was conflict as to whether the health sector advocated for drug diversion. A number of policy makers contended that the IDDI was an imposition upon health professionals:
Health was the reluctant partner in embracing diversion. There was the principle that we should look after those who need help and those who ask for help. We were not adequately responding to the burden of demand, there were more people wanting treatment than there were treatment places available.


The advocacy for the IDDI occurred in a context of a drug law reform movement and increased push for harm reduction responses, particularly heroin trials and decriminalisation:

There were some other competing approaches at the time. In the mid 1990s there was a very major lobby towards decriminalisation and indeed legalisation of drug use. Some people thought that to break the drug-crime nexus the best approach was to decriminalise or legalise. At a stroke a lot of the drug crimes would be no longer, they would be redefined as nothing.


There is a strong influence in our society from illicit drug user groups who under the name of harm reduction are promoting drug law reform and believe that drug use should be accepted as a normal part of our society and should be at least decriminalised.

Brian Watters – Former health of the ANCD – [2]

While the drug law reform movement did not advocate for drug diversion, their actions were argued to have increased the likelihood of a political response to the drugs issue. Thus, it appeared the mutual advocacy by the law enforcement and non-government sectors was important in pushing drug diversion onto the agenda, and that the drug law reform movement provided the political context for a new reform.

**Political factors**

Policy makers asserted that the primary reason for the development of the IDDI was the presence of a political window of opportunity, specifically from the Prime Minister’s Office:

It was a personal initiative of the Prime Minister.

Brian Watters – Former ANCD Chair – [5]

But that’s the evolution of it….. It was very much from Prime Minister’s Department.


There was conflict as to why the IDDI emerged and what drove the opening of the political window. In particular, there was conflict as to whether the Prime Minister and the Prime Minister’s Office intended to propose drug diversion, something contended by John Perrin:

The idea of the Diversion Initiative has been in my mind ever since we started the Tough on Drugs back in 1997 although it didn’t get off the ground until 1999.

John Perrin – Prime Minister’s Office – [4]
This was one plausible explanation since discussions held by ADCA with the Prime Minister’s Office suggested drug diversion was an option for the Prime Minister.

A more nuanced view suggested, however, that drug diversion emerged as a political compromise. A number of members from the ANCD were involved in discussions conducted by the Prime Minister’s Office preceding the April 1999 COAG meeting. The meeting involved senior bureaucrats from health, law enforcement and education and was convened by Max Moore-Wilton, the then head of the Prime Minister’s Office. ANCD members revealed that the initial proposal of the Prime Minister’s Office was to increase law enforcement, and introduce a zero tolerance approach towards drug users:

I think there were some very senior political figures, who had a mind to do something about it nationally, wanted to fund a response to that concern and who among other things gave consideration to increasing the capacity of the states and territories around law enforcement and incarceration including the potential to just increase bin space, you know increase jail.

DC – ANCD – [8]

I sat on some high level committees where it was amazing the primitive, political conservative ideas that were constantly being put forward and had to be prevented from dominating; unrealistic, stupid ideas. I will never forget that I was part of a high level committee chaired by Max Moore-Wilton and in the public service. All the heads of department acquiesced to the Prime Minister’s department but I happened to be involved as an independent person with [ANCD members].

Ian Webster – Health Professional/ANCD – [9]

This suggests that the initial preference of the Prime Minister’s Office was to shift from a rhetoric to a practice of “Tough on Drugs.” ANCD members noted that they played a key role in questioning and countering such proposals and encouraging the consideration of and debate around alternative options:

We changed the dynamics of those meetings, so that people would realise that a, they had people there who knew what was going on and b, it enabled government departments to say, instead of being just quiet, saying this is what we do. The dialogue changed so that public servants were more open about what the problem would be and what should be done.

Ian Webster – Health Professional/ANCD – [9]

Through discussion, negotiation and persuasion other options were considered and led to an agreement involving voluntary diversion to treatment and education, one that formed the basis of the IDDI:

The early knee-jerk reaction was to increase law enforcement as a response to this but then a recognition [developed], or senior politicians were persuaded, that these are young people for whom a law enforcement response alone was inadequate and may actually be dysfunctional.

DC – ANCD – [8]
Many policy makers thus stated that the proposal for drug diversion emerged as an acceptable alternative. This suggested that the IDDI emerged through a political compromise that converted a doctrinal response into a more humane response. In this light, the accumulation of crises, evidence and policy advocacy facilitated the political likelihood of a response and the conversion of an initially doctrinal proposal into a more evidence-based response. The following examines why and how.

First, it appeared that increasing advocacy upon the federal government drove the perceived need for a political response. This followed the expanding drug law reform movement and calls by state and territory Premiers for Prime Minister John Howard to reverse his decision on the heroin trial (Johnston 1999). Indeed one of the issues of the COAG meeting was to have been the heroin trial, specifically the proposal from Victorian Premier Jeff Kennett. Media debates from March 1999 show increasing pressure on John Howard to seize the initiative (Charlton 1999). Moreover, analysis of talk back by Alan Jones and callers to radio station 2UE suggested a shift in public opinion towards heroin trials. This led to the conclusion that "the callers are not necessarily embracing the heroin trials but they are strongly against the Government strategy of doing nothing" (Javes 1999). Throughout the increasing pressure, the Federal Coalition remained clearly opposed to heroin trials, due in particular to the perceived signal it would send to the community:

> Clearly that was antithesis to the Federal Government. The last thing they wanted to do was be perceived to be liberal, not just to be perceived, but to be liberal.

Thus, the states, territory and federal governments were at a bit of a standstill over the issue, something that was clearly summed up by Walker one month prior to COAG:

> Grappling with heroin, as a policy issue, is something akin to herding cats. There are a host of conflicting legal, health, social, behavioural and moral concerns. The pyrotechnics between John Howard and Victoria's Jeff Kennett over zero tolerance policing and controlled heroin trials reflects a wider uncertainty as to how to proceed…… While the PM was continuing to insist yesterday that he was open to ideas - this, after all, is his rationale for putting heroin on the agenda of April's Premier's Conference - he has firmly slammed the door on the controlled trial. Staking out his position, Howard said on Wednesday: "Yes, I am looking for constructive alternatives but the views that I have on a heroin trial have not changed." (Walker 1999, p. 19)

The push by drug law reformers and Premiers throughout 1998-99 to introduce safe injecting facilities, heroin trials and cannabis decriminalisation created a political imperative for the Federal Government to respond to the drug problem.
In this context drug diversion appeared to be a more acceptable option and means of turning around the drug law reform push:

I think there was a cry for new approaches and a re-evaluation, “how can we do it better and how can we turn this thing around without giving in to a call for what was really a decriminalisation?”

Brian Watters – Former ANCD head – [12]

I think the Prime Minster might have realised he would be better off taking that away from the drug law reforms and then arguing nonsensically that this was “Tough on Drugs.”

Alex Wodak – Health professional/Drug law reformer – [6]

The pressure thus enhanced the receptivity to the drug diversion proposal.

Second, advocacy by David Crosbie appeared critical to understanding how and why drug diversion became a more politically acceptable option. A potential impediment to the initiative was community concern, particularly over how the community would receive the initiative:

There were some people who were a bit worried by the Diversion Initiative because if people break the law, which they do by being charged with possession or using illicit drugs then they should go to gaol or face the consequences of their actions.

John Perrin – Prime Minister’s Office – [5-6]

As noted by many policy makers, community perception was perceived to be Tough on Drugs, and indeed the original terminology for the Prime Minister’s Strategy evolved from community sentiment. Since that time being “Tough on Drugs” has been a political imperative:

There were twenty names were put up and “Tough on Drugs” wasn’t one of them but they researched what the community wanted that and the community wanted government to be tough on drugs and that was a consistent theme in their focus groups.

David Crosbie – Non-Government Treatment Professional – [7-8]

I think this whole “Tough on Drugs” approach has been guided by what might work politically and what works in focus groups rather than what the drug and alcohol experts tell us and what do the libraries tell us, so what has happened is we have forgotten the evidence and we have gone back to things where it is the rule of the lynch mob.

Alex Wodak – Health Professional/Drug Law Reformer – [6-7]

Indeed figures demonstrated mixed support for diversion prior to the introduction of the IDDI. In 1998, 37% of Australians surveyed aged 14 and older supported the use of a fine, 35.9% supported compulsory drug education and 12.3% supported the use of a caution or warning (Australian Institute of Health and Welfare 1999). Spooner et al. (2000) concurred that a major impediment to the expansion of drug diversion programs was the perception that they were a soft option.
David Crosbie contended his advocacy was critical to capitalise upon the community concern and pressure for a response, and demonstrate that the pre-developed pragmatic proposal of drug diversion could address community concerns:

When I talked with them drugs were in the top five priorities for people in the community so they needed to be seen to be doing something about drugs. Crime was also up there and we were basically saying you knock, you could be seen to be showing real leadership on both drugs and crime and at the same time reducing expenditure on prisons and enforcement…. It wasn’t so much about showing leadership, it was really about here is a solution that will go some of the way to addressing community expectations and supporting all those people trying to do things and the bottom line is studies have shown it is a good way of spending money.

David Crosbie – Non-Government Treatment Professional – [9]

He noted that the strength of such advocacy was enhanced by his grass-roots experience:

They are quite powerful arguments particularly if they are delivered by people who are not researchers or “talking tooths” or bureaucrats but people who have those experiences or have worked in that kind of environment.

David Crosbie – Non-Government Treatment Professional – [9]

The third and final strand to the political compromise was the evidence from in particular the Victoria Police pilots of the technical and political feasibility of drug diversion:

You have to get political endorsement for them because pollies don’t want to be seen to be going soft because politically it is not always comfortable for them. But if we’ve got something that says it is not actually going soft, it’s a better option for minor offending…

Frank Hansen – Senior law enforcement officer – [8]

As previously noted the Victoria Police pilots demonstrated that diversion was not perceived as being soft. It therefore could be argued that the most important evidence from diversion pilots and trials was to allay fears that diversion would be perceived as soft, and hence anti the political rhetoric of “Tough on Drugs.” The Victoria Police Cannabis Cautioning Pilot appeared to suggest cannabis cautioning could be a strategic means of controlling the push for drug law reform, and therefore that drug diversion could be an answer to the political problem facing the government. In the launch of the initiative, John Howard expressly referred to the Victoria Police model as an exemplar of how the IDDI would operate. As he noted “there are many elements of that that I think are very good” (Radio 3AW 1999).

The involvement of ANCD members in discussions with the Prime Minister’s Office was critical to increase opportunities to counter-mobilise doctrinal solutions, to increase consideration of evidence and compromise. However, Professor Ian Webster
noted that despite the agreement of voluntary drug diversion the Prime Minister’s Office delivered a proposal to the COAG meeting of compulsory treatment (zero tolerance) for drug users. Such a proposal was challenged by the Victorian Premier Jeff Kennett and NSW Premier Bob Carr:

Then the night before the COAG meeting I was faxed the paper that the Commonwealth Government was presenting and I nearly died. It had reverted back to all these extreme “zero tolerance”. Ideas we had worked out had disappeared and I said to myself “how can I face anybody after this?” since I was at least partly involved. The document produced at the end of the next day was totally different from the document I saw then. The words “zero tolerance” were in brackets after school education. It was Victoria and New South Wales, Kennett and Carr with their advisers and ministers said “we won’t go along with that” and the whole thing was re-written. The Prime Minister’s office was probably writing that sort of stuff, little people, who fear the world.

Ian Webster – Health Professional/ANCD member – [9]

The COAG-IDDI agreement thus emerged on 9 April 1999 involving drug diversion to voluntary treatment. It represented a political compromise developed through a combination of increasing pressure for a Government response, advocacy of a pre-developed and technically feasible proposal and consensus-making.

Between April and November 1999, the framework or model for the Illicit Drug Diversion Initiative was devised. The process of consultation was very broad involving not only the governance structure (MCDS, IGCD and ANCD) but also multiple levels of government and health, law enforcement and education sectors. This inevitably posed a challenge because of competing interests, however there was less conflict than might have been expected since the money was guaranteed:

When all of the high level people on those committees got together with a task and sat down in a workshop format it really helped forge links because there was a task to do, everyone was committed to doing it and it was quite successful and of course there was a wonderful carrot, there was money.

Paul Ditchburn – Victoria Police – [1]

The IDDI framework evolved through consultation and compromise, and hence through consensus-making. This was seen as a good process since it meant multiple people had input into the development. Through the process, a number of changes were made shifting from a police-only model of diversion to include court diversion, and adapting the model to suit state and territory requirements. The resulting reform ended up receiving considerable support from even those who were against the reform:

Now in the process of the discussion on that, it actually evolved into a much more reasonable outcome than we originally envisaged.

I am not a big rap for the diversion initiative, but because I know what it might have been
I think it is a good thing we’ve got it.

DC – ANCD – [10]

A number of policy makers suggested that despite the shifts, from a doctrinal to a
more humane approach, drug diversion in fact “struck a chord” with the Prime
Minister’s department. The more humane model thus became a highly significant
initiative. The IDDI received considerable levels of political and financial support
involving $110 million in November 1999 and also involved the introduction of a
tied-grant system that was counter to the trends at the time:

I think you can never underestimate the importance of the shift in practice that diversion
represents. …..Significant money in an area that was against the public rhetoric in a way
that was actually being more considerate of drug users and drug users who commit
crime, a tied-grant process at a time when tied grants weren’t happening and the
involvement of people outside bureaucracy developing the processes and structures,
really innovative and really unheard of.

David Crosbie - Non-Government Treatment Professional – [10-11]

Certainly Government has been very supportive of it $115.53 million in 1999, $215
million in 2002 so without that support at a local and federal level you don’t get the
funding to do something this big.

K - Victoria Police– [12]

It appeared the biggest reason for the change in commitment was that drug diversion
was within the operating platform. Principally it could “fit” within the Tough on
Drugs rhetoric and hence send the message to the community that the Federal
Coalition was not “soft” on drugs:

Diversion was within the operating platform where you could still be seen to be tough,
having laws in place but doing the nice thing, trying to divert people to treatment as a
better option.

Ian Webster – Health professional/ANCD member – [5]

Further, it could conceivably fit the so called “social coalition” principles of the
Federal Coalition. These included the provision of early intervention, emphasis upon
individual responsibility and increasing involvement of the non-government sector
(Liberal Party of Australia & National Party of Australia 1999; Liberal Party of
Australia & National Party of Australia 2001). The IDDI therefore enabled a means of
responding to the push for drug law reform, while fitting within the Tough on Drugs
and “social coalition” principles. The IDDI thus fit the political imperatives, namely
to meet community expectations and the mandate on which the politicians were
elected. The IDDI therefore evolved as a political compromise.
Summary
In summary, policymakers asserted that the IDDI developed through an accumulation of advocacy, pressure for a response, research and a political window of opportunity. ADCA played a vital role in softening up the Government and bureaucracy to the idea of drug diversion and in continual lobbying for its introduction. It remains unresolved as to the roles of David Crosbie and the ANCD in converting the zero tolerance proposal into drug diversion. From one perspective, the IDDI evolved through entrepreneurial means and hinged upon David Crosbie’s relationship with John Perrin. From another perspective, concerted advocacy by ANCD members was necessary to facilitate a broader mobilisation of bureaucratic support and hence adoption of the IDDI. While unresolved it appeared that without input from both non-government sectors into the Prime Minister’s Office the IDDI was unlikely to have evolved. Ultimately, the drug law reform movement provided the impetus for the Federal government to respond and the law enforcement sector facilitated venue shifting of drug diversion pilots from Victoria to the national level. Critically research in this development demonstrated not only “what works”, but that drug diversion had technical and political feasibility.

While the introduction of Tough on Drugs and appointment of Major Brian Watters, a staunch abstinence supporter, as the head of ANCD led to concerns of more politically and ideologically driven drug policy, this had in the main a rhetorical impact upon the development of the IDDI. The initial proposal could have led to a very doctrinal response, but this did not eventuate due to many of the features that drove incremental reform. Policymakers asserted that despite the apparent threats and the contradictions, ideological decision-making was discouraged by the research, emphasis upon consensus-making and common sense:

> There is no significant threat in Australia to closing down needle-syringe availability, as in the United States. So I think the government, all governments, have shown good sense to say “Much though we want to shift the goal posts in favour of a non-use approach, we recognise that these pragmatic harm reduction approaches are important and we will continue to support them. We might not advocate too strongly but we will continue to support them, we won’t destroy them.”
> John Saunders – Health professional/ANCD – [5]

Arguably, the most important constraint upon reform was community perception, but through demonstrating political feasibility of drug diversion, the doctrinal proposal evolved into a more humane approach.
Framing of the Illicit Drug Diversion Initiative

According to policy makers, the key principles of the IDDI were early intervention, use of the criminal justice system as a gateway to drug education and treatment services and emphasis upon education and treatment rather than punishment. The IDDI offered diversion across the spectrum of the criminal justice system from police cautioning to drug courts (Health Outcomes International Pty Ltd in association with Catherine Spooner Consulting & National Drug and Alcohol Research Centre and Turning Point Alcohol and Drug Centre 2002b; Spooner, Hall & Mattick 2001). The emphasis however has been upon intervening as early as possible, preferably through pre-arrest approaches. Despite an initial emphasis upon compulsory drug education or treatment, this was not been incorporated into the Illicit Drug Diversion Initiative Framework and thus varying levels of intervention have been provided. The following section contrasts the official objectives of the IDDI with those highlighted by policy makers.

The official objectives of the Illicit Drug Diversion Initiative were to provide incentives for drug users to address illicit drug use, decrease the social impacts of illicit drug use and “to prevent a new generation of drug users committing drug-related crime” (Commonwealth Department of Health and Ageing 2004a, p. 1). These objectives stressed the potential to reduce drug use, crime and social impacts. The policy makers showed slightly different emphases.

Objectives of the Illicit Drug Diversion Initiative
The first objective of the IDDI was early intervention and maximising the potential to educate drug users and provide treatment options:

The important thing was it gave the people involved an opportunity to intervene usually fairly early. Diversion is geared towards people who are very early in their career and have no serious offences.
Brian Watters – Former head of ANCD – 9

The evidence base is there that young people will try drugs, it is part of growing up, risk taking behaviour that young people engage in and we’ve been also to intercept them at the risk taking level and divert them into another and say “hey this is where you might end up if you go down this track, these are the dangers.”

The second objective was breaking the drugs-crime nexus. From this perspective, diversion of drug users to education and treatment could reduce drug use and crime resulting in a more effective response than a traditional criminal justice penalty:
I think there was an interest in helping people access treatment at an earlier stage and what was described as breaking the “nexus” between drug use and crime.


The idea of diverting people from going to gaol – a clear pathway to getting on a lifetime of illicit drugs is going to goal – and to divert people from that sort of pathway in the criminal justice system into drug treatment which was a) a lot cheaper than going to goal, goal is an expensive deal for a couple of months in goal, public money and b) a lot more effective in getting them off drugs.

John Perrin – Prime Minister’s Office – [5]

Policy makers highlighted a third objective, one that was not emphasised by the official framing. This was to provide a more pragmatic response, increase the efficiency of the criminal justice system, reduce costs and perhaps most importantly provide a more appropriate response to drug users:

I see it as a typically Australian pragmatic approach combined with a desire to cut costs and a desire to channel people into a rather more appropriate environment than being incarcerated in a prison.


A minority of individuals including Major Brian Watters contended that incarcerating drug users was barbaric and thus that the IDDI provided a more humane response:

Probably the most significant was the diversion program. To me that was so significant. It didn’t remove the legal strictures and the place that law enforcement has, but it allows for a humane response.

Brian Watters – Former ANCD Head – [5]

However, very few policy makers saw the purpose of the IDDI as being explicitly humane. This appeared to be due to its development through and promotion under “Tough on Drugs.” The tough message was encouraged primarily through the emphasis upon the (arguably false) dichotomy of traffickers versus drugs users. Some policy makers asserted rehabilitation was and is tough, particularly through an emphasis upon abstinence:

Our view in the case of smaller time users, the message there is that it is still a tough message, it is not as if they let off scot free or anything, it is a tough message that if they accept the option of rehabilitation and they have to go ahead with that and rehabilitation can be very tough, going to residential rehabilitation and living there or other forms of rehabilitation, if they accept that as an alternative to the criminal justice system that is an option they can be provided with.

John Perrin – Prime Minister’s Office – [6]

Generally it was accepted that this was going to reduce crime and reduce drug use so they were the key messages, the third message was this won’t be for the rapist, the drug importer, the people who we really want to get to. So they created a kind of dichotomy about being tough but trying to support the people who’ve actually been the victim of these horrible drug dealers.

The toughness of the approach was central to the IDDI message, particularly the promotion by Prime Minister John Howard. As the Tough on Drugs Diversion Programme Fact Sheet stated:

"The central diversion initiative and the supporting measure sends a clear message from the government, on behalf of our communities, of the unacceptability of drug use and the damage this causes to individuals, families and communities (Office of the Prime Minister 1999)."

Further, the principles of personal responsibility were clearly emphasised in references to the reform:

"We are saying to people who use drugs, that, in return for the community providing treatment, rehabilitation and education services, you must take personal responsibility for your addiction and participate in these services with the aim of getting yourself off drugs (Howard 1999)."

The IDDI thus reflected a balance, and compromise between liberal and democratic values. While it enhanced the liberal individual rights of drug users, it emphasised the democratic values, of individual responsibility to the community and reducing drug use and crime. Overall, the resulting initiative can be seen as contradictory, due to the inherent conflict between the political rhetoric and the diversion principles:

"They are unashamed about the fact they have thrown a large sum of money, $200 million, at diverting people from the criminal justice system to the drug treatment system even though that flies in the face of being “Tough on Drugs” so the whole approach is riddled with contradictions."

Alex Wodak – Health Professional/Drug Law Reformer – [3]

However, for most policy makers the rhetoric was less important than the IDDI itself.

**Conclusion**

In conclusion, this chapter has shown that the development of Australian drug policy was influenced by a number of core factors. In particular, it has shown that in the development of the 1998-99 – 2002-03 National Drug Strategic Framework incremental reform was reinforced through decision-making through the governance structure. The restricted input, belief and support for harm minimisation and the emphasis upon pragmatic and consensus decision-making facilitated the maintenance of harm minimisation and incremental adjustments.

The development of the IDDI, in contrast, was facilitated through increased opportunities for policy input, crisis and community concern and most importantly advocacy. Advocacy by multiple policy actors from outside the bureaucracy, and in particular the advocacy for drug law reform, were crucial in provoking the political
opportunity for reform. While the policy window was created through political circumstances and in a more ideological and conservative environment a doctrinal reform did not result. In spite of the initial zero tolerance proposal by the federal government, not only was this prevented, but a new proposal – the IDDI – was adopted instead. Two key reasons for such a transformation were the increased involvement of policy actors in policy formulation and the entrepreneurial advocacy by ADCA. The IDDI represents therefore a political compromise, one that has strong political influences upon the framing of the initiative, most evidently through the emphasis upon Tough on Drugs, not on harm reduction, but that is not a zero tolerance of true “Tough on Drugs” reform. Thus the development of the IDDI, despite the presentation as “Tough on Drugs,” can be deemed a double success, for converting a doctrinal proposal, and obtaining a potentially more humane pragmatic reform.
<table>
<thead>
<tr>
<th>Date</th>
<th>Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>ADCA Diversion study funded</td>
</tr>
<tr>
<td>1996 (Mar)</td>
<td>PDAC Report – Victoria – recommended and cannabis decriminalisation and diversion</td>
</tr>
<tr>
<td>1996 (Jun)</td>
<td>Cannabis decriminalisation failed to win support – liberal backbenchers opposed</td>
</tr>
<tr>
<td>1996 (Jun)</td>
<td>Turning the Tide – Victorian Drug Strategy released</td>
</tr>
<tr>
<td>1996 (Oct)</td>
<td>ADCA Diversion workshop</td>
</tr>
<tr>
<td>1997</td>
<td>Diversion onto Ministerial Council of Drug Strategy agenda</td>
</tr>
<tr>
<td>1997 (Jun)</td>
<td>National campaign “treatment works” held by ADCA</td>
</tr>
<tr>
<td>1997 (Jul)</td>
<td>Health minister met to discuss ACT heroin trial – supported trial</td>
</tr>
<tr>
<td>1997-1998</td>
<td>Cannabis Cautioning Program trial – Victoria Police</td>
</tr>
<tr>
<td>1997 (Aug)</td>
<td>ACT Heroin trial supported by all state and territory premiers</td>
</tr>
<tr>
<td>1997 (Aug)</td>
<td>Prime Minister John Howard blocked ACT heroin trial</td>
</tr>
<tr>
<td>1997 (Nov)</td>
<td>Prime Minister’s “Tough on Drugs” strategy commenced</td>
</tr>
<tr>
<td>1998 (Jan)</td>
<td>1996-97 National Illicit Drug Report noted need for alternative responses to drug users</td>
</tr>
<tr>
<td>1998 (Mar)</td>
<td>Launch of Australian National Council on Drugs – Chaired by Major Brian Watters</td>
</tr>
<tr>
<td>1998 (Jul)</td>
<td>Victorian Premier announced Cannabis Cautioning Trial and Drug Diversion Pilot</td>
</tr>
<tr>
<td>1998 (Sep)</td>
<td>Cannabis Cautioning Program state-wide – Victoria Police</td>
</tr>
<tr>
<td>1998 –1999</td>
<td>Court Referral &amp; Evaluation for Drug Intervention and Treatment (CREDIT) Trial - Vic</td>
</tr>
<tr>
<td>1998 (Nov)</td>
<td>“Tough on Drugs” extended</td>
</tr>
<tr>
<td>1999 (Feb)</td>
<td>Prime Minister John Howard announced zero tolerance on drugs</td>
</tr>
<tr>
<td>1999 (Feb)</td>
<td>NSW Drug Court trial commenced</td>
</tr>
<tr>
<td>1999 (Jan)</td>
<td>Victorian Premier Jeff Kennett announced support for heroin trial</td>
</tr>
<tr>
<td>1999 (Mar)</td>
<td>Victorian Premier Jeff Kennett held a premiers meeting involving the NSW, SA and WA Premiers and ACT health minister on heroin trial</td>
</tr>
<tr>
<td>1999 (Apr)</td>
<td>Council of Australian Government agreed to set up nationally consistent approach to diversion</td>
</tr>
<tr>
<td>1999 (May)</td>
<td>Tolerance or T Room injecting room opened by a group of clergy, social workers and health professionals in the Wayside Chapel in Kings Cross.</td>
</tr>
<tr>
<td>1999 (May)</td>
<td>NSW Drug Summit</td>
</tr>
<tr>
<td>1999 (Jul)</td>
<td>PM John Howard met with US director of National Drug Control Policy, Barry McCaffrey in USA – invited him to Australia in November 1999</td>
</tr>
<tr>
<td>1999 (Jul)</td>
<td>NSW Premier Bob Carr announced NSW would get an injecting room</td>
</tr>
<tr>
<td>1999 (Nov)</td>
<td>Final NIDS framework was devised and signed off by COAG</td>
</tr>
<tr>
<td>1999 (Nov)</td>
<td>Prime Minister John Howard allocated $110 million to first stage of Illicit Drug Diversion Initiative</td>
</tr>
</tbody>
</table>
CHAPTER SIX: IMPLEMENTATION AND OUTCOMES FROM ATYPICAL REFORMS

Chapters Four and Five outlined how and why decriminalisation and the Illicit Drug Diversion Initiative were adopted. The chapters highlighted considerable differences in the instigators and process of reform. While the development of decriminalisation was a problem-led, evidence-based approach, the IDDI developed through an evidence-based political compromise. To examine how these differences may have influenced the implementation of the reforms the present chapter examines, through four sections, the implementation and outcomes from the atypical reforms:

1. Developments post-atypical reform
2. National trends in drug use and crime: Pre- and post- reform
3. National outcomes: Evaluations and impressions
4. Constraints upon implementation

The first section provides an overview of key developments that occurred between the adoption of the atypical reforms and July 2006. Key changes, including the election of a new government, may have impacted on the outcomes or the ability to assess the reform outcomes. The second section outlines the national trends in criminal justice and health outcomes gathered before and after the reforms. The third section highlights strengths and weaknesses in each reform, using the publicly available outcomes from the national evaluations, and the expert impressions of policy makers. The final section examines the major constraints, to date, upon implementation namely the role of politics and research.

This chapter is not intended to provide a comprehensive outcome evaluation or to identify whether these reforms were “successful” or not. Such a judgement is inherently difficult to make, particularly as this chapter shows there were gaps in the publicly available knowledge. Instead, it serves to identify similarities and differences in the implementation and outcomes, and suggest how these may relate to the process of policy development.
Developments post-atypical reform

Portugal

As Chapter Four showed the Portuguese national drug strategy and decriminalisation were introduced during the reign of the Socialist Party. During this period 18 Commissions for the Dissuasion of Drug Addiction (CDTs) were established in mainland Portugal, three in Madeira and one in Acores (Instituto Português da Droga e da Toxicodependência 2002). Subsequently decriminalisation commenced on 1 July 2001.

However, the period following the legislative enactment was a tumultuous political period. The Social Democratic Party was elected in April 2002 and led until November 2004 when it was dissolved. Subsequently the Socialist Party was elected under Prime Minister José Sócrates (Comissão Nacional de Eleições 2005), the former National Strategy Coordinator. Over the same period the leader of the IDT, and hence National Coordinator, shifted between Fernando Negrão (2002-2004), Nuno Freitas (2004-2005) and João Goulão (2005-current).

The political changes arguably impacted on the outcomes of decriminalisation for a number of reasons, most important of which was the variable support for decriminalisation. The election of the Social Democratic Party (PSD) in 2002 was accompanied by threats to re-criminalise consumption, acquisition and possession for personal use (Felner & Gomes 2002). While the PSD opted to retain decriminalisation, many policy makers questioned their level of support. Further, the PSD shifted the responsibility for drug strategy coordination from the Prime Minister’s Office to the Ministry of Health where it has since remained and merged the two primary bodies in charge of treatment (SPTT) and prevention (IPDT), creating the Institute for Drugs and Drug Addiction (IDT) (Decreto-Lei n.º 1/2003 de 6 de Janeiro 2003).

The new legislative framework was the subject of two evaluations. The first was an independent evaluation of the outcomes from the CDTs. While established and

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25 In November 2001 Socialist Prime Minister António Guterres resigned after heavy losses at municipal elections. This resulted in the election of the Social Democratic Party (PSD) led by Prime Minister Durão Barroso in April 2002. However, in July 2004 Durão Barroso stepped down to become President of the European Union, and in November 2004 Portuguese President Jorge Sampaio dissolved the PSD Government (led by the substitute Prime Minister Santana Lopes) due to a lack of public confidence.
conducted under Professor Cândido Agra and the University of Porto it was never released. The second was a three part evaluation consisting of an external evaluation conducted by the National Institute of Administration (INA), an internal evaluation conducted by the IDT and public surveys and submissions (Instituto da Droga e da Toxicodependência 2004a). In May 2005 a new drug strategy was adopted, called the National Plan Against Drugs and Drug Addiction 2005-2012 (Instituto da Droga e da Toxicodependência 2005b) of which decriminalisation was an integral part.

**Australia**

A heroin shortage was arguably the major change that impacted on the implementation and outcomes from the IDDI. Between 2000 and 2001, Australia experienced a sustained reduction in heroin supply which bottomed out between January and April 2001. The cause of the heroin shortage has been subject to heated discussion and has been attributed by various sources to law enforcement activities by the Australian Federal Police and Customs under “Tough on Drugs,” a reduction in demand, and reduced heroin production in Burma (Bush 2004; Degenhardt, Day & Hall 2004; Degenhardt, Reuter, Collins & Hall 2005; Howard 2004).

There was limited change in the political situation in Australia between 1999 and 2006. Prime Minister John Howard and the Federal Coalition Government were re-elected for their fourth term in 2004. Following the departure of Victorian Premier Jeff Kennett and ACT Chief Minister Kate Carnell in 1999 and 2000 respectively, there were Labor Premiers in all states and territories. Both the National Illicit Drug Strategy “Tough on Drugs” and the new National Drug Strategy 2004-2009 (Ministerial Council on Drug Strategy 2004) were renewed.

Despite the signing of the COAG-IDDI agreement in April 1999, considerable time elapsed before agreements were signed with states and territories and programs commenced. As shown in Table 4 the earliest programs commenced in Tasmania in 2000, and most states and territories began in 2000-2001. The Northern Territory was the notable exception as their component of the IDDI did not commence until 2002 (personal communication with Officer in Charge, NT Police, Mitchell 2005). The roll-out of the IDDI was therefore protracted.
Table 4: Roll-out of the COAG-IDDI Program, showing the date of agreement and commencement by state and territory

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Date Agreement Signed</th>
<th>Date Program Commenced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tasmania</td>
<td>February 2000</td>
<td>February 2000</td>
</tr>
<tr>
<td>NSW</td>
<td>April 2000</td>
<td>April 2000</td>
</tr>
<tr>
<td>Victoria</td>
<td>August 2000</td>
<td>November 2000</td>
</tr>
<tr>
<td>West Aust</td>
<td>October 2000</td>
<td>November 2000</td>
</tr>
<tr>
<td>Queensland</td>
<td>March 2001</td>
<td>June 2001</td>
</tr>
<tr>
<td>ACT</td>
<td>May 2001</td>
<td>October 2001</td>
</tr>
<tr>
<td>South Aust</td>
<td>June 2001</td>
<td>September 2001</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>January 2002</td>
<td>December 2002</td>
</tr>
</tbody>
</table>

Source: Health Outcomes International, 2002 and personal communication with NT

There was substantial variability in the number of programs that were implemented, ranging from two in Queensland to eight in Victoria and Western Australia. There was further variability in the type of programs adopted, characterised by Spooner, Hall and Mattick (2001) as pre-arrest to post-sentence programs. Pre-arrest programs however dominate. Most states and territories opted for progressive implementation; they commenced with police cannabis cautioning and then rolled out additional court based or targeted programs. Victoria, for example, started with three programs, Cannabis Cautioning, Illicit Drug Diversion and Court Referral & Evaluation for Drug Intervention & Treatment (CREDIT) in 2000, and then added an additional five programs between 2001 and 2004, including rural outreach and a Koori alcohol and drug diversion program (Australian Community Support Organisation 2003).

The IDDI has been subject to two evaluations. The first was an independent evaluation by Health Outcomes International (HOI) in 2002. The HOI (2002b) evaluation aimed to assess the effectiveness of targeting early intervention, arresting/preventing illicit drug use, and assisting drug users to receive treatment. In practice many of these objectives could not be assessed, which meant that study served as a process evaluation. Nevertheless, an additional $215 million was provided for the IDDI in 2003 (Howard 2002). Consequently, the IDDI has been funded until at least June 2007. The second evaluation commenced with a private workshop involving 80 stakeholders in November 2005, the results of which were not released.
An evaluation subsequently commenced in July 2006, which is due to finish in March 2007.

National trends in drug use and crime: Pre- and post-reform

Both the IDDI and decriminalisation aimed to reduce drug use and crime. National trends provide one means of assessing whether this occurred. While it must be acknowledged that many factors including changes in demand and supply reduction could affect such trends, these provide a superficial means of examining whether the reforms might be contributing towards the desired objectives. The following section examines trends in drug use and crime prior to and following the atypical reforms, from 1996 to 2004 in Portugal and 1996-1997 to 2004-2005 in Australia. The following data should be interpreted with caution, and in conjunction with the perspectives of policy makers on the implementation and outcomes to date.

Portugal

In the late 1990s there was a marked reduction in the prevalence of drug-related harms in Portugal. Reductions in drug-related harms largely followed the introduction of the national strategy, ENLCD, in 1999, rather than introduction of decriminalisation per se. Nevertheless, decriminalisation appeared to be accompanied by a number of positive trends. There was a considerable reduction in drug-related AIDS, from 625 to 200 cases in 1999 and 2004 respectively (see Figure 7). Of equal importance was a significant reduction in the proportion of drug-related AIDS cases from 58% to 39%. The number of drug-related deaths also decreased significantly between 1999 and 2002. Deaths remained stable following that point. Reductions in drug-related harms were claimed to be the major achievement of the national strategy (Instituto da Droga e da Toxicodependência 2004a). Such trends suggested that heroin use and/or heroin-related harms declined, and were consistent with the hypothesis that decriminalisation ought to facilitate access to harm reduction and treatment measures.
Figure 7: Number of cases of AIDS and drug-related deaths in Portugal, 1996-2004

Source: IDT 2002 and 2005

Trends in the prevalence of illicit drug use were however more mixed, and indeed difficult to interpret. Portugal only commenced national surveys into the prevalence of illicit drug use in 2001. As noted in Chapter Two the national survey of 14,184 individuals indicated a lifetime prevalence of illicit drug use of 7.8% amongst 15-64 year olds, of which 7.6% was for cannabis use (Balsa et al. 2004). Prevalence was greatest amongst 15-34 year olds: 12.4-12.9%. National school surveys, as part of the European School Survey Project on Alcohol and Other Drugs (ESPAD), indicated that lifetime prevalence of illicit drug use doubled between 1995 and 2003 (see Figure 8). The surveys of students aged 16-18 suggested increases in most illicit drugs, particularly in the lifetime prevalence of hash consumption (7% to 15%) (2000; 2004; 1997). Such increases were however negligible for use over the last 30 days (5% to 8%). Moreover, these trends were offset by reductions in the lifetime prevalence of heroin and amphetamines, between 1999 and 2004.
Figure 8: Lifetime prevalence of illicit drug use amongst Portuguese school students aged 16-18 by drug, 1995, 1999 and 2003

The interpretation of such trends deserves caution due to a number of reasons. Firstly, in the absence of population wide surveys, it was unclear whether trends in prevalence, particularly increased cannabis use, were mirrored outside the school population. Secondly, while a pessimistic interpretation may contend that the introduction of decriminalisation and the national strategy contributed towards increased cannabis use, European trends suggest other factors may also have been at play. During the period of study cannabis use increased in the majority of European nations. Specifically, the EMCDDA (2005a) noted three distinct trends in cannabis through the 1990s and 2000s: in a minority of nations such as Sweden and Greece cannabis use remained low (less than 10%); in a minority of nations including Ireland and the United Kingdom cannabis use remained stable, but at high prevalence (35%); finally, in the majority of nations including Portugal, France, Spain and Italy there were substantial increases (up to 26%) in cannabis use. Given the common trend in neighbouring Spain and Italy, this suggested that the slight increase in cannabis use in Portugal might have been part of a European trend. In contrast, reductions in heroin use and heroin-related harms were much more marked in Portugal than other nations.

Trends in drug offences were positive following the introduction of decriminalisation. It should be noted that Law 30/2000 was not enacted until 1 July 2001. Accordingly, consumer offences, while reduced, were still considerable in 2001. The proportion of all drug offenders arrested for drug trafficking increased significantly from 23% to 44% between 1999 and 2004 (see Figure 9). It was suggested that decriminalisation might have enabled the law enforcement sector to focus on drug traffickers.

Significant changes in the type of drug trafficked were noted between 1999 and 2004, including a decrease in the proportion of arrests for heroin trafficking from 39% to 10%, which was offset by an increase in the proportion of arrests for marijuana trafficking from 26% to 42%. The IDT (2005a) attributed this trend to changes in demand and/or law enforcement efforts.

**Figure 9: Number of individuals accused by type of drug offence in Portugal, 1996-2004**

![Graph showing number of individuals accused by type of drug offence](image)


* Following the enactment of Law 30/2000 on 1 July 2001 drug consumption, possession and acquisition constitute contra-ordenações

The number of individuals convicted for drug trafficking was on average greater following the introduction of decriminalisation. However, the total number of individuals convicted for drug offences by the courts declined, particularly for trafficker-consumers (see Figure 10). It appeared that the overall reduction in convictions was due to changes in court practices, rather than decriminalisation per...
There was a considerable reduction in the number of drug cases finalised before the courts after 2002. The average number of cases finalised decreased from 2,919 cases in 1996-2001 to 1,721 cases in 2002-2004 (Instituto da Droga e da Toxicodependência 2005a). The criminal justice system in Portugal and other countries, including Spain and Italy, has tended to endure backlogs due to the inquisitorial approach to processing offenders. Accordingly, Portugal has taken and continues to take many years to process criminal cases, including drug offences (Machado 1999; Pedroso 2002). Further, many cases are dropped prior to court due to insufficient evidence or to downgrading of offences (Personal communication with head of Portuguese drug research centre, Moreira 2006). While the trend in convictions for drug offences in Portugal was not straight-forward, it suggested that convictions for drug trafficking did not decrease, and might even have increased.

Figure 10: Number of individuals convicted for drug offences in Portugal, by type of offence, 1996-2004

* Following the enactment of Law 30/2000 on 1 July 2001 drug consumption, possession and acquisition constitute contra-ordenações, however cultivation for personal use remains a “consumer” offence under Decree-Law 15/93
Australia

The introduction of the IDDI was accompanied by some positive trends regarding illicit drug use. The National Drug Household Surveys reported reductions in the use of all illicit drugs excluding ecstasy (see Figure 11). The National Drug Household Surveys have been conducted every three years since the development of the NCADA; the most recent surveyed almost 30,000 people in 2004 aged 12 and over on drug use and attitudes. Comparisons of the prevalence of illicit drug use in the last 12 months between 1993 and 2004 indicated that use of any illicit drug declined from 22% in 1998 to 15% in 2004; the reduction was particularly for marijuana use (Australian Institute of Health and Welfare 1999, 2005b).

Figure 11: Prevalence of illicit drug use in the last 12 months in Australia by persons aged 14 and over between 1993-2004

![Figure 11: Prevalence of illicit drug use in the last 12 months in Australia by persons aged 14 and over between 1993-2004](image)

Source: AIHW 1999, 2002 & 2005

The Illicit Drug Reporting System (IDRS), a national survey of injecting drug users (IDUs) and key experts, reported that heroin consumption dropped over 2001-2002, but stabilised since that point with 24% of IDUs reporting daily heroin use in 2005, compared to 29% in 2000 (Stafford, Degenhardt, Black, Bruno, Buckingham, Fetherston, Jenkinson, Kinner, Newman & Weekley 2006). The most significant change was a reduction in opioid deaths from 1,116 in 1999 to 357 in 2004.
Australian trends in crime were less marked following the introduction of the IDDI. The main national data on drug offences in Australia was collected by the Australian Crime Commission (ACC), formerly the Australian Bureau of Criminal Intelligence and the National Crime Authority. The ACC collect data on the number of “arrests” for drug offences committed by consumers (consumption and possession) and providers (trafficking, manufacturing and cultivation). Such data measures trends in offence prevalence, not offender behaviour, hence may include numerous counts for repeat offenders. Figure 12 highlights the number of arrests for drug offences between 1996-1997 and 2004-2005. This indicated that the number of consumer arrests dropped from the high of 66,723 offences in 1999-2000, particularly during 2001-2002 and 2002-2003, to around 62,500 offences (Australian Crime Commission 2003, 2004, 2005, 2006). Throughout the period of study consumer offences accounted for around 80% of all arrests. This was associated with a reduction, since 1998-1999, in the average number of arrests for drug trafficking.

**Figure 12: Number of arrests for drug offences in Australia between 1996-1997 and 2004-2005 by type of offender**

<table>
<thead>
<tr>
<th>Year</th>
<th>Consumer</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996/97</td>
<td>25,000</td>
<td>10,000</td>
</tr>
<tr>
<td>1997/98</td>
<td>20,000</td>
<td>10,000</td>
</tr>
<tr>
<td>1998/99</td>
<td>15,000</td>
<td>10,000</td>
</tr>
<tr>
<td>1999/00</td>
<td>12,000</td>
<td>10,000</td>
</tr>
<tr>
<td>2000/01</td>
<td>10,000</td>
<td>10,000</td>
</tr>
<tr>
<td>2001/02</td>
<td>8,000</td>
<td>10,000</td>
</tr>
<tr>
<td>2002/03</td>
<td>6,000</td>
<td>10,000</td>
</tr>
<tr>
<td>2003/04</td>
<td>5,000</td>
<td>10,000</td>
</tr>
<tr>
<td>2004/05</td>
<td>4,000</td>
<td>10,000</td>
</tr>
</tbody>
</table>

**Source:** ABCI 1998-2002. ACC 2003-2006

The meaning of such data needs consideration. The ACC definition of “drug arrests” includes formal and informal diversions, and thus represents the total number of contacts with police. These data suggest that there while there were some changes in
the years following the roll-out of the IDDI programs, the overall level of police contact with drug consumers reduced only slightly. The reduction was most evident immediately following the introduction of the IDDI (2000-2001), but appeared to subside in recent years. It was not possible to tell if there was a reduction in the level of formal charges laid to drug consumers, since national data on drug convictions were not publicly reported.

The primary area of reduced police contact, concerned heroin consumers and traffickers. As Figure 13 shows the number of arrests for heroin consumption/possession declined from 10,607 to 2,051 between 1998-1999 and 2004-2005. However, reductions also occurred in heroin trafficking; thus while the IDDI may have contributed to reductions in heroin consumers, a more plausible cause was the heroin shortage in Australia (Bush 2004). At the same time the number of arrests for cannabis use/possession remained high, occupying about 59% of all consumer offences (Australian Crime Commission 2003, 2004, 2005, 2006).

Figure 13: Number of arrests for heroin offences in Australia between 1996-1997 and 2004-2005 by type of offender


These trends suggested that following the introduction of the IDDI the use and harms from heroin consumption in Australia declined, that the use of other illicit drugs also
declined, but that the overall level of police contact with drug consumers, particularly cannabis consumers, did not decline.

Since factors well outside the national strategies might have affected the trends, the trends alone are merely suggestive of whether or not the atypical reforms have had positive or adverse consequences. Trends to date indicated that neither reform was followed by a significant reduction in drug use or crime. Nevertheless, some positive trends were evident. Public health improvements were evident in both nations, particularly a reduction in illicit drug use in Australia and a reduction in drug-related AIDS in Portugal. Trends in drug offences, particularly in Portugal, suggested that the introduction of the atypical reforms might have reduced the number of minor drug offences without having an adverse impact upon the rate of drug trafficking. That said, more questionable impacts were also evident. Most notably, while it appeared that the introduction of ENLCD and decriminalisation might have contributed towards reductions in heroin and heroin-related harms, the overall prevalence of use, particularly of cannabis use, increased following the Portuguese decriminalisation. While it remained unclear whether the increased cannabis use ought to be attributed to the introduction of decriminalisation, it was clear that the introduction of the IDDI was not associated with an increase in cannabis prevalence. To the contrary, overall use declined. On the other hand, in contrast to the marked reduction in the rate of drug offences following the Portuguese decriminalisation, reductions in offending appeared questionable at best, following the introduction of the IDDI. Thus, while the trends suggested the reforms might contribute towards the hypothesised improvements in health and criminal outcomes, they were inconclusive.

**National outcomes: Evaluations and impressions**

The following section seeks to clarify the relationship between the national trends and the publicly available outcomes to date. It examines the national evaluations and key informant impressions on the merits of the reforms. Outcomes are analysed in terms of the objectives of the reforms: to reduce use, reduce crime, increase efficiency of the criminal justice system and, in Portugal, to change perceptions of drug users. As noted in Chapter Three access to data on the outcomes from the atypical reforms was sub-optimal. There were considerable delays establishing the data set to monitor the IDDI and since that time, the data have been subject to restricted access. In contrast, data
concerning decriminalisation was publicly available and plentiful. Evaluations and workshops on both reforms were however restricted. To compensate for the limitations the following section includes a number of studies that provide insight into the outcomes and impressions from the atypical reforms. This was of particular necessity in examining the outcomes from the IDDI.

**Decriminalisation**

**Evaluation**

The INA evaluation (2004a) concluded that most of the objectives of the action plan were partly or wholly achieved. The evaluators and policy makers showed resounding support for the notion of decriminalisation and asserted that the atypical reform was the major achievement of the national strategy:

> Our approach is one of the most modern in the world…. Our approach is very modern mainly because we decriminalised the consuming of drugs.

Alexandre Rosa – page [4-5]

Surveys of the public also supported the approach. An online survey (n=8,152) found 47% agreed with decriminalisation and 38% opposed (Instituto da Droga e da Toxicodependência 2004d). An independent survey by CESOP (n=1585) found 52% people supported the use of alternative sanctions such as fines not prison.26

The INA evaluators (2004a) and internal evaluators (Freitas 2004) concluded that it was difficult to assess the outcomes of decriminalisation due to two factors. The first factor was the absence of data in all areas. The data collected was deemed insufficient to judge many of the outcomes of decriminalisation. In particular, the INA evaluators (2004a) noted that it was not possible to verify whether individuals complied with treatment, nor was it possible to know the impacts of CDT sanctions. The most obvious impediment to this knowledge was the failure to follow through with the assessment and evaluation of the CDTs following the change in Government.27

Second, despite decriminalisation being a key goal of the national strategy, objectives were specified in neither the national action plan nor Law 30/2000. Nevertheless, as was highlighted in Chapter Four, policy makers overwhelmingly saw the primary

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26 Fines were in practice the dominant sanction imposed by the CDTs as will shortly be examined.

27 There was some conflict as to whether this was deliberate or not. A subsequent evaluation was set up by Fernando Negrão with internal and external experts to assess the CDTs in 2003 but was never released. It was not known whether this impacted upon subsequent implementation.
objective of decriminalisation as changing social views about drug users. Decriminalisation heralded a different response to non-dependent and dependent drug users; viewing the latter as people who were sick not criminal. The following section therefore uses the evaluation and impressions from policy makers to examine the impacts upon paradigmatic change, health and criminal justice outcomes.

**Number of processes**
Approximately 6,000 people were sent to the CDTs every year, mainly for offences relating to hash use or possession. The number of people sent to the CDTs increased between 2001 and 2003 to a peak of 6,100 processes, but reduced to 5,370 in 2004 (Instituto da Droga e da Toxicodependência 2003, 2004b, 2005a; Instituto Português da Droga e da Toxicodependência 2002). As of December 2004, a total of 19,416 offenders had been sent to the CDTs. There was a reduction in offenders appearing before the CDTs for heroin use or possession from 29% to 15%, and an increase related to marijuana use or possession from 41% to 61%. A review by the Beckley Foundation suggested this trend might have been linked to poor targeting or increased hash use (Allen, Trace & Klein 2004).

Figure 14 shows the type of sanctions applied by the CDTs. On average, 66% sanctions were for provisional suspension for non-drug dependent individuals and 22% were provisional suspensions with treatment. Punitive sanctions were given only in 8% of cases, of which the majority were for fines or periodic presentation at a designated site such as a treatment centre. Thus in the vast majority of cases, offenders were not sent to treatment. Since the commencement of decriminalisation there was a shift in the type of sanctions given. Most notably between 2001 and 2004 the proportion of people receiving suspended sentences with the condition of attending treatment decreased from 32% to 18% (Instituto da Droga e da Toxicodependência 2005a). This trend appeared to relate to the increased sentencing of marijuana users.
Evidence suggested that decriminalisation encouraged a paradigmatic change in the conceptualisation of the drug addict, from a criminal to a sick person, and of non-dependent individuals from criminal to people who might be sick. This supported what policy makers asserted was the main objective of decriminalisation:

It also allowed people to talk about this issue more freely. You don’t label people as much with the fact that you’re a drug addict. [A drug dependence person is] very much more seen not as a criminal but more as somebody that needs treatment, needs support and I think that has been a very positive development.

Alexandre Quintanilha – Former head of CNDS – [12]

They changed our perception about drug addicts. Now we have a new opinion of drug addicts. Drug addicts with the new opinion of the community can be more integrated.

Elza Pais – Former National Coordinator – [9]

Surveys conducted as part of the national evaluation revealed high proportions of professionals viewed drug users as people needing medical and social assistance. Such a view appeared greatest amongst those involved in government or health fields, with 77% of IDT respondents (n=191) in November 2004 asserting drug users were people in need of medical care (Instituto da Droga e da Toxicodependência 2004d). A survey of health professionals in 2003 found 67% doctors and 73% psychiatrists saw
drug users as “sick people,” whereby drug use was attributed to social, psychological and health causes (Rojas, Boto & Relvas 2003). No surveys have been conducted to date assessing societal perceptions of drug users. Nevertheless, this reinforced the observations from this research that decriminalisation achieved its primary objective of initiating a paradigmatic change.

Health outcomes — drug use/drug-related health problems
Policy makers contended that decriminalisation ought to have had a positive impact due to increased treatment attendance:

Now a larger number of drug addicts perhaps are going to the treatment centres in Portugal for their socio-medical problems.

Jorge Negreiros – Academic – [10]

Treatment attendance increased from 27,750 in 1999 to a peak of 32,064 people receiving treatment. This subsided to 30,266 in 2004 (Instituto da Droga e da Toxicodependência 2005a). However, as noted earlier it is not known how many clients sent through the CDTs continued to receive treatment, if they were successfully treated, nor whether there were long term impacts upon drug-related problems.

A survey of IDT bureaucrats (n=191) conducted in November 2004 found almost half (47%) said decriminalisation had had an impact, primarily through facilitating contact with drug users (79%) and decreasing social exclusion (74%) (Instituto da Droga e da Toxicodependência 2004d). This suggested that increased treatment or decreased drug use might not be primary outcomes from this reform. At the same time other grassroots policy makers said that decriminalisation had not improved the situation. As will be examined subsequently this was attributed to difficulties in implementation:

It is very depressing. To know that we are in a country that has a very good law, that is looked by several people around the world as being a very good example but we have to say, it is very sad, but it didn’t change.

Maria José Campos – Political Lobbieist – [17]

Additionally the INA evaluators and some policy makers suggested that decriminalisation might have encouraged illicit drug use. It was perceived that there was insufficient attention to explaining the new legal situation and to installing preventative messages prior to the entrance of decriminalisation. Thus, policy makers suggested that many Portuguese citizens thought that decriminalisation implied legalisation:
The message in the law. It was clear to us, but who sees the law?


I saw maybe, from a lack of control from the media the people got the idea in Portugal that to try drugs is not a problem.

José Castanheira – Psychiatrist/Academic – [5-6]

As noted earlier the use of most illicit drugs, particularly cannabis, increased following decriminalisation. The INA evaluation (2004a) highlighted the need to pay increased attention to the message to society balancing the desire to discourage use without marginalising drug users. The difficulty of such a message was noted.

**Criminal justice outcomes – drug offences**

Following the enactment of decriminalisation drug use and possession became contra-ordenações or public order offences. Figure 15 shows that the enactment of decriminalisation was followed by a reduction in arrests for drug consumption or possession offences. The overall number of people arrested decreased from 8,030 in 1999 to 4,998 in 2004, a 62% reduction (Instituto da Droga e da Toxicodependência 2005a). There was no evidence of net-widening in Portugal. Indeed data from the CDTs showed that each year only 5% of individuals were repeat offenders.

**Figure 15: Number of individuals arrested for criminal offences or contra-ordenações for drug consumption, possession or acquisition in Portugal between 1996-2004**


*Following the enactment of Law 30/2000 on 1 July 2001 drug consumption, possession and acquisition constitute contra-ordenações.*
Once again it was not known whether decriminalisation had or will have a long-term impact upon the level of offending. One key issue was whether decriminalisation would decrease drug-related crime. Some policy makers suggested this was unlikely as users would still need to obtain money to acquire drugs:

In my opinion the main consequence of decriminalisation as I said it was for the person itself. Perhaps it won’t have a major effect on drug-related crime, because if people are addicted to drugs and have no money to buy drugs, perhaps they will continue committing crime in order to have money to buy the product. But [decriminalisation] has a symbolic importance in the way that the drug user is treated firstly as a person, rather than a criminal, is firstly treated as someone who needs help.


The local police services, particularly the Public Security Police, noted there had been some misuse of the new law for some minor drug trafficking (Fernandes 2004). This was an issue also highlighted in interviews. Since the law did not take into account the intention to traffic, merely the quantity of drugs, this was perceived to have given rise to a situation where drug-traffickers abused the decriminalisation law and would traffic in small quantities without fear of punishment. Some therefore taunted the police by repeatedly making small deals, in quantities under the threshold limit established under Law 30/2000, while claiming that the drugs were for their personal use. This increased police frustration at their inability to respond:

Now with the decriminalisation of the consumption of drugs it is not easy to separate what is traffic and what is consumption. So for us in the streets it is every day more difficult to combat this phenomenon.

Law Enforcement Officer - GNR – [1]

There is a perception of impunity if you want. Some quarters in cities where small traffic is very big like some years ago we had Casal Ventoso.

José Braz - Law Enforcement Officer – PJ – [3]

Despite these beliefs most policy makers from the criminal justice sector were supportive of the decriminalisation, particularly those whose focus was on major drug trafficking. The Judicial Police reported a 7% increase in drug-related crime. Further, while they noted a 27% decline in drug trafficking arrests following the introduction of decriminalisation, this was offset by a 499% increase in the amount of drugs apprehended (Polícia Judiciária - Direcção Central de Investigação do Tráfico de Estupefacientes 2004). From their point of view, they had more time to concentrate on the major traffickers and suppliers. This suggested that the efficiency of the criminal justice system might have increased. Thus, decriminalisation was seen to have contributed to a more effective response to major drug traffickers.
Overall, the criminal justice sector supported the continuation of decriminalisation, since as noted in Chapter Four they did not believe that drug users should be the focus of their activity. They however desired a clearer distinction between users and traffickers, so they could take into account motivation for drug possession.

In summary, policy makers in Portugal showed considerable support for the concept of decriminalisation. They contended that decriminalisation aided a paradigmatic shift and increased the potential to offer treatment, harm reduction and social reintegration. It therefore facilitated the implementation of the national drug strategy. Outcomes showed treatment services expanded considerably. There were reductions in heroin use and improvements in public health particularly in AIDS, which suggested there was a shift away from heroin use. The counter view was that, as of 2004-2005, decriminalisation had limited impact upon health outcomes, which raised questions as to whether the outcomes could have been improved through better implementation. Counter outcomes that were attributed to the law, included the increased cannabis consumption and increased sense of impunity by minor drug traffickers. Nevertheless, criminal justice outcomes suggested decriminalisation might have increased the efficiency of law enforcement targeting of major drug traffickers.

I illicit Drug Diversion Initiative

The following section draws upon the Health Outcomes International Evaluation and data from the Alcohol and Other Drugs Treatment Services-National Minimum Data Sets (AODTS-NMDS). This data will be supplemented by evaluations from a number of diversion programs, including pre-arrest programs – NSW Cannabis Cautioning Program, the Queensland Police Diversion Program and the WA Cannabis Cautioning and Mandatory Education System – and pre-court programs – Court Referral and Evaluation for Drug Intervention and Treatment (CREDIT), Magistrates Early Referral Into Treatment (MERIT) and the Queensland Court Diversion Program – from the jurisdictions of Victoria, New South Wales, Queensland and Western Australia.

The Health Outcomes International evaluation – 2002

The first evaluation of the IDDI showed mixed results. Health Outcomes International (HOI) (2002a) found that the expansion of infrastructure, development of relationships, organisational training and greater acceptance of diversion by police
and magistrates provided the potential to achieve good outcomes. However, the evaluators found that many of the objectives of the IDDI were unable to be assessed due to delays in the roll-out of the initiative and in the establishment of the National Diversion Minimum Data Set (an empirical database that was designed to enable monitoring of the number and type of diversions). Accordingly, data collection concerning the IDDI was ad hoc. Impact evaluations were conducted in two jurisdictions, Victoria and Tasmania, but these were of limited generalisability due to a total sample of 23 participants. The evaluator’s conclusion, that the IDDI had achieved its objectives, therefore appeared questionable. There was essentially too little data and too little time to tell. A second evaluation commenced with a workshop in 2005 but has not been completed at the time of writing.

**Number and type of people diverted**

The HOI evaluation (2002b) noted there were 19,181 diversions between the roll-out of the IDDI (2000) and 31 March 2002. The evaluators were not able to report details of monthly or yearly levels of diversion since such information was not available. Nevertheless, HOI reported that the majority of diversions in 2002 were for police diversion (90%), particularly for cannabis diversion (87%). Many clients were more advanced in their drug use than predicted in the original IDDI framework. Further, an HOI Indigenous study highlighted that engagement with Indigenous illicit drug users was extremely low, due to the requirement to admit an offence to receive a caution or diversion. This was a concern given the over-representation of Indigenous offenders in the criminal justice system and raised issues over the equity of the IDDI.

Data from the Alcohol and Other Drugs Treatment Services-National Minimum Data Sets (AODTS-NMDS) provided some insight into the outcomes from police and court drug diversion. These figures underestimated the total number of people diverted through the IDDI for a number of reasons: firstly, health interventions were not required by all states and territories for cannabis cautioning; secondly, some states and territories failed to collect or report all requested data, for example during the period of analysis Queensland only collected data on police diversion; and thirdly, there were errors in reporting in some jurisdictions, for example in Tasmania during 2003-2004 (Australian Institute of Health and Welfare 2005a). Nevertheless, this data set provided insight into the client pool and outcomes.
The data concurred with the HOI evaluation that the majority of drug diversion clients were referred to treatment for cannabis use, but indicated that there had been some changes in client characteristics. According to the AODTS-NMDS 35,202 clients were referred to treatment by police and court diversion between 2000-2001 and 2003-2004 (Australian Institute of Health and Welfare 2003, 2004, 2005a). During this period, the principal drug of concern identified by clients was cannabis (60%), followed by heroin (13%), alcohol (12%) and amphetamines (9%). However, the AODTS-NMDS indicated changes in the principal drug of concern during these four years. Between 2000-2001 and 2003-2004 the proportion of clients reporting cannabis as the principal drug of concern increased from 32% to 63%, while heroin reporting decreased from 30% to 9%. Further, the AODTS-NMDS showed that most clients ceased treatment at expiation (see Table 5) and that a smaller group, of 25% to 30% of drug diversion clients completed the recommended treatment programs (Australian Institute of Health and Welfare 2003, 2004, 2005a).

Table 5: Reason for treatment cessation of clients diverted through drug and court diversion in Australia, 2001-2002 to 2003-2004

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Treatment completed</td>
<td>2,603 (29%)</td>
<td>2,973 (25%)</td>
<td>3,171 (28%)</td>
</tr>
<tr>
<td>Transfer to other treatment provider</td>
<td>233 (3%)</td>
<td>390 (3%)</td>
<td>367 (3%)</td>
</tr>
<tr>
<td>Ceased at expiation</td>
<td>4,224 (47%)</td>
<td>6,396 (55%)</td>
<td>5,899 (53%)</td>
</tr>
<tr>
<td>Ceased – withdrew</td>
<td>551 (6%)</td>
<td>455 (4%)</td>
<td>693 (6%)</td>
</tr>
<tr>
<td>Ceased – non-compliance/drug court sanction</td>
<td>348 (4%)</td>
<td>672 (5.7%)</td>
<td>483 (4%)</td>
</tr>
<tr>
<td>Other</td>
<td>862 (10%)</td>
<td>727 (6.2%)</td>
<td>427 (4%)</td>
</tr>
<tr>
<td>Not stated</td>
<td>101 (1%)</td>
<td>74 (1%)</td>
<td>23 (1%)</td>
</tr>
<tr>
<td>Total</td>
<td>8,922 (100%)</td>
<td>11,687 (100%)</td>
<td>11,062 (100%)</td>
</tr>
</tbody>
</table>


Impacts - impressions
The optimism and support found in the HOI evaluation was echoed by many policy makers interviewed in late 2005. Most viewed the initiative as a positive development, due to the potential to keep individuals out of the criminal justice system, to give drug users a second chance and an opportunity to attend treatment:
The early impressions were it was a tool that people were very happy with. Health was happy to get people at the right stage in the drug cycle into treatment even if it was only for one or two initial meetings. Police were happy to have an alternative.

Paul Ditchburn – Victoria Police – [8]

Two other benefits included increased treatment capacity and enhanced partnerships between the law enforcement and health sectors:

In every police station we’ve got lists of agencies right across Victoria. We’ve got people going into police stations where they didn’t before and the barriers have been broken down.

K - Victoria Police – [10]

From my own agencies perspective 22 of our residential beds are occupied by people who would, at least 50% of those people would be in prison if they weren’t with us. I can say at a personal level I know the people who have benefited and it has had a very real impact having that capacity.

David Crosbie – Non-Government Treatment Professional – [12]

Politicians and law enforcement officers tended to be highly supportive:

I think it is probably one of the more useful initiatives undertaken under the Tough on Drugs.

John Perrin – Prime Minister’s Office – [5]

However, there was much greater reticence by health professionals. The majority of health professionals supported the concept of drug diversion, and deemed it preferable to the traditional criminal justice response. Yet, a number of concerns were raised over the objective of the IDDI, the lack of knowledge of the impacts and the variability in the programs. The presence of these concerns meant there was not resounding support for drug diversion in practice.

The primary concern was differing expectations over the IDDI, particularly in relation to drug use: use reduction versus harm reduction. As noted in Chapter Five while the ADCA document and proposal for “best practice” drug diversion emphasised harm reduction the IDDI emphasised use reduction. Policy makers from the current research suggested that the shift in emphasis contributed to dual objectives.

Principally law enforcement and government officials were more likely to attest to the life-saving or life changing properties of diversion:
In relation to drug diversion in this state we have changed the lives of 14,000 plus people in Victoria. I think that is incredible.

K - Victoria Police – [2]

We saved 700 lives in one year on drug diversion.

Brian Watters – Former head of ANCD – [12]

In contrast, health professionals contended that given drug use is a chronic relapsing disease, diversion was unlikely to stop drug use. Therefore, to assert that drug diversion would and had “saved lives” was deemed unrealistic:

The problem with that is mandatory treatment doesn’t work. That’s the problem with diversion. The model on which these ideas of drug treatment inherent in diversion are based are seen with rose-coloured glasses.

Nick Crofts - Health Professional – [5]

I think others saw it as a legitimate attempt to promote the idea that treatment was an effective response and divert people to treatment, but the idea of treatment still had, politically a rather naïve construct of abstinence.

Ian Webster – Health Professional – [5]

Such differences of opinion had considerable implications for the expectations from and assessment of the IDDI.28

Moreover, policy makers noted that while the concept of diversion was well supported, there was significant variability between the schemes, their objectives, mechanism and impacts. As Associate Professor Robert Ali noted diversion had been rolled out “unevenly, widely unevenly: different states, different approaches” [7]. The variability in turn had implications for the potential implementation and outcomes:

Frankly I have had some concerns about what some jurisdictions are doing. I find it quite bizarre what some jurisdictions are doing and the way the money is being spent but, I think that is often the price in involving each jurisdiction and having a say because some jurisdictions are better at this than others.


The primary concern of policy makers about the IDDI was the lack of knowledge of the outcomes from the initiative:

The jury is out I think, it is probably an appropriate metaphor.


The following section examines the impacts and impressions of the IDDI through three areas: political objectives, health and criminal justice outcomes. It draws upon the HOI evaluation, state and territory evaluations and expert impressions.

28 It was unclear whether the ADCA campaigns that “treatment works” contributed towards such unrealistic expectations.
**Political objectives**

As noted in Chapter Five there was considerable concern by the Government and the law enforcement sector as to whether drug diversion would send the wrong message. One of the HOI objectives - the presence of a consistent message on the unacceptability of illicit drug use - clearly reflected political imperatives. The HOI evaluators (2002b, p. 3) provided conclusive support for the presence of such a message, including frequent references to "tough on drugs." Policy makers agreed that the IDDI sent a clear message of the unacceptability of illicit drug use. While many noted the contradictions between the rhetoric of Tough on Drugs and the practice of a more humane response, the symbolic message supported the political desire to discourage drug use:

> It is probably the centrepiece of the Tough on Drugs strategy so it should mean Tough on Drugs. But what it actually does is provides what most people see as the humane option.
> Gino Vumbaca – ANCD [2-3]

> The Diversion Initiative has been widely accepted right across the whole sector of people in the field including very conservative people, like Major Brian Watters who is one of the chief advocates of the Diversion Initiative.
> John Perrin – Prime Minister’s Office – [6]

Further, it appeared that there was broad community support for drug diversion:

> I think the public are pretty on side with what we are doing. We are certainly not seeing a backlash in relation to…

National Drug Household Surveys indicated public support for the use of cautions or drug treatment for drug offenders increased following the introduction of the IDDI. There was a 36% increase in support for the use of a caution for offenders found in possession of cannabis for personal use (from 12% in 1999 to 48% in 2004) (Australian Institute of Health and Welfare 1999, 2002). This corresponded with a decrease in the percentage of individuals advocating a fine (37% to 17%). The surveys also revealed considerable public support for diversion of *other* illicit drug users. Diversion to drug education and treatment was supported for other illicit drug users by over 40% individuals in 2001 and 2004 (Australian Institute of Health and Welfare 2005b). This was not necessarily attributable to the IDDI, but suggested there was public support for the current practice of drug diversion.

A number of policy makers raised the increasing support as a reason to increase public awareness of drug diversion:
I would take the view that it would be very positive for the population to see the
government, not only the Australian Government, but all states and territories are trying
to do something positive for drug users and to divert them away from their destructive
course of action.

Stephen Vaughan – Health Bureaucrat – [10]

Fears that drug diversion could be seen as soft or covert drug law reform therefore
appear unwarranted.

**Health outcomes**

Health professionals suggested that while drug diversion might have had limited
impact upon drug use *per se*, it had contributed to improvements in health outcomes,
including reducing harmful or problematic use and drug-related health problems.
There was therefore considerable belief that harms had been minimised through the
IDDI:

> There have been people coming to treatment where treatment has been quite significant
> in ameliorating their harms, pain, trouble, strife without necessarily giving them a tough
> time.

DC – ANCD – [10]

From this perspective the IDDI had contributed towards a more adaptive and effective
response.

A number of evaluations from jurisdictional programs appeared to support this
assertion. Impact evaluations conducted in Victoria and Tasmania as part of the HOI
evaluation (2002b) indicated that diversion appeared to reduce drug use and criminal
behaviour, and increase physical health and mental health, including appetite,
emotional well-being, and relationships with significant others. However, greater
improvements were noted in the Victorian study, which targeted more serious drug
users.

Evaluations of pre-arrest programs showed variable impact upon health outcomes,
particularly drug use which was attributed in part to the difficulty ensuring drug
diversion clients, particularly cannabis users, contacted the health and education
systems. The New South Wales Cannabis Cautioning Scheme showed low levels of
contact to the Alcohol and Drug Information Service help-line and limited impacts
(Baker & Goh 2004). In particular they found only 0.4% of total cautions resulted in
contact with the service. Even after the introduction of a mandatory education session
for second cautions, only 14% cautions resulted in contact. They attributed this to
client perceptions that they did not have a drug problem (Baker & Goh 2004). In
contrast, the Queensland Police Diversion Program had considerable impacts upon the level of drug use (Health Outcomes International Pty Ltd and Turning Point Alcohol and Drug Centre 2004). The proportion of offenders described as regular cannabis users decreased from 95% to 74% over six months. It is unknown however whether this was due to the program design, which had compulsory attendance at treatment, or the greater number of occasional users going through the Queensland PDP.

Evaluation of the pilot WA Cannabis Cautioning and Mandatory Education System indicated changes in participant knowledge and attitudes towards cannabis. The benefits for in particular young clients were noted, as summed up by one client: “it was a wake up call I guess” (Penter, Walker & Devenish-Meares 1999, p. 14). The major demonstrable impact was increased knowledge of the harms caused by cannabis (from 47% to 71%). Moreover, the program increased contact with the treatment and health services that drug users previously would not have known about. However, evaluators of the subsequent Cannabis Infringement Notice Scheme reiterated that behavioural change was unlikely: “the research suggests that the CIN scheme will not have much, if any, impact on the cannabis use of regular users” (Lenton, Chanteloup, Fetherston, Sutton, Hawks, Barratt & Farringdon 2005, p. ix).

Impacts upon drug use appeared slightly higher from pre-plea diversion programs. The number of people in treatment before and after the Lismore MERIT Pilot Program increased from 44% to 53%, and there were statistically significant reductions in the rate of participants citing heroin and amphetamines as their major drug of choice (Northern Rivers University Department of Rural Health 2003). Reductions were noted in the number of drugs used and HIV risk taking behaviour, and improvements were noted in social and health functioning. Similarly, a high proportion of respondents involved in the Queensland Court Diversion Program said they were likely to reduce their drug use (53%) or stop drug use (32%) (Health Outcomes International Pty Ltd 2005). Impacts were however unknown. Other programs, including CREDIT, found negligible impacts on drug use and asserted that the major benefit was increased contact with the health service (Heale & Lang 2001). These studies suggested the IDDI contributed towards increased knowledge of harmful drug use, and through changes in the type or patterns of use, reductions in harmful drug use. Moreover studies suggested the IDDI enhanced social and health functioning. Impacts however upon drug use appeared more variable, and appeared
more likely for pre-plea programs and hence more serious drug users. The lack of consistency in the impacts from the reported evaluations raised questions about whether other IDDI programs had similarly variable impacts. Further, the cause of the variability was unknown.

Criminal Justice Outcomes – drug offences
There were variable findings again concerning the impact of drug diversion upon crime. The evaluation of the WA Cannabis Cautioning and Mandatory Education System demonstrated only 5.2% re-offended during the 12 month trial (Penter, Walker & Devenish-Meares 1999). However, evaluations of pre-plea diversion programs CREDIT and MERIT showed contrasting impacts upon drug offending. The evaluation of CREDIT found 24% of clients re-offended during the bail period, and there was little difference between rate of offending for CREDIT clients, and those who were referred but did not participate in CREDIT (Heale & Lang 2001). However, the Lismore MERIT Pilot showed completers were half as likely as non-completers to re-offend, during and up to twelve months post-completion (Northern Rivers University Department of Rural Health 2003).

Stephen Vaughan, a former law enforcement officer, argued that the primary outcomes from the IDDI might not be reductions in crime. He nevertheless contended that drug diversion might be worthwhile, through reducing the negative impacts from the traditional criminal justice system:

> I know we have diverted more than 50,000 people across the nation and granted a lot of that has been for cannabis, but what does it mean? What does it mean? To me it is quite substantial that we have managed to keep a lot of people out of the criminal justice system with its attendant harms.


As noted previously national trends suggested that the level of recorded drug offences did not decline. It was evident that some diversion programs aimed to maximise contact with the educational or treatment sector and thus “widen the net.” As noted in Chapter Five, one of the concerns with drug diversion was net-widening, whereby either more offenders were sent through the criminal justice system (wider nets), or offenders received more onerous sanctions than they would through the traditional criminal justice system (deeper nets) (Bull 2005). During the establishment of the diversion programs this was highlighted as a potentially counter-productive impact, and led to the incorporation of principle 15 of the IDDI Framework; that the
participation in treatment not be more onerous than the traditional response (Commonwealth Department of Health and Ageing 2004d).

It appeared however, that many programs expressly aimed to widen the net. This was often due to the belief that this would reduce the likelihood of further drug use or crime (Roberts, L. & Indermaur forthcoming). This was particularly evident in Queensland, where it was compulsory for law enforcement officers to offer cannabis diversion, and where individuals who failed to attend a 1-2 hour program, the Drug Diversion Assessment Program (DDAP), could receive criminal penalties for wasting police time. Between June 2001 and 30 March 2003 a total of 10,623 offenders were diverted through the Queensland Police Diversion Program, of whom 81% attended the education session (Health Outcomes International Pty Ltd and Turning Point Alcohol and Drug Centre 2004). Through such a program, Queensland diverted far more offenders than any other diversion program in Australia. Similarly, Baker and Goh (2004) demonstrated the existence of net-widening in the NSW Cannabis Cautioning Scheme. They found that the overall number of charges decreased following the introduction, but the total number of legal processes increased albeit slightly. While net-widening could arguably have some positive effects, the apparent emphasis on this by criminal justice sectors might be problematic.

A final impact of drug diversion appeared to be increased efficiency and cost-effectiveness of the criminal justice system. It was difficult to conclude whether the latter objectives were achieved as very few evaluations assessed efficiency and impacts upon police and court time, resources and money. Exceptions to this suggested that the IDDI might have increased the efficiency and reduced costs. Baker and Goh (2004) estimated that despite net-widening, over 6000 police hours were saved each year of the NSW Cannabis Cautioning Program. This amounted to over $1 million for the period of the scheme, which at least met the costs of implementing the scheme. Further, it was estimated that for every $1 spent on the Lismore MERIT program, there was a benefit of between $2.41 and $5.54 or $16,622 per completer (Northern Rivers University Department of Rural Health 2003). A key concern remained as to the extent of benefits – increased efficiency, reduced costs and harms averted – if programmatic costs, such as net widening were taken into consideration.

Further questions remained as to the health and criminal justice outcomes of completers and non-completers. Unfortunately, no study had revealed whether
participants were worse off – increased crime or drug use – following non-completion of diversion programs. Undertaking this research is essential to ensure that diversion is not more onerous than criminal justice intervention. Finally, questions remained as to whether increasing the efficiency of the criminal justice system had or would impact upon the efficiency of the health system.

**Summary**
The concept of diversion appeared to be supported by most policy makers, evaluators and the community. It appeared to have achieved the political objective of changing criminal justice practice without condoning drug use. Evaluations and policy makers highlighted considerable variation in the impacts from schemes, which made it difficult to attest to the outcomes. Findings to date nevertheless suggested two key implications. It appeared that the IDDI was beneficial. Yet, given the primary benefits concerned reductions in harms and improvements in health outcomes, findings were more in line with the original ADCA proposal, whereby drug diversion was promoted as a means of *initiating* the process of social change. This suggested that the stated objectives of the IDDI – to reduce drug use and crime – might be unrealistic.
Constraints upon implementation

While both the IDDI and decriminalisation appeared to have enabled more adaptive responses to drug users, policy makers contended that the process of implementation reduced the potential outcomes from both reforms. The following section overviews the constraints upon implementation.

Decriminalisation: political mismanagement? short-sightedness?

Policy makers asserted that the outcomes from decriminalisation were limited by the failure to fully implement the strategy. Accordingly, the impacts were yet to be seen:

> I think the strategy has not been implemented in the last three years. I think it has been implemented for only one year

Nuno Miguel – Health Professional/Bureaucrat - [10]

The dominant belief was that the primary constraint upon the implementation of the decriminalisation were political factors. From this perspective, decriminalisation was poorly implemented due to the political situation following the election of the Social Democratic Party (PSD), and associated reduction in philosophical and financial support for decriminalisation. However, from another perspective decriminalisation was constrained by inattention to evidence.

Political indecision over decriminalisation

As noted earlier the PSD threatened to re-criminalise drug use and possession upon election. Policy makers, particularly politicians, contended that the PSD opposed the decriminalisation but lacked the political will to revoke the law:

> Some thought that the change of Government would have the effect of changing the policy, of putting criminalisation again in law, because the reaction of the PSD and CDS had been very strong. They fought against this reform. But when they got to the Government they just decided to keep the policy. So no visible effects, no visible changes, but there are some subtle changes.


Despite the continuation of decriminalisation disquiet continued. According to policy makers this led to three main impacts. Firstly, questioning and criticism of decriminalisation continued throughout the PSD reign:

> Still today you can notice rumours of this fear, because the new strategy... they said this was a system that would go forward, but there were always some member of government criticising this system.

What is different between us and them, us the Socialist Government and them the Social Democratic Government, is not the policy, but the engagement and investment. They have no money and they have not the political will to improve, so they are just managing the status quo.


Secondly, it was asserted that the PSD neglected the CDTs. Meetings between the CDTs and Government were either stopped or reduced, and staff levels were not maintained. Hence, resources and guidance prevented appropriate implementation:

Today I feel they are very demoralised because they have no money, they have no funds to work in the field. So today, money is not like this and so they really have no ways of acting.

Elza Pais – Former Head of IPDT – [8]

In legal terms, the laws are the same, the strategy is the same but this government has not the same, how can I say, the same hook on this problem

Alexandre Rosa – Socialist Politician – [10]

The INA evaluation (2004b) and Berkley Foundation (Allen, Trace & Klein 2004) similarly contended that the lack of PSD support, both conceptual and financial, was a major impediment to decriminalisation.

Thirdly, there was evidence of political interference and a desire to stop evidence-based improvements to decriminalisation. In particular, the Socialist Party commenced an evaluation of the CDTs by the University of Porto; however, this was either not finished or not released. There was some suggestion that this was cancelled by the new PSD director Fernando Negrão:

We need the results and we haven’t anything because the IDT President and the Government stopped this research.

Elza Pais – Former National Coordinator – [18]

A subsequent evaluation was conducted in 2003 and again never released. Some policy makers, including Jorge Negreiros, attributed the failure to release or respond to the evaluations to the presence of “men of inaction.” From this perspective, the absence of proven benefits served political objectives, namely to reduce funding and raise doubts as to the future of projects:

The problem is that use some kind of men of inaction. Well we are going to evaluate and keep evaluating and evaluating, and this is used as a reason not to give money to projects that are operating in the community and that are of vital importance for the people who use those projects and this is very mainly in the field of harm reduction.

Jorge Negreiros – Academic – [9]

Some Socialist Politicians contended such political moves were designed to create a reason to change the law and introduce a new and more extremist direction:
We have members of parliament saying we will change the strategy we want a new way, and the new way is drug-free. If this is true then I believe that this non-political intervention may have the objective of saying that the results of this evaluation were not that good.


However, a more nuanced view suggested that decriminalisation remained relatively non-ideological:

It also appears to be evidence-based, not ideology, here is the problem, we will deal with it, we will try and do the best we can, appears to be and for me the one reason I say that, and the one reason I think that is that the law was introduced by a left-wing government then a centre-right government came to power and at least some members of the coalition greatly opposed the law and that law is still there, they haven’t changed it, despite party politics. I think that speaks volume, frankly.

Brendan Hughes – EMCDDA – [10]

From this perspective, the problems in implementation were not due to the PSD per se. Many policy makers attributed problems to the actions of the first PSD drug strategy coordinator. As noted earlier the national drug strategy coordinator has shifted between Fernando Negrão (2001-2004), Nuno Freitas (2004-2005) and João Goulão (2005-current). The two PSD leaders Fernando Negrão and Nuno Freitas had different backgrounds, a former lawyer and former doctor respectively, which was seen by policy makers as symbolic of their approach to drug policy issues. João Goulão was a former director of a drug treatment centre and member of the CNDS. Policy makers asserted that Fernando Negrão was much less supportive of decriminalisation, particularly the CDTs:

I think that Dr Fernando Negrão really was a bad president. He didn’t implement neither this strategy nor a different strategy. He did nothing. This is very odd indeed because he never took a stance clearly against the strategy. But on the other hand he fired all the important directors that were crucial for the implementation of the strategy.


In contrast, there was greater support for Nuno Freitas. During his brief term he held the national evaluation of the drug strategy and stated that the continuation of decriminalisation was “incontestable” (Gomes 2004). Perhaps most crucially, in his opening of the drug strategy evaluation in December 2004 he identified the failure to release the evaluation into the CDTs as an example of how politics had hurt Portuguese drug policy in recent years:
“The paradigmatic case was the Protocol assigned in 2001 and never undertaken until 2004 ... [regarding] the assessment and evaluation of the Commissions for the Dissuasion of Drug Addiction. This is a good example of the reactions of bureaucrats, organisations and closed minds, that reject academic investigation and [of the] the meddling in evaluation” (Freitas 2004, p. 5)\textsuperscript{29}

From this perspective, it was the director, and their approach, rather than the party that was critical for the implementation of decriminalisation. The appointment of the former head of the SPTT and member of the CNDS – João Goulão – as director of the IDT was argued to bode well for the future of decriminalisation.

\textit{Attention/inattention to research}

Another issue that was suggested to have impacted upon the outcomes and assessment of decriminalisation was the attention or inattention to research. As noted in Chapter Four there was a significant role played by experts and evidence in the development of the strategy and decriminalisation, however there was less involvement with the development of the CDTs.

Many concerns were raised over the design of the CDTs and whether the CDTs could be effective. The majority of policy makers thought they were excessively bureaucratic and resource-intensive structures. It was therefore suggested that too much money was spent establishing multiple CDTs, which limited the funds provided to harm reduction, treatment and integration for serious drug users. Of particular concern was whether the CDTs were the right way to respond to marijuana users. These structures were not thought to be evidence-based, and there was some suggestion their development was spurred by a desire for “jobs for the boys”:

There are people that consider that the strategy and the commissions have been created to create jobs for the boys.


Due to the establishment of a new regime, research and evaluation were seen as critical to enable an effective response. The failure to specify the objectives of decriminalisation, and to have ongoing process evaluation, were seen to limit both the capacity to assess and obtain desired outcomes:

\textsuperscript{29} Translation of “O caso paradigmático do Protocolo assinado em 2001, e nunca concretizado até 2004 ... sobre o acompanhamento e a avaliação das comissões de dissuasão da toxicodependência é bem exemplo de reacções burocráticas, corporativas e fechadas que rejeitam a investigação académica e a ‘intromissão’ avaliativa...” Note once again that the reasons for the lack of assessment remained unclear.
The central problem was that there was no one with a disposition to accompany, coordinate and evaluate the implementation of all the measures of the strategy.


It was suggested that one cause of this lapse was the focus on a conceptual objective: paradigmatic change. Thus, the major impediment on the implementation of decriminalisation was perhaps the failure to consider the practical objectives:

The last strategy was philosophical. But the results, we concluded that it was good, it was a good answer but we must in the next strategy more specific, more objective, more clear.

Law Enforcement Officer - GNR – [4]

Accordingly, policy makers felt that the conceptual objective was largely attained. Yet there were more doubts as to the practical objectives. This was supported by Pereira (2003) who concluded that the decriminalisation of consumption had added more dignity to the responses to drug users, yet had not been a decisive measure in dissuading drug addiction.

Policy makers revealed that the primary concern with the CDTs and decriminalisation was the limited attention to the process of implementation, and in particular, the practical implications of decriminalisation for consumers, trafficker-consumers and for law enforcement officers. Key concerns included the need to examine the application of decriminalisation, particularly current CDTs procedures and requirements. While policy makers contended CDTs offered a good response to the drug dependent heroin user, questions were raised as to how the CDTs ought to respond to the occasional cannabis user. Moreover, policy makers expressed concern over the equity of responses for drug users from rural areas. For example, in rural areas the requirement to attend CDTs necessitated half a day’s travel for some consumers, a far greater imposition than for the equivalent city-based drug user:

This system is so perverse that instead of helping the consumers it is creating more hurdles.


Finally, the current legislation excluded consideration of the intention to consume or traffic drugs, which as noted earlier was deemed to have encouraged minor trafficking. Many of these issues were highlighted in the INA evaluation, and the Portuguese response to their national evaluation. The response to the evaluation was notable for three reasons. The new strategy – the National Plan Against Drugs and Drug Addiction 2005-2012 – recognised that the lack of coordination and investment
in the CDTs reduced the potential effectiveness and ultimately the credibility of decriminalisation. Further, the new strategy specified objectives: that decriminalisation aimed to dissuade drug use; and that the CDTs aimed to reduce illicit drug consumption in a just and equitable manner (Instituto da Droga e da Toxicodependência 2005b). Unfortunately, the new strategy still did not specify how Portugal would achieve these objectives in practice. Nevertheless, two new slogans were adopted to explain the meaning of Portugal’s legislative framework, and discourage non-drug users:

- “Descriminalização não é despenalização.” – Decriminalisation isn’t depenalisation.
- “Consumir drogas em Portugal é ilegal.” – Consuming drugs in Portugal is illegal (Instituto da Droga e da Toxicodependência 2006).

Both slogans informed the public that drug use and possession remained an offence in Portugal, sanctionable through the Commissions.

Finally, a significant element of the new strategy was the intention to increase the effectiveness of decriminalisation, through assessment of the impacts of decriminalisation. The response to the ENLCD evaluation suggested that the Portuguese government had publicly accepted the criticism of the CDTs, and were intent on developing a more evidence-based approach to decriminalisation.

**Illicit Drug Diversion Initiative: An evidence-based policy?**

The IDDI has been characterised by a significant investment and roll-out of initiatives. Yet while there was conceptual support, and evidence of positive impacts, particularly reductions in harms, concerns remained as to whether the IDDI was evidence-based. Australian policy makers and evaluators asserted that such a situation evolved due to a lack of attention to evidence and expert advice in the design and implementation of the IDDI. This was seen to have limited the capacity to assess the outcomes and more importantly to obtain effective outcomes. The following section overviews the role of evidence in three areas: the initial roll-out of the diversion programs; the assessment of outcomes; and the response to evaluations.
Role of evidence in roll-out of IDDI

Considerable questions remained over why the impacts from diversion programs were inconsistent, particularly why some exhibited outcomes that were more favourable. It was unclear whether this was due to program design, eligibility criteria or jurisdictional differences concerning implementation, and hence whether variable outcomes were likely to continue. There was evidence that some diversion programs were not following evidence-based practice, something that may in turn have reduced the effectiveness of diversion programs.

Some policy makers attributed this to minimal emphasis upon best-practice in the roll-out of the IDDI. As noted by Robert Ali, the roll-out of diversion practices represented state and territory greed:

Unevenly, widely unevenly. Different states, different approaches, some of them don’t make any sense. Everybody trying to siphon as many bucks from the Commonwealth as possible without doing much at all, so they can be diverted into other initiatives.


This contributed towards variable models, some of which did not reflect best-practice or commonsense. The program of particular note was the Queensland Police Diversion Program for two reasons: firstly, it was compulsory for police to offer offenders a caution; secondly, charges could be imposed for individuals who did not attend assessment for wasting police time (Health Outcomes International Pty Ltd and Turning Point Alcohol and Drug Centre 2004). Both the pressure to divert individuals and to punish for non-attendance could have contributed to net widening. While the extent of net widening remained unclear such objectives were counter to expert recommendations (for example Bull 2005) and best-practice principles and might have contributed to counter-productive impacts.

Selective use of evidence

Evidence concerning the assessment and outcomes from the IDDI appeared limited and access was often restricted. Despite the Data Set being a core principle of the IDDI framework there were lengthy delays in establishing the National Diversion Minimum Data Set (Commonwealth Department of Health and Ageing 2004c). Further, at the time of writing the dataset remained confidential, as did the workshop from the second evaluation. This decreased the potential to gain knowledge of the effectiveness of the IDDI.
It appeared that many of the concerns and problems raised in the HOI evaluation were overlooked. Prime Minister John Howard (2002) responded to the HOI evaluation by stating “the Diversion Initiative has proven to be one of the most successful elements of the rehabilitation process.” Such a conclusion could only have been based on a simplistic interpretation of the HOI evaluation. Moreover, policy makers and state/territory evaluations showed that many of the issues raised by the HOI evaluation concerning implementation remained. These included the need for a proportional diversionary response, attention to targeting and retaining Indigenous offenders and the need for different objectives for first-time and recidivist offenders. As will shortly be examined, the issue of greatest concern remained attitudes and practices within the criminal justice sector. Thus, evidence and recommendations from the early evaluation appeared to have had limited impact.

The second phase evaluation commenced in September 2005 with a closed workshop. The sole published memo stated that it discussed the “successes, challenges and future for the Diversion Initiative” (Vumbaca 2005, p. 3) and pointed to the need for evaluation of the outcomes, a view supported by policy makers in this Chapter. An evaluation has recently commenced and is expected to run until March 2007, when the future of the IDDI will be decided. Prior to this time however, there has been reluctance to publicly discuss the findings. Despite the ANCD saying that the findings from the workshop would be published (Vumbaca 2005) the Commonwealth Department of Health and Ageing said, in February 2006, that these would not be released (Personal communication with a Member of the Drug Strategy Branch 2006). At the time of writing it was unclear whether such an evaluation would be made public, which suggested continued reticence towards public evaluation or discussion of this reform.

*Future of IDDI: conceptual change may be limited by a lack of evidence*

Policy makers recognised that diversion represented a huge challenge and shift from viewing drug users as criminals. Some policy makers, particularly from the law enforcement sector, felt that a significant shift had occurred during the period 1999-2005:

> There is a lot of dialogue now, a lot of people putting on very much a conceptual hat to try to do things better. So I think it has been the one turning point if I could say that in drug policy that I am aware of in the last thirty years.

However, the more dominant view was that while the law enforcement sector’s conceptualisation of drug users had started to change, practice was harder to influence, and it would take many more years to institute a paradigmatic change:

It acts like a ….. I am thinking of eroding, the sort of drip, drip, drip way of changing practices.

DC – ANCD – [10]

So it is not something that you say we are going to do this today and it happens tomorrow. It is actually a process of quite gradual change and people have to shift philosophically to take it in, but ten years down the track it will be integral to the tools of both police and courts that they use.

Marion Simmonds – Health Bureaucrat – [6]

Many policy makers, including law enforcement officers, argued for more training on the rationale and method of diversion:

My view is we’ve got keep working on attitudinal change and attitudinal acceptance of these sorts of things at ground level and that takes a bit of work but from a senior position that’s been driven down and that does take time sometimes. But needle syringe would be a good example: 1988, 1989 most people said to me “cops aren’t going to wear this, I mean allowing people to come up to get a syringe so they can go and shoot up drugs, this are just not going to do that.” Now admittedly that was ten or fifteen years ago but that’s just part of the furniture now.

Frank Hansen – Senior Law Enforcement Officer – [8]

I think the major problem with the diversion initiative is getting police culture shifted and police to understand it and not just to appreciate its potential but actually how to do it, the administrative kind of way. So getting police aware, appreciative and able administratively to use it I think that is still its major impediment.

DC – ANCD – [10]

Some of the reasons for the gradual change were attributed to false expectations of the IDDI. In particular, this included the lack of realistic expectations on the capacity of diversion to dramatically change the behaviour of drug users:

I think the shift is still fairly limited and it is still fairly limited by often unrealistic ideas say on the behalf of magistrates, that somebody will go in for five days detox and come our miraculously cured.

John Saunders – Health Professional/ANCD – [9-10]

This was a view echoed in many evaluations of state and territory diversion programs. Both the CREDIT evaluation and the evaluation of the Queensland Police Diversion Program noted little conceptual change, due to unrealistic expectations (Heale & Lang 2001; Health Outcomes International Pty Ltd and Turning Point Alcohol and Drug Centre 2004). In particular, it was noted that the conflicting objectives (use versus harm reduction) might be a key barrier to the implementation and outcomes from the IDDI.
It is arguable that the limited role of evidence and/or feedback may have contributed to differences in viewpoints. Unrealistic expectations might lead to a loss of support or even discredit diversion as a strategy (O’Callaghan, Sonderegger & Klag 2004). Ultimately, this may limit the potential effectiveness of the IDDI.

**Conclusion**

A number of similarities were highlighted between the atypical reforms. Both atypical reforms have received extensive conceptual support, particularly in Portugal where decriminalisation has been viewed as giving rise to a paradigmatic change. However, there was less consensus about drug diversion in Australia, due to the more selective and policy-based evidence, most notably the emphasis upon use reduction. A key success of the IDDI was arguably retaining the message that drug use was not condoned.

Difficulties in assessing the outcomes were evident in both nations. Due to such difficulties, the outcomes remain debatable, particularly in Australia where national data were far more scarce and restricted. Nevertheless, the data indicated that similar numbers of drug users were diverted, with approximately 10,000 and 6,000 individuals per year in Australia and Portugal respectively (0.005 and 0.006 per head of population). The reforms served primarily cannabis users with 87% in Australia and 61% in Portugal. While both reforms initially targeted a substantial proportion of heroin consumers, notable reductions occurred in recent years in both nations. Such shifts however were more evident in Australia (30% to 9%) than in Portugal (29% to 15%). The atypical reforms have been associated with positive health and criminal justice outcomes, but it appeared that reductions in drug use and crime were more likely for serious drug offenders. It further appeared that the objectives of reducing crime or drug use might be less realistic for occasional consumers, but that diversion or decriminalisation might decrease harms to drug users and increase the efficiency of the criminal justice system. In this regard, both reforms could be seen as more adaptive than the traditional criminal justice system.

Concerns were identified with the implementation in both initiatives, due to issues of design, assessment and political factors. While policy makers attributed this to the limited role of evidence in Australia about the IDDI and the political indecision in Portugal, a more nuanced analysis suggests perhaps the causes ought to be reversed.
Notably the problems, to date, with the Portuguese decriminalisation were publicly recognised. Questions remain as to whether issues in implementation can be overcome and thus whether more effective outcomes can and will be obtained. Ideally the new IDDI and CDT evaluations will include impact and outcome evaluations of not only of those that succeed, but also those who fail.
Despite the complexity of incremental and atypical policy development and the variable impacts observed in Portugal and Australia, Chapters Four and Five demonstrated common drivers. Yet the process of atypical reform gave rise to contrasting reforms and different impacts. The following chapter seeks to make sense of this process, examine the similarities and differences and assess the theoretical applicability of the public policy theories highlighted in Chapter Two. It undertakes this through the following three sections:

1. Similarities and differences in drug policy development
2. Application of the theoretical frameworks
3. Appraising the theoretical frameworks

The first section draws together the similarities and differences underlying incremental and atypical reform in Portugal and Australia. The second section applies the three public policy theories, and the final section identifies their strengths and weaknesses, and appraises the applicability of the theories for understanding incremental and atypical drug policy reform.

**Similarities and differences in drug policy development**

*Incremental reform*

National drug policy in Portugal and Australia was driven by similar factors. The major factors influencing incremental drug policy development in Portugal and Australia are highlighted in Table 6. Policy makers argued that in the early 1990s there were limited opportunities to challenge the criminalisation of drug users in Portugal and Australia due to three main factors: policy making through the Governance structures; the small circle of actors involved in policy making; and dominant beliefs supporting the policy direction. Despite increasing evidence or criticism, and a growing drug problem in Portugal, there was considerable consensus that the presence of these factors facilitated path dependence, and the maintenance of differing objectives of abstinence in Portugal and harm minimisation in Australia. The
closed policy making structure reduced the number, strength and visibility of voices in the drug policy making arena. This decreased the potential for political or other policy actors to challenge the status quo and hence challenge the dominant policy direction.

A key difference was that drug policy in Australia was driven by evidence, whereas policy in Portugal was driven by ideology. In addition, Australia’s federated structure constrained opportunities for atypical reform due to the necessity of “watered-down” consensus. In contrast, in Portugal the primary constraint upon atypical reform was the dominance of the drug-free supporters, which decreased the potential to attend to harm reduction views. A final difference was that in the heightened political climate preceding the introduction of the NDSF, incremental reform was deemed by many a positive occurrence. In contrast, the parliamentary conclusion preceding the development of decriminalisation that there had been “twenty years of failure,” demonstrated incremental reform was deemed less effective in Portugal. Nevertheless, whether incremental reform was supported or opposed, the governance arrangements tended to facilitate incremental reform and hence the maintenance of past paradigms.

Table 6: Similarities and differences underlying incremental drug policy development in Australia and Portugal

<table>
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<th>Differences</th>
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<td><strong>Involvement of non-government sector - Australia</strong></td>
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<td>Small/closed circle of actors</td>
<td><strong>Dominance of health and law enforcement sectors</strong></td>
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<tr>
<td>Dominance of health and law enforcement sectors</td>
<td><strong>Silos</strong></td>
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<td><strong>Political</strong></td>
<td><strong>Bipartisan – Australia</strong></td>
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<tr>
<td><strong>Policy making by sub-systems</strong></td>
<td><strong>Low priority – Portugal</strong></td>
</tr>
<tr>
<td><strong>Past paradigms</strong></td>
<td><strong>Policy objective:</strong></td>
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<td><strong>Support for past paradigms/beliefs</strong></td>
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<td><strong>Limited impact</strong></td>
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<td><strong>Low level of knowledge – Portugal</strong></td>
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<td><strong>Limited impact</strong></td>
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<td><strong>Values</strong></td>
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Atypical reform
In contrast, in the development of decriminalisation and the IDDI policy makers highlighted a number of key changes. Similarities included the necessity of a political opening, advocacy by multiple interest groups, research depicting models of the reforms and fit of the proposed solution with societal values (see Table 7). Differences concerned the roles of politicians, research and problems, which impacted upon policy formulation and adoption.

Similarities

Crises
Policy makers contended increased public and media attention to the drug problem contributed to agenda setting. Both reforms were preceded by an accumulation of events that obtained heightened media attention. In Portugal media attention of the drug market, Casal Ventoso, escalated particularly following the expansion of public media services. This was perceived to have heightened community concern over the drug problem. Similarly, in the period preceding the IDDI heroin overdoses, and a drug law reform push were the subject of media attention. Moreover, a similar concern over the efficiency of the criminal justice system’s response to drug users, facilitated a change in law enforcement attitudes. It should be acknowledged that the role of media attention in agenda setting may have been elevated by hindsight bias.

Political factors
Politicians in both nations became increasingly involved in the drug problems. While politicians set the initial agenda of zero tolerance and mandatory treatment of drug users, they were persuaded of the need for non-criminal justice responses. Decriminalisation and drug diversion thus emerged through negotiation and compromise. One key reason for this change was that politicians heeded to varying degrees the advice of policy advocates.

Policy makers also suggested that politicians grew to like the proposed solutions. Decriminalisation and the IDDI became political flagships in both nations and received significant financial and conceptual support. Indeed, both reforms were identified as the primary successes of the ENLCD and of the “Tough on Drugs” strategy. Arguably, such commitment was facilitated by the adoption of commonsense approaches that had considerable fit with political and societal values. Accordingly,
while both had political framing, the solutions appeared responsive to the evidence base.

Policy actors
The strength and type of advocacy increased in the lead up to atypical reform, influencing both agenda setting and policy proposals. In Portugal and Australia, three key changes increased the possibility of reform: expansion of voices into the political arena; presence of entrepreneurs; and mutual advocacy by interest groups. Firstly, prior to the reforms there was an expansion of policy actors at the political level, which increased opportunities for input into political and sub-system circles, particularly by experts from drug treatment, academia and criminal justice fields. Further, the increased strength of advocacy had significant impact upon policy formation. This appeared particularly important in increasing the power of persuasion.

Secondly, in both nations multiple interest groups advocated for change and/or for the reforms. This included the common sectors of the law enforcement sector, political lobbying and drug law reform movements, in addition to the the health sector in Portugal and the non-government sector in Australia. Critical to the adoption of the reforms was the support of the law enforcement sector. A further similarity was that arguments raised by interest groups in both nations were complementary, and in the apparent absence of consistent opposition to the reforms.

Finally, entrepreneurs played significant roles in both nations. As exemplified by the experience of Rodrigo Coutinho and David Crosbie entrepreneurs from both nations had first hand experience in drug treatment provision. They fostered links with politicians and senior bureaucrats including Alexandre Rosa and John Perrin, and thus bridged the gap between the political and grass-roots arena. Arguably their grass-roots experience was critical to them becoming believable messengers, and thus to their ability to advocate effectively for both agenda setting and input into policy formulation.

Research
Research had similar roles through promoting learning and providing proposals for reform. In both nations, there was an accumulation of evidence of problems within the criminal justice system before the atypical reforms. It did not appear that research drove agenda setting in either nation, but the accumulation of evidence influenced key
stakeholder views in the years preceding the reforms. This was particularly attributed to the Portuguese parliamentary committee in Portugal, and the ADCA reports, which questioned the desirability of continued punishment of drug users.

Research appeared particularly important in outlining feasible alternatives for reforms. Key pieces of evidence were operational models of the reforms. Models included the Victoria Police Cannabis Cautioning Pilot in Australia, and the Spanish and Italian commissions in Portugal. Arguably, the evidence base about the impacts of these reforms was less critical than the demonstration of their technical and practical feasibility. In particular, the Victoria Police pilot showed that drug diversion had law enforcement support and did not provoke community backlash, and the Spanish and Italian commissions showed a culturally suitable approach.

*Structural arrangements*
Advocacy occurred from outside the sub-system which increased the potential to attract new supporters. Reforms were preceded by advocacy from state jurisdictions in Australia and by the President in Portugal. In particular, there was advocacy by the Victoria Police and the NSW Premier for the diversion initiative, and by the Portuguese President on the need for reform. The President used his unique position in Portuguese society with arguably much success. Alternate venues were also used in policy formulation, namely through the specially devised CNDS in Portugal and the Prime Minister’s Office and COAG in Australia.

*Values*
Political and national values constrained the type of policy that was deemed acceptable. Proposals for depenalisation were deemed unacceptable in Portugal. Similarly, prior to the COAG meeting it was made clear that liberal alternatives such as a heroin trial were off the agenda. Thus, the adopted reforms reflected political and national values. In particular, the Portuguese reform reflected the constitutional emphasis upon rights to health and proportional punishment. In contrast, the Australian reform emphasised primarily the public benefits from drug diversion. Through the emphasis upon reducing drug use and crime it attended to democratic values of common benefit, rather than emphasising the liberal individual rights of drug users. Prime Minister John Howard clearly emphasised that the IDDI represented a chance for drug users, but that it was up to them to take responsibility for their actions.
Proposals for treatment rather than punishment of drug users increased prior to the atypical reforms as dominant values were challenged. In the years preceding the Portuguese reform, the dominance of the drug-free supporters was challenged, particularly after the change of leadership of the SPTT. This encouraged a gradual change of viewpoint within the health sector. Arguably, a key but gradual change in Australia concerned the views of the law enforcement sector on the best means of responding to drug users, and in particular how to incorporate harm minimisation into the practice of frontline policing. Confronting the view that criminal penalties were the only means of responding was, and continues to be, necessary to enable drug diversion to occur. At the time of writing it remained arguable as to the extent of change that occurred. Nevertheless, it appeared that viewpoints changed within two key sectors, which enabled increased advocacy for an alternate position.

Differences
Differences in the process of reform arguably related to how the reforms were formulated and adopted. The Portuguese drug problem was the major protagonist in the adoption of the Portuguese Drug Strategy and the decriminalisation, whereas the primary driver in Australia was political. This had considerable impact upon the roles played by problems, politicians, policy actors, evidence and international conventions.

Crises
The drug problem had a greater role in agenda setting and policy formation in Portugal, through increasing public and political concern, and thus setting the agenda for reform. Further, Casal Ventoso spurred advocacy for a more humanistic response and thus for a paradigmatic change. In contrast, the heroin overdose crisis in Australia spurred advocacy for heroin trials and injecting rooms, not for diversion. This was nevertheless important since it heightened attention to the drugs issue, and due to the federal opposition to such proposals created an opportunity in which drug diversion became a more acceptable solution. Thus, in Australia the heroin overdose crisis increased the potential for political acceptance of the IDDI, while in Portugal the crisis was a key protagonist in setting the agenda for reform and in changing societal viewpoints on drug users.
**Political influences**

Politicians had a greater role in agenda setting and policy formulation in Australia, controlling who had access to policy formulation, their roles and the final framing of the reforms. The political desire to counter-mobilise the drug law reform push, led to the placement of “the heroin issue” on the COAG agenda. This therefore created the opportunity to advocate for a national drug diversion framework. In the lead up to the COAG meeting it appeared drug diversion became the one proposed solution. In contrast, politicians in Portugal were encouraged through concerted advocacy to use an evidence-based approach to devise a solution to the Portuguese drug problem.

Policy formulation in Portugal involved a broad array of actors involving the specially devised CNDS, politicians from all parties and the public. That said the development of Law 30/2000 involved a much smaller group of actors, primarily Socialist politicians, and thus reflected a political design. Policy formulation of the IDDI was conducted by a small, closed group of policy makers consisting of bureaucrats, the Prime Minister’s Office and some members of the ANCD.

Conflict and persuasion had arguably greater impact on the development of the IDDI than decriminalisation. Consensus decision making had substantial impact in the development of the IDDI through two key decisions: the advocacy of the ANCD for drug diversion rather than zero tolerance; and the advocacy of NSW Premier Carr and Victorian Premier Kennett for non-compulsory, rather than compulsory drug diversion. In contrast, the development of Law 30/2000 was marked by partisan decision making. This was particularly through bypassing the parliamentary right for veto/input into the development of the law. In contrast, the adoption of the decriminalisation and the IDDI were non-politicised.

Policy makers argued that the adoption of decriminalisation required strong political commitment to withstand national and international criticism. The decision to proceed with decriminalisation was attributed to the presence of a number of strong political leaders, and the belief that this decision was both evidence-based and had societal support. In contrast, the decision to adopt the IDDI was seen as necessitating lesser leadership.
Research

Research had differing impacts upon policy formulation in the two nations through the mechanism and timing of input and the type of data used. Critically, the option of drug diversion had been mapped out by ADCA in 1995-1996, many years prior to the consideration of the IDDI. It was later raised as a counter to the proposition of increased drug law enforcement and used to demonstrate how drug diversion could be more effective. The prior filtering through of the reasons and benefits of drug diversion appeared important in persuading the key stakeholders to support the drug diversion proposal.

In contrast, in Portugal policy proposals emerged following the identification of the problem. It was therefore as noted by Brendan Hughes “a response that is designed for the Portuguese setting” [7]. The solution of decriminalisation was one of a few possible options including depenalisation and was perceived to offer the most effective option, within the constraints of the time. This was quite similar to a rational approach to policy making. The expert recommendations were subsequently incorporated into the national strategy. The role of research in the development of Law 30/2000 was more controversial, with the development of the CDTs seen as either a dogmatic solution or derived through a smaller evidence-based approach.

A key difference concerned the role of evidence in the design and implementation of the reforms. Research from Australia provided “best practice” guidelines to maximise the effectiveness of drug diversion and outlined the practical rationale and potential benefits from drug diversion. In contrast, notable differences in the development of decriminalisation were the focus upon the ethical and cultural rationales for reform, and the absence of guidelines as to how to implement the reform. Such research did appear to guide the design of the IDDI framework, however it was questionable the extent to which it guided the design of the programs themselves. Variable implementation was arguably inevitable in the federal context of Australia, but it was also clear that many programs did not follow best practice, which arguably contributed to the diversity of responses and outcomes.

Policy actors

Policy actors influenced the type of arguments used for reforms and the definitions of the problems. In Portugal the primary interest group advocating for change was the health sector who argued for the rights of the drug user, and thus advocated to
humanise the drug user. In contrast, in Australia the primary interest group was the non-government sector, who emphasised the need to change practices. The emphasis was therefore on selling a solution, not a paradigm shift. The other key advocates were the criminal justice sector who in Portugal were a long time supporter of decriminalisation, and argued that drug users should not be in the criminal justice system. In Australia, the criminal justice sector argued that diversion offered a more pragmatic solution, a means of increasing the efficiency and improving health and criminal outcomes. The latter argument therefore emphasised a change in the criminal justice process, while the former emphasised a change in law. Finally, it should be noted that the health sector was seen as a “reluctant partner” in the IDDI, and it mainly advocated against compulsory treatment. This was notably different to policy development in Portugal, where not only were the health sector the chief advocates, but prior to the heightened political environment there were no obvious opponents to decriminalisation.
Table 7: Similarities and differences underlying atypical drug policy reform in Australia and Portugal

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<thead>
<tr>
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<th>Similarities</th>
<th>Differences</th>
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<tr>
<td>Crises</td>
<td>Heightened media attention</td>
<td>Visibility – greater visibility in Portugal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Type of problem – health and human rights (Portugal) or criminal justice efficiency (Australia)</td>
</tr>
<tr>
<td>Research</td>
<td>Accumulation of evidence</td>
<td>Response by politicians – greater receptivity to evidence in Portugal</td>
</tr>
<tr>
<td></td>
<td>Filtering ideas</td>
<td>Type of evidence</td>
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<tr>
<td></td>
<td>Providing option(s)</td>
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<td></td>
<td>Evidence of models</td>
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<tr>
<td>Policy actors</td>
<td>Enlarged circle of actors</td>
<td>Dominant advocates: Non-government and law enforcement (Australia) and health and law enforcement (Portugal)</td>
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<td></td>
<td>Advocacy by multiple interest groups</td>
<td>Arguments: to humanise drug user (Portugal) and provide practical solution (Australia)</td>
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<td></td>
<td>Complementary arguments</td>
<td>Higher public involvement in Portugal</td>
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<td>Entrepreneurs</td>
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<td>Political</td>
<td>Political opportunity for change</td>
<td>Visibility of discussions – high in Portugal, low in Australia</td>
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<td>Desire for simple solution</td>
<td>Breadth of policy actors involvement – broader in Portugal</td>
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<td>Discussion and compromise</td>
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<td>Past paradigms</td>
<td>Questioning of past paradigms</td>
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<td>Values</td>
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<td>Structural arrangements</td>
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<td>Constraint upon policy alternatives</td>
<td>Response to international conventions – more defiant in Portugal</td>
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Application of the theoretical frameworks

The following section looks at the application of the public policy theories, overviewed in Chapter Two, to the incremental and atypical developments: Multiple Streams (MS); Advocacy Coalition (AC); and Punctuated Equilibrium (PE). It examines how the theories make sense of drug policy developments in Portugal and Australia, and the strengths and weaknesses of each theoretical framework. Through doing so it seeks to determine the adequacy of existing theoretical frameworks for understanding drug policy development. Such a judgement is based upon the ability of the three theories to explain the similarities and the differences underlying the incremental and atypical reforms.

Multiple Streams

Incremental reforms in Portugal and Australia can be attributed though Kingdon’s (1984) theory of Multiple Streams (MS) to policy making dominated by the sub-systems. In particular, incremental reform is due to either the lack of opportunities for reform or failure to link the three streams of problem recognition, political receptivity and a policy proposal together. The absence of a perceived problem in Portugal and low level of political attention in both nations could therefore have minimised opportunities for atypical reform. In contrast, the period preceding atypical reform involved a confluence of events: heightened attention, perceived problems, political receptivity and the accumulation of evidence on the need for reform.

Decriminalisation and the IDDI could be attributed though MS to different modes of agenda setting, namely a problematic public health crisis and a politically propitious event. A major factor in the development of decriminalisation was the severity and visibility of the drug problem in Casal Ventoso: a “problem window”. In contrast, the primary factor in the development of the IDDI appeared the Prime Minister’s desire to introduce a counter to the drug law reform movement: a “political window”. As predicted by MS the confluence of events enabled the coupling of the streams by policy entrepreneurs, particularly David Crosbie and João Goulão, who not only linked the streams, but encouraged politicians to adopt their definition of the problem – as a drugs/crime problem and human rights problem – and thus shape the desired solution.
From the perspective of MS, the development of the IDDI was aided by the prior development of the ADCA proposal for a national drug diversion framework and discussions within the policy community on drug diversion. At the peak of advocacy by the drug law reform movement (for decriminalisation, heroin trials and safe injecting rooms) heroin was placed on the agenda for the COAG meeting. This created a narrow political opportunity to advocate for drug diversion. A swift response by David Crosbie encouraged coupling of the streams, attaching the pre-developed solution to the political problem. According to MS, such a solution was likely to succeed because the solution was malleable and fit the Tough on Drugs principles.

MS contends that political windows are more likely to lead to doctrinal solutions due to the need for proposed solutions to fit political mandates (Zahariadis 1999). The development of the IDDI supported this to some degree. The initial “zero tolerance” proposal by the Prime Minister’s Office was a doctrinal solution. However, the resulting reform – IDDI – was not a doctrinal solution. The approach, while fitting the Tough on Drugs principles, appeared guided by the ADCA submission and also by input from the ANCD and bureaucrats. It was therefore evidence-influenced. That said, drug diversion was unlikely to have been adopted were it not able to fit the rhetoric of Tough on Drugs, since this increased the likelihood of political compromise. From this theory, the successful coupling of the streams relied upon a pre-developed solution, particularly one with proven technical feasibility, a persuasive entrepreneur and swift response.

In contrast, the opportunity for reform in Portugal commenced as the drug problem gained increasing public and political recognition. Numerous entrepreneurs were critical in drawing attention to the problem and advocating a more humane response. Policy makers argued that the appointment of José Sócrates as Minister Adjunct to the Prime Minister provided an opportunity to link the problem and political streams. Entrepreneurs, particularly João Goulão, responded swiftly to his appointment, through advocacy and the use of visits to Casal Ventoso, which as predicted by MS, can facilitate the adoption of the desired problem definition. However, there was a critical difference between the development of the IDDI and decriminalisation, since all three streams were not linked in the latter.

Major challenges to the application of MS included the linkage of only two streams and the relatively long span between problem detection and response. Kingdon (1984)
asserted that politicians were almost certain to avoid the evidence-based approach used to canvass policy alternatives in Portugal. Doing so was deemed riskier since it might force politicians to adopt a politically undesirable solution. Nevertheless, MS had considerable application to the development of the CDTs where the heightened opposition and calls of being “soft” (a political problem) might have encouraged the application of a modified version of the Spanish approach, a pre-developed solution.

**Advocacy Coalition**

Sabatier and Jenkins-Smiths’ (1999) Advocacy Coalition Framework (AC) contended that since it necessitates challenge to and change in core values, atypical policy change was extremely rare. Thus, incremental reforms in Portugal and Australia could be attributed to the dominance of coalitions within the sub-systems, and the presence of fixed normative values regarding the drug problem and strong belief in the policy goals: harm minimisation and drug-free. Such values according to AC would have filtered out counter research, thereby encouraging path dependence.

The AC suggests two possible routes for obtaining atypical reform. The first involves increased dominance of a minority coalition through many years of policy-oriented learning, followed by a non-cognitive change and mobilisation to obtain a dominant coalition. The second involves policy-oriented learning followed by the formation of temporary or permanent coalitions. The former provided a good description of activities in Portugal, but neither appeared to have occurred in the development of the IDDI. Accordingly, this theory suggested that decriminalisation ought to be viewed as a major change, whereas the IDDI represented an incremental reform to practices (secondary beliefs).

For AC the adoption of decriminalisation could be attributed to a change in the dominant coalition, and thus views on drug users over a period of about a decade. In the early 1990s, two coalitions could be identified in Portugal, the dominant abstinence coalition and minority harm reduction coalition. Towards the end of the 1990s advocacy by the harm reduction coalition increased due to non-cognitive disruptions to the sub-systems, through the election of the Socialist Party, and changes in leadership. In particular, the appointment of members from the harm reduction coalition as head of the SPTT and Projecto VIDA increased the potential to advocate for a more humanistic response to drug users, and to change the values of members of
the abstinence coalition. It could be argued that the change in opinion, from criminals to citizens needing health and social care, was facilitated by the use of the media, and multiple forums for policy learning. This included the parliamentary committee, CNDS and local conferences designed to confront drug-free values and beliefs on the necessity of criminalisation of drug use. Thus, for the AC the expansion of the harm reduction coalition resulted in a change in core beliefs about the cause of drug use and also to the desirable response (secondary beliefs). Decriminalisation was adopted because it fit harm reduction values. This was supported by the assertion of Alexandre Rosa: “when we decriminalise the consuming of drugs we are wanting to have a harm reduction approach” [5].

In contrast, the adoption of the IDDI could be seen through the AC as representing a change in beliefs about “best practices” to drug users, but not core values. One coalition, the harm minimisation coalition, could be identified in Australia. This advocated minimal criminal justice intervention due to the belief that drug use was primarily a health and social problem. Nevertheless, drug use remained a criminal offence. It could be argued that the IDDI developed through policy learning, following vicarious experience and the accumulation of evidence in the 1990s showing that harm minimisation was not, in practice, applied to drug users. Forums, such as the ADCA forum, conducted through a professional environment facilitated such learning. Since there was no evidence that non-cognitive changes impacted upon the development of the IDDI, the AC is likely to contend that the adoption of the IDDI represents the result of policy learning but did not involve a change to core values.

**Punctuated Equilibrium**

Incremental drug policy reform in Portugal and Australia could be attributed through Baumgartner and Jones’ (1993) theory of Punctuated Equilibrium (PE) to two sources: limited opportunities for input into policy making; and the presence of policy images that supported criminal justice responses to drug users. The three theories all emphasised that sub-systems facilitate incremental reform, but PE provided the best explanation for why and how. From this perspective, incremental reform in Portugal and Australia was due to the limited input into the governance structure, consensus-decision making and negative feedback of non-congruent information, problems and ideas. Path dependence was facilitated through a dominant policy image. Such
features, especially consensus-decision making, were notable features of the governance arrangements in Portugal and Australia. This was particularly evident in Australia where consensus-making facilitated the maintenance of the harm minimisation approach.

The development of decriminalisation and the IDDI could be attributed through PE to strategic advocacy, sidestepping traditional processes to mobilise support for reform through the use of alternate venues, and a new policy image of the drug user. In the years preceding atypical reform, it was evident that dominant policy images in Portugal and Australia facilitated the status quo. Images of drug users were inherently fluid, shifting between illicit drug users as criminal and sick people, however in both nations the former was the dominant image, particularly within the criminal justice sector. Such images could be deemed pervasive due to their links to political and emotive appeal, namely that you must be tough to fight drugs and to be “tough” requires use of a criminal justice response. According to PE poor framing of policy proposals are often critiqued through the dominant image, as was seen in Victoria when the suggestion to decriminalise cannabis was condemned for “giving up the fight” against drugs (Green, S. 1996). By drawing upon PE it can be seen that incremental reform in Portugal and Australia was facilitated not only through the sub-systems, but also through strategic use of diverse structural arrangements and dominant images of the drug user.

PE states that given the context of increasing conflict, atypical change could occur through two means: mass mobilisation of new policy actors or strategic venue shopping and mobilisation of key sectors. The former was evident in the development of decriminalisation and the latter in the development of the IDDI.

Utilising PE the development of decriminalisation could be attributed to the strategic use of public and political venues to mobilise society, and the promotion of a new policy image. Multiple venues were used in Portugal, including the parliamentary committee, public forums and Casal Ventoso, to engage support for a new response. Mobilisation was aided by the presence of persuasive entrepreneurs and positive feedback, namely research on the problematic nature and increasing size of the drug problem and also extensive use of media. In such a context, the crisis of Casal Ventoso could be seen as adopting a symbolic role, used by advocates through its visceral appeal to heighten concern and calls for action. Public health advocates
consistently promoted a new image of the drug user – as a citizen or sick person – as epitomized by the call to “fight the disease, not the addict” (Presidência do Conselho de Ministros 1999). This image was adopted by other interest groups, including the criminal justice sector and politicians, and used to mobilise society and drive the issue of drugs onto the macro-political agenda. The mass mobilisation mimicked what PE termed a “Schattschneider-like mobilization,” producing a wave of enthusiasm for reform (Schattschneider 1960).

Through PE it was evident that the framing of the issue and choice of venue influenced the mechanism of development. For PE the framing of the issue as both a health and human rights problem (citizens who are sick) was important to encourage the use of an evidence-based approach, exemplified through the CNDS (Baumgartner & Jones 1991). Thus, it could be argued that the image encouraged the use of an expert venue for policy formation and political support for the resulting proposal of decriminalisation. It could also be argued that the development of the CNDS served a second purpose; to depoliticise the issue and thus increase bipartisan support. From this perspective, it could be argued that the development and adoption of decriminalisation through an evidence-based, non-politicised manner reflected the image and venue for policy development.

In contrast, the development of the IDDI could be viewed through PE as the result of a strategic venue shifting through closed arenas. During the mid 1990s, advocates including ADCA promoted a new means of seeing the drug user as requiring coerced education and treatment, not punishment. Such an argument appeared to inspire positive feedback through state and territory forums, stakeholder support and diversion pilots particularly by the Victoria Police. Arguably media appeals that “treatment works” and that you can “break the drugs-crime cycle” encouraged a more enthusiastic response to drug diversion.

However, the mainstay of the development of the IDDI was conducted through closed venues. The initial ADCA proposal for a national drug diversion framework was put onto MCDS agenda in March 1997 but the issue did not proceed from there. PE emphasises that some venues may be more amenable to proposals than others. The failure of the MCDS proposal could be offset by advocacy through another venue, namely the Prime Minister’s Office and COAG. PE contends that successful venue shifting requires knowledge and access to alternate venues, and the ability to
manipulate an image to suit the desired venue (True, James, Jones & Baumgartner 1999). The chosen image therefore had to appeal to all state and territory Premiers and the Prime Minister. Advocacy emphasising that drug diversion offered the potential to save lives, be cost efficient and to address community concerns of drug use and crime was arguably critical to the IDDI appeal. Such advocacy highlighted that drug diversion could be effective, without a change in the law.

Crucially PE recognised that proposals might be vetoed due to institutional or group resistance (Baumgartner, Green-Pedersen & Jones forthcoming). It appeared crucial that drug diversion was adopted by Victorian Premier Jeff Kennett in 1998. First, it gave other state and territory premiers the time to observe the ramifications from the change and observe the presence of community and institutional support for drug diversion. Support for such proposals increased significantly following the initial Victoria Police pilot. Second, since the Victoria Police model was non-compulsory this might have given Premier Jeff Kennett greater leverage within the COAG meeting to advocate against compulsory diversion. The closed, but nonetheless non-politicised development of the IDDI, could be attributed from this perspective to strategic venue shifting of the ADCA proposal to the Prime Minister’s Office and COAG.

**Appraising the theoretical frameworks**

The three theories of Multiple Streams, Advocacy Coalition and Punctuated Equilibrium provided insight into incremental and atypical drug policy change in Portugal and Australia. Their explanations showed some differences, but the theories were in the main complementary. The following section examines their strengths and weaknesses in their application to the atypical drug policy reforms.

**Multiple Streams**

MS had considerable utility for understanding the agenda setting process, particularly the importance of a concurrence of events, entrepreneurs and the distinction between the modes of agenda setting: problem versus political. The major limitation with the theory was it appeared to oversimplify the policy formulation process, particularly the emphasis upon pre-developed solutions and doctrinal versus consequential framing. That said it had greater application to the adoption of the IDDI. Key strengths to this
theory were the emphasis upon policy windows and hence particularly opportune times for reform. Moreover, PE and AC placed less emphasis upon political framing and the need for entrepreneurs to meld proposals to the political climate, something that particular resonance with the reforms in Portugal and Australia.\(^{30}\)

It is questionable whether the applicability of this theory to understanding drug policy development is inherently limited by the contention that solutions must be developed prior to the problem emerging. In more recent years the theory of Multiple Streams has been amended with the assertion that ‘windows of opportunity’ may have varying lengths (Zahariadis 1999). This is a significant change since the evidence-based approach to the development of decriminalisation followed a long window of opportunity. The Portuguese reform took almost 18 months between agenda setting and adoption of the national drug strategy, and even longer till the adoption of Law 30/2000. Sharp (1994) found that US drug policy was almost permanently on the political agenda, which suggested that perhaps long windows were not unique. Based on this finding, Zahariadis (1999) has suggested longer windows might facilitate a more problem solving approach. A more nuanced approach to how policy formulation impacts upon implementation and outcomes might enhance the application of this theory to understanding drug policy development.

**Advocacy Coalition**

The major strengths of the AC were the attention to values, the recognition that drug policy was often based on commonsense and beliefs, and the contention that paradigmatic changes were likely to take substantial time, requiring long periods of policy learning. The emphasis upon policy learning and modes of learning was particularly apt, including in particular the role of professional forums in reducing potential for normative responses to research and new ideas. Moreover, the AC had great application to understanding the role of leadership changes in facilitating changes within sub-systems.

Limitations remained in understanding the role of institutional beliefs in resisting or supporting changes to core values. Consequently, the AC was a poor model for explaining the process of IDDI development. A key concern was the contention of AC

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\(^{30}\) For PE while a shift in dominant images may be facilitated by consideration of political climate, this theory asserts that is less critical for successful advocacy. Instead policy advocates can reduce the likelihood of political framing by the use of alternate, non political venues.
that professional beliefs were only important if they conflict with policy core beliefs, something that Sabatier and Jenkins-Smith (1999, p. 135) asserted “happens very infrequently.” There was considerable evidence that the dual objectives, of harm minimisation and enforcing the criminal law, place law enforcement officers in Australia in a dubious role, one in which the core value of harm minimisation has often been neglected (Beyer, Crofts & Reid 2002; James & Sutton 2000). It was difficult to apply AC to such a situation. If the stance was adopted that law enforcement officers followed a different set of beliefs (not harm minimisation), then AC provided limited guidance as to how policy formation proceeds in this situation.

However, the contrasting position – that professional differences do not matter – was still problematic for understanding the development of the IDDI due to two reasons. First, AC asserted that advocacy occurred on the basis of coalitions, but the advocacy for drug diversion appeared to have primarily been driven by the non-government sector. Second, and most problematically, the initial push for drug diversion through the MCDS suggested that efforts were undertaken to form consensus and modify practices without resorting to political intervention. To contend that the subsequent adoption through the Prime Minister’s Office and COAG was “consensual” therefore appeared unsupported by the evidence. Without a better understanding of how institutional differences influence values, the AC appeared poorly suited to describing the process of drug policy reforms. Nevertheless, the core contention of the AC, particularly the distinction between major and minor reform, bore resonance. Hence, future attention to this theory appears warranted.

**Punctuated Equilibrium**

The PE was able to explain many of the features of both the incremental and atypical reforms. It highlighted that policy images were crucial in garnering support, through the use of images, venues and either mass or strategic mobilisation. The primary strength was the focus upon how contemporary circumstances were utilised to produce reform. Thus, from this theory outcomes were not determined by circumstances. Nor was advocacy determined by values. Instead, policy actors in both nations used different circumstances to produce similar advocacy, hence facilitating expert input into both reforms. This theory was primarily useful since it helped to link the process to the outcomes, something that MS and AC were less equipped to do.
The main limitation was that the theory appeared to underestimate the role of contemporary events in creating opportunities for strategic advocacy. While PE contended that political circumstances and problems were useful tools for shaping advocacy, these factors appeared critical in the likelihood of successful venue shifts. Without the severity and visibility of the drug problem in Casal Ventoso it was hard to imagine that the new image of the drug use or value of harm reduction would have been so enthusiastically embraced. Similarly in Australia, in the absence of the political context of the push for drug law reform it appeared unlikely that heroin would have been on the COAG agenda, or that the Prime Minister would have embraced drug diversion, which as Alex Wodak so eloquently summed up “flies in the face of being Tough on Drugs” [3]. That said, PE appeared to provide the best explanation of why the Portuguese and Australian reforms were pragmatic, and indeed why one reform was more evidence-influenced.

**Neglect of cultural beliefs**

A key limitation with the three theories was the neglect of the role of cultural beliefs, an argument that was supported by John (2000). The theories recognised that structural arrangements, sectoral dominance and legislative processes were influenced by national contexts, however it was necessary to also consider how cultural beliefs influenced policy development. MS is the main theory to consider community beliefs, since it recognises that a change in the “mood” may increase receptivity to proposals. National beliefs were of critical importance to understanding the policy developments in Portugal and Australia. In particular, the differences in national beliefs helped explain the chosen framing of the problem problems and resulting solutions.

While both Portugal and Australia were liberal democracies, the former placed greater emphasis upon liberal values and the human rights of citizens. Australia, in contrast, placed greater emphasis upon democratic values. Accordingly, the adoption of decriminalisation and the IDDI could be seen as reflecting these values. In Portugal, the primary objective of decriminalisation was to recognize the human rights of the drug user. It was therefore deemed society’s responsibility to meet the rights of drug users to health and social care. While decriminalisation was also argued to increase the potential for social cohesion, the primary emphasis was upon liberal values. In contrast, the primary objective of the IDDI was to encourage individual responsibility for drug use. While opportunities for drug education and treatment were provided,
these were conditional on a social contract, such that the individual drug user was deemed responsible and accountable for their drug use. By emphasising responsibility, the IDDI emphasised that drug use was the result of individual rational choice. This was consistent with the democratic values perspective outlined by Parkin (1998).

Attention to cultural beliefs helps explain why decriminalisation was seen as a plausible solution in Portugal and was therefore able to be adopted with minimal conflict. In contrast, similar proposals in Australia for cannabis decriminalisation met with heated debate. Thus, these factors point to the need for theories of policy development to consider not only the influence of the image and venue, but also cultural values and traditions. Cultural beliefs are not fixed, but images or proposals that run counter to such beliefs are unlikely to be deemed acceptable. This appears a primary reason why US drug policy has remained on the political agenda. As Sharp (1994, p. 14) noted the issue of drugs was readily connected to cultural concerns of the “controllability of youth” and “predatory drug dealers.”

It appears that the role of national beliefs can be incorporated into the theory of Punctuated Equilibrium to enable a more adequate theoretical framework. The theoretical perspectives emphasise that policy advocates should be aware of political rhetoric. The present research concurs, but goes further to suggest that policy advocates should also be aware of cultural beliefs. While this can easily be incorporated into Punctuated Equilibrium, it remains unclear whether Advocacy Coalition can explain the role of community perceptions. The assertion that advocacy is undertaken in accordance with a policy coalition’s values and beliefs, not that of the nation or politicians, appears a major impediment.

**Conclusion**

The public policy theories have shown considerable relevance for understanding the incremental and atypical drug policy reforms in Portugal and Australia. These theories reflect complementary perspectives, including that the development of decriminalisation was aided by a challenge to the values of the dominant drug-free coalition, and strategic advocacy using an expert image to facilitate input into policy formulation. On the other hand, the development of the IDDI was aided by the
strategic venue shift from one failed venue to a more receptive venue, and entrepreneurial coupling of the streams, in response to a political window.

However, their applications to the cross-national reforms have highlighted that AC and MS provided better explanations for either the Portuguese or the Australian reform. AC and PE provided the best explanations for understanding the development of decriminalisation. In contrast, the development of the IDDI was best understood through MS and PE. PE was the only theory that was applicable to both reforms, since it focused primarily upon the actions of the policy actors. Pragmatic reforms therefore appear driven by the policy actors, not by the policy windows. Contrasting the theories has illustrated that the implications from the present research about how pragmatic reforms emerge may have been very different, were it not for the cross-national design.
CHAPTER EIGHT: DISCUSSION AND IMPLICATIONS

Decriminalisation and the Illicit Drug Diversion Initiative symbolised momentous events, namely the response to the years of advocacy for more humane and effective responses to drug users. The developments in Portugal and Australia demonstrated that while atypical reform offers the potential for significant changes, it produces variable impacts and outcomes. Moreover, it suggested that some policy making approaches may facilitate more effective policy making and increase the opportunity for more major reform. The following chapter is divided into five sections in order to examine the meaning of these findings, and the practical and theoretical implications for understanding and promoting drug policy reform:

1. Atypical reform: Capitalising upon windows of opportunity
2. Critiquing the policy making process: Portugal and Australia
3. Theoretical implications: Understanding drug policy reform
4. Practical implications: Promoting atypical reform
5. Towards more effective drug policy

The first section draws together the findings from the development of the decriminalisation and the IDDI to show why and how the reforms emerged. The second section critiques the process of development in Portugal and Australia in light of the framing and potential outcomes from the reforms. The theoretical implications of this research for understanding drug policy development are examined in the third section which also revisits the findings from previous studies of drug policy development. The fourth section examines the practical implications from this research for promoting drug policy reform. The final section raises questions as to the future of “effective drug policy making,” and the implications of the inter-relationship between politicians, political venues and evidence. It concludes by reflecting upon the analytical process utilised in this research.
Atypical reform: Capitalising upon windows of opportunity

The thesis has demonstrated a number of key drivers of drug policy development in Portugal and Australia, the most important of which were problems, evidence, politicians and policy actors. In both nations the atypical reforms were preceded by the accumulation of evidence, increasing problems and many years of advocacy that questioned the need for and desirability of the traditional criminal justice response to drug users. The fundamental distinction between incremental and atypical reform was that the latter represented increased receptivity to ideas and proposals.

Policy actors increased opportunities to advocate for reform and highlight problems, evidence and new directions through the use of strategic advocacy; however such advocacy was more likely to give rise to atypical reform during the emergence of policy windows. Decriminalisation in particular was proposed at least 30 years prior to its development, yet was deemed unachievable prior to the events in 1997-1998 and emergence of windows of opportunity. This was because, as contended by the public policy theorists, policy development was not driven by a rational process, but required challenge to perceptual filters and restricted venues, both of which reduced the capacity to influence policy making.

Policy windows – problems or political – increased the possibility for change, through increasing receptivity to the actions of policy advocates. They therefore provided the opportunity to highlight previously ignored problems, proposals and ideas and to set the policy agenda. While the accumulation of events and circumstances facilitated atypical reform in Portugal and Australia, decriminalisation and the IDDI came about fundamentally due to the actions of policy advocates and capitalisation upon windows of opportunity. They used such opportunities to persuade politicians on the need for or desirability of alternative responses to drug users.

This thesis demonstrated that the likelihood of and the outcomes from reform were influenced by both the policy window and the process of capitalisation. The following section examines the roles of the policy windows and the process of policy formulation in the development of decriminalisation and the IDDI.
**Problem and political windows**

Decriminalisation and the IDDI developed following different instigators, namely a problem and political window, which facilitated the development of varied solutions. The “problem window” in Portugal created a substantial opportunity for reform and indeed for major change. The visibility and perceived enormity and depravity of the crisis of drug abuse in Casal Ventoso increased the opportunity for a political response to the drug problem. Moreover, it facilitated the framing of the problem as a health and social issue, which in turn, enhanced expert control over agenda setting and policy making. Perhaps most importantly the crisis increased the potential to question and to challenge the status quo on the necessity and effectiveness of the criminalisation of drug users. Thus, the presence of a major drug problem increased the potential for paradigmatic change.

In contrast, the development of a “political window” in Australia created a more constrained opportunity for reform. Pressure on the Federal Government to respond to the increasing drug law reform movement increased the potential for a political response to the drug problem by the Prime Minister’s Office. However, political imperatives meant any reform arising in such a context had to “fit” within the political mandate of “Tough on Drugs.” It therefore constrained the type of response that could emerge. Political imperatives had considerable impact upon the development of the IDDI most notably through the initial doctrinal proposal for “zero tolerance” towards drug users. They also restricted the capacity for expert involvement in and influence on policy making. As Professor Ian Webster noted political ideas dominated discussions and proposals:

> It was amazing the primitive, political conservative ideas were constantly being put forward and had to be prevented from dominating; unrealistic, stupid ideas.

> Ian Webster – Health Professional/ANCD member – [9]

This decreased the potential for policy actors, especially experts, to set and frame the policy agenda and to challenge the status quo. In theory the emergence of different policy windows could have led to a more doctrinal response in Australia and a more consequential response in Portugal, as predicted by Zahariadis (1999).

**Importance of policy formulation**

While the emergence of such opportunities facilitated the receptivity to reform, the actions of policy makers, especially entrepreneurs, had considerable impact upon the
process of capitalisation and thus the framing and outcomes from the policy windows. There were a number of notable similarities underlying the process of policy formulation, facilitated primarily by the actions of policy advocates. The following section overviews the actions of policy actors in the development of the atypical reforms.

**Entrepreneurs**

Strategic advocacy by policy actors, particularly entrepreneurs, facilitated the consideration of evidence in both nations. They promoted expert images and solutions, used new venues and mobilised support. This increased receptivity to evidence and encouraged input into policy formulation, particularly through building relationships with influential politicians. In Portugal the use of multiple entrepreneurs, promotion of expert images of the drug user as sick, and the mobilisation of support through multiple venues facilitated the establishment of the CNDS, and the adoption of the expert recommendations for decriminalisation. Similarly, the development of the IDDI was aided by the presence of entrepreneurs and expert images, but also by the presence of a pre-developed evidence-based solution. The mobilisation of public or sectoral support facilitated the adoption of evidence-influenced proposals.

Policy actors converted evidence, ideas and contemporary events into a persuasive argument. This was exemplified through the successful advocacy for the IDDI. The evidence from the ADCA diversion studies had filtered through to the Commonwealth government and particularly the Prime Minister’s Office years prior to the development, but as noted by the NSW Government (1999) had resulted in “little action.” While this would later prove essential for increasing the receptivity of key politicians to the notion of drug diversion, the proposal was less persuasive at the earlier period. The power of persuasion increased as community concern rose, as pressure groups advocated for change, and as the law enforcement sector increasingly mirrored the arguments by the non-government sector and showed the political and technical feasibility of the proposal. Thus, strategic advocacy meant both policy windows gave rise to evidence-influenced reforms.

**Negotiation and compromise**

The emphasis upon evidence facilitated expert input into policy formulation, which increased the opportunity for negotiation and compromise. Entrepreneurs in both
nations played key roles in advocating against, and converting “magic bullet” solutions into more complex responses, and thus negotiating and advocating the benefits of alternate reforms. This was clearly indicated through the following quotes about the National Strategy Coordinator José Sócrates and the Prime Minister’s Office:

He had some ideas he wanted to put in the field then he understood that things were not so easy. He thought that substitution treatment would solve the problem. Need psychiatrists, we need social workers working on it and we need methadone and we will lower the problem. I think that he understood that this was not so simple. So he decided to make the Commission.

João Goulão – Health Professional – [3]

The early knee-jerk reaction was to increase law enforcement as a response to this but then a recognition or senior politicians were persuaded that these are young people for whom a law enforcement response alone was inadequate and may actually be dysfunctional.

DC – ANCD – [8]

Thus, the involvement of experts in policy formulation enhanced the potential to counter potentially doctrinal solutions, such as the zero tolerance ideas, and to facilitate the input of evidence. The grass-roots experience and positions of status were critical to how more complex responses evolved.

In conclusion, the atypical reforms – decriminalisation and the IDDI – developed due to the emergence of and capitalisation upon windows for reform. While the type of opportunity shaped the potential for reform, and created the opportunity for a more doctrinal solution in Australia, and a more consequential or substantial reform in Portugal, the actions of policy actors facilitated evidence-influenced policy developments in both nations. The actions of policy actors were therefore critical for why the different policy windows gave rise to similar diversionary responses, particularly the conversion of the zero tolerance proposal into a drug diversion response. The policy actors were the ultimate drivers of the reforms.
Critiquing the policy making process: Portugal and Australia

The following section critically examines the policy making process and strategies used to obtain decriminalisation and the IDDI. Through examining the processes and strategies, it identifies their strengths and limitations, and their impacts upon the framing, mechanism and implementation of the atypical reforms.

Strategies used for policy adoption

It is clear that the development of the decriminalisation was driven by the production of a visceral and emotive image, particularly live footage from Casal Ventoso. This drew attention to the plight of drug users, which increased not only the likelihood of action, but also shaped the type of reform that emerged. The broad group of entrepreneurs including directors from drug treatment centres, a politician and the President himself, were particularly powerful due to their concerted actions. They used their multiple positions of power to mobilise societal support for reform.

The key strength to this approach was the strategic use of contemporary events to mobilise society. Casal Ventoso was used as a tool to promote the new image and paradigm, even taking the National Strategy Coordinator José Sócrates to see and reinforce for himself the drug problem. The use of multiple venues most notably Casal Ventoso and parliament expanded support, mobilised politicians and society, and increased Government’s willingness to “solve” the problem. The use of visual imagery from Casal Ventoso, and the framing of the issue as a human rights and health issue, increased the persuasiveness of the imagery and potential for paradigmatic change. Such a situation could have been framed as an example of undeserving criminals who were a threat to society. Instead, the chosen image stressed that society had neglected the needs of the drug users. Further, policy advocates held to the conviction that decriminalisation was essential for a new, more humane response. The new conceptualisation and paradigm became driving forces behind the advocacy.

Public mobilisation appeared to have three principal benefits. It increased the power to challenge dogmatic beliefs. This was particularly through the bringing together of individuals with different views:
[It] was one of the most pragmatic experiences and the most impressive experiences, logistical, of bringing people together - some from the Left party, some from the Right-wing party… Some Social Democratic, some Socialist. It was really amazing how it was possible to get all these people together.


It increased expert control over framing and images. This facilitated the partnership between experts and politicians – what Alexandre Rosa termed the “marriage” – and the establishment of and support for the recommendations of the expert commission. The ultimate power of mass mobilisation was that it increased the likelihood that politicians would support and adopt the proposed reform. The level of public support that had been generated was a key component of the Government’s decision to adopt the recommendation of the Commission:

I think because the Government felt that it had sufficient public support for such a document, that it wouldn’t loose votes by adopting such a strategy. That was the feeling I got, to be very pragmatic, and also because they also believed in this view. I think that the Government felt that the current world strategy was not working and that Portugal might be a good place in order to test a different way of dealing with the issue.

Alexander Quintanilha – Former head of CNDS – [9]

Accordingly, decriminalisation was seen as a reform driven by society, not by a political party. This was arguably the primary reason why, despite threats, the new Social Democratic Government did not re-criminalise drug consumption.

Finally, in the development of the decriminalisation it appeared that belief in the new direction contributed to enthusiasm and desire to try a new paradigm:

Even though we are not sure that our strategy will work, we certainly need to try something different.

Alexander Quintanilha – Head of CNDS – [2]

The enthusiasm surrounding the reform and belief in the necessity of taking a chance pervaded the interviews conducted as part of this research. There was a strong conviction that drug users needed increased access to health and social care, but that opportunities to integrate or reintegrate would be futile without changing perceptions of drug users. This was arguably why decriminalisation and the new humane paradigm became the flagship of the new Portuguese drug policy. In this regard it appears that mass mobilisation has a number of strengths through facilitating consequential solutions, demonstrating societal support and challenging the status quo.

Mass mobilisation was however a risky approach and was arguably dependent upon the presence of multiple entrepreneurs. The risk of this approach was clear through
the rapid dissipation of enthusiasm following the adoption of the principle of
decriminalisation. This indicated how the power of mass mobilisation can rapidly
decline, contributing to a more politicised situation. It appeared advocacy or
receptivity to advocacy waned following the adoption of the principle, which may
have resulted in the failure to adopt Law 30/2000. The fact that it was adopted was
arguably due to the process of policy development. The expert solution, enthusiasm
and belief in the new direction facilitated the Government’s willingness to adopt Law
30/2000, even as the situation became more politicised. The development of
decriminalisation therefore shows that expert input and challenge to the status quo can
be triggered through the power of mass mobilisation.

In contrast, the IDDI emerged through a very different process, namely through
strategic venue shifting as political receptivity to drug diversion increased. Given that
drug diversion “flies in the face of the rhetoric” of Tough on Drugs, ADCA’s proposal
for drug diversion was unlikely to have been adopted through the Prime Minister’s
Office. This was particularly as the initial proposal by the Prime Minister’s Office
was for “zero tolerance” towards drug users. The adoption of the IDDI was therefore a
masterful piece of persuasion since it not only converted a doctrinal reform – zero
tolerance – into a more humane and potentially more effective response, but was
adopted against the rhetoric of “Tough on Drugs:"

It is probably the centrepiece of the “Tough on Drugs” strategy so it should mean “Tough
on Drugs”, but what it actually does is provides what most people see as the humane
option.

Gino Vumbaca – ANCD – [2-3]

Given this turnaround even those who had concerns over the initiative, have supported
the process:

I think if you’d left it with the knee-jerk you would have had a much more law
enforcement, justice, corrections response. I think what we’ve ended up with is not a bad
mixture given where we could have ended up.

DC – ANCD – [8-9]

There were four reasons why the development of the IDDI became possible. The
presence of a pre-developed evidence-based approach and prior filtering of evidence
and advocacy by ADCA to the Prime Minister’s Office increased the receptivity to the
idea of drug diversion. Further, the pilots showed that drug diversion had technical
and political feasibility. As Superintendent Paul Ditchburn noted the Victoria Police
had trialled and evaluated drug diversion and therefore “had something on the table to
offer” [5]. This demonstrated support of at least some of the law enforcement sector, positive impacts and perhaps most importantly that the proposals were supported, or at least not opposed by the community. Most importantly the likelihood of drug diversion increased due the political pressure for reform and swift capitalisation upon the emerging opportunity. The perceived need to respond increased receptivity to the proposal and enhanced the likelihood of a political compromise by the Prime Minister’s Office.

Finally, the expanded input into policy formulation and roll-out enhanced the potential for a more evidence-influenced model. The involvement of ANCD members in policy formulation played critical roles through counter-mobilising the potentially doctrinal solution, and facilitating the consideration of evidence. Further, input into decision-making in the roll-out of the initiative increased opportunities to challenge views, negotiate and compromise:

Now in the process of the discussion on that, it actually evolved into a much more reasonable outcome than we originally envisaged.


The expanded input into policy formulation was arguably facilitated by the type of arguments put forward, on the necessity of an expert solution. The development of IDDI shows that even ideas that are counter to rhetoric can have considerable power if they are demonstrated to be evidence-based, technically and politically feasible, and can address community concerns. This is particularly if they are advocated by grass-roots entrepreneurs.

Venue shifting into a political opportunity increased the potential for swift adoption and provision of resources. It capitalised upon the increased receptivity but also the need for a less doctrinal solution. The adoption of an approach that was against the rhetoric and the allocation of significant funds by the Prime Minister’s Office was as summed up by David Crosbie “really innovative and really unheard of” [10-11].

However, such an approach also had some limitations. The political opportunity through the Tough on Drugs strategy constrained the type of response that could emerge. The need to at least appear “tough” meant it would not have been possible, in the arena of the Prime Minister’s Office, to have challenged the necessity of criminal penalties for drug users as was done in Portugal. There was thus less opportunity for paradigmatic change. Further, the strategic venue shift meant the IDDI was obtained
in spite of a lack of consensus across the drug policy sector, most notably concerns by the health professionals. Most importantly, the development through the Prime Minister’s Office meant that the initiative had to fit the political mandate. While the stated purpose of drug diversion and indeed the first philosophical principle of the ADCA (1996) drug diversion framework was harm reduction, the IDDI represented a compromise of the conceptual objectives. Advocating for and obtaining drug diversion through the Prime Minister’s Office necessitated that harm reduction and humanism were neither the principal objectives, nor conceptual rationales of the IDDI.

**Impacts**
The introduction of the decriminalisation and the IDDI resulted in a number of positive changes in both nations. In particular, the criminal justice system is now used to funnel many drug users to drug education and treatment. Evidence demonstrated that the reforms may have reduced the stigmatisation of drug users, enhanced cooperation between the criminal justice and health sectors, and increased the humanity of responses. Further, the reforms may have increased treatment attendance and completion, and improved health and social wellbeing. Both reforms therefore appear to have enhanced the capacity of the criminal justice system to respond to drug users, and contributed towards more adaptive responses.

However, this research suggests that while both reforms ought to be viewed as more adaptive responses, due to the process of policy making in Portugal decriminalisation has greater capacity to be effective. This is not to imply it is without fault, since Chapter Six showed the limited research on best practice and failure to release evaluations affected the implementation of the reform. Moreover, it remains unclear whether decriminalisation has contributed towards increased cannabis use. Nevertheless, this research contends that the process of policy making in Portugal was more effective and more likely to facilitate effective reform than that undertaken in Australia.

There are four principal reasons for the contention above, three of which relate to the policy making process. First, policy makers exhibited greater consensual support for decriminalisation than the IDDI. In particular, many health professionals viewed the IDDI as more of an imposition, since it prioritised coerced treatment over voluntary
treatment. Second, there are concerns over the presence of unrealistic objectives in the IDDI. In particular the adoption of the IDDI through Tough on Drugs meant the prime objective was use reduction, something deemed unrealistic for many health professionals. The conflicting objectives appeared to have impacted upon the implementation and might have reduced the potential effectiveness of the reform. Many studies noted the need for clarity of objectives and that use reduction was often an unrealistic objective (McLeod Nelson and Associates Pty Ltd 1999; Morrison & Burdon 2000; Premier's Drug Advisory Council 1996). In contrast to the optimism expressed over decriminalisation, policy makers expressed considerable reticence over the capacity of drug diversion to be effective.

Third, there was far more emphasis upon evidence-base and evidence-based learning in Portugal than Australia. This appeared to reflect the policy formulation process through a problem-led versus politically-led approach. While evidence influenced the development of both reforms, the development of the IDDI was more suggestive of policy-based evidence and thus selective use of evidence (Marmot 2006). This was due to the modification of the ADCA drug diversion model such that the emphasis was upon abstinence and reducing drug use and crime, rather than harm reduction and initiating the process of behavioural change. The reduced emphasis upon public evaluations or collection of data mirrors the focus upon policy-based evidence, rather than evidence-based policy. Due to the political imperatives under which the IDDI was adopted and need for the reform to appear “tough,” problems and issues with implementation in Australia, particularly over the capacity to achieve use reduction or the need to evaluate impacts, appear less likely to be addressed.

While this thesis contends that the similarities in policy formulation, namely the emphasis upon expert images and expert input into policy formulation, facilitated the emergence of evidence-influenced reforms, the reduced consensus about the merits of the initiative, conflicting goals and greater emphasis upon policy-based evidence reduced the capacity of the Australian reform to produce effective outcomes. Closer examination of the process of policy advocacy provides insight into why the process of development in Australia constrained the capacity for effective reform. The research contends that the potential outcomes of decriminalisation and the IDDI were less constrained by the political versus problem-led reforms, but rather by differences in the methods and persuasiveness of policy advocacy. A key difference in the
advocacy by policy actors was the use of mass mobilisation versus strategic mobilisation.

**Mass versus strategic mobilisation**

While both reforms involved the promotion of expert images and expert input into policy formulation the Portuguese reform involved the use of mass mobilisation whereas the Australian reform used strategic mobilisation. As noted earlier mass mobilisation was critical for why the Portuguese reform was more able to build and demonstrate community support for reform. Prior to the atypical reforms the community in both nations were perceived to oppose the proposals, but mass mobilisation and the actions of policy actors in Portugal facilitated receptivity to decriminalisation. In contrast, there was fear in Australia that the public wanted politicians to be “Tough on Drugs” and would not therefore support drug diversion. Given that the community were seen as a perceived constraint upon politicians in Australia the use of strategic mobilisation in Australia was arguably less useful for obtaining drug diversion. Strategic mobilisation was less able to demonstrate community support and was therefore a less powerful tool for persuasion. It appeared that the perceived community opposition meant that obtaining reform, particularly a “harm reduction” reform, would have been near impossible; this contributed to the adoption of what many perceive as unrealistic objectives.

The difference played a considerable impact upon political receptivity to the proposals and in particular upon the role of expert recommendations. This thesis contends that the major constraint upon the development of the IDDI was not the political venue per se but community perception. The actions of the Portuguese policy advocates facilitated a more expert-led development. This arguably contributed to the differing roles of evidence, namely the more evidence-based policy in Portugal and more policy-based evidence in Australia.

**Paradigmatic versus practical change**

The present research suggests that the most fundamental factor that shaped the potential for effective reform was not the policy making process per se, but instead the objectives of the reforms. The fact that Portugal obtained a paradigmatic shift and a new conceptualisation of the drug user was a significant difference from the Australian reform. From a harm minimisation perspective it is clearly more desirable
than continuing to operate within the criminal justice system, and thus maintaining the duality of drug users as criminals and people with health problems. Moreover, as the following section will show there are a number of reasons to suggest that it has created the capacity for a more adaptive and hence potentially effective reform.

The conceptual basis for the use of diversionary responses to drug users is well supported: treatment instead of punishment, partnerships and pragmatism. The IDDI like the majority of diversionary responses treats drug use as fundamentally a criminal justice issue through the criminal mindset (Bull 2003; EMCDDA 2004, 2005b; Sondhi, O'Shea & Williams 2002). Portugal remains one of the few nations to not do this. The emphasis upon humanising the drug users is deemed to facilitate a better response to drug users, something that appears difficult within the confines of the criminal justice system. Room (1991) highlighted the importance of a shift in the conceptualisation of alcoholics, from seeing alcohol as the source of evil, to the distinction between alcoholics and “consumers.” He noted that this may have normalised the consumption of alcohol such as to encourage more productive responses. Such a change has not, he noted, occurred with illicit drugs. The necessity of shifting societal perceptions of drug users was the driving focus of the Portuguese approach:

To change the law was a way of changing the social views about drug use and drug addiction. If the law says that to use drugs is a crime, of course the approach of common people to drug users would be negative. If we start to say that to use drugs is not a crime, but a problematic thing, a health problem, then the problem might change.

Vitalino Canas – Former National Coordinator – [2]

Public policy theories, particularly Advocacy Coalition, support the view that the attainment of such an objective will facilitate more effective reform. The contention of Advocacy Coalition that atypical reform can give rise to minor or major (paradigmatic) reform has considerable resonance to the current research. From this perspective changes to secondary beliefs may give rise to minor change, but changes to core beliefs may give rise to major change. The thesis suggests that the IDDI has and may continue to change practices of criminal justice officials (secondary beliefs), but through maintaining conflicting images or perceptions (core values) of the drug user as a criminal, sick or “morally deviant” person drug users are more likely to be treated as criminals. While this is arguably more adaptive than the former situation, the maintenance of conflicting images is likely to retain dissonance in the criminal
justice response to drug users. Many drug users will still be stigmatised, receive criminal records and be punished as criminal offenders.

Further, it is contended that such dissonance may reduce the potential for effective policy. Roberts (1998) noted that even radical shifts to practices have been doomed to fail or at least have reduced impact. To be adaptive and effective reforms need to change practices and also the system. In this case changing how the criminal justice system addresses the issue of drug use is preferable to tinkering in a piecemeal manner. Since it challenged criminal justice and societal views of the drug user, the Portuguese approach was therefore a more effective form of policy making.

The difference in objectives came about fundamentally due to the aims of the policy advocates: to change practices only, versus to change both views and practices. As exemplified through the following quotes, while the objective of decriminalisation was to change perceptions, the IDDI aimed to provide a new “tool”:

I think that decriminalisation was very, very important. It was a very, very important issue in the national strategy. Why? Most people moralise, but with this decision we give one signal to society, to the justice, to the police “hey they are not committing a crime.”
Alexandre Rosa – Former National Coordinator – [14]

It provides police with another option in their kit bag that they can use.
Frank Hansen – Senior Law Enforcement Officer – [10]

While both reforms enhanced the capacity to change criminal justice practices, the Portuguese approach enabled drug users to receive treatment and education in a less hypocritical situation; as Almeida Santos said “to have a hypocritical attitude I think it is not a good place to go on” [4]. The notion of a hypocritical system was the primary reason that Portuguese did not want to adopt a scheme like the IDDI, since it maintained dissonance within the system.

While the introduction of the IDDI has been noted as having a gradual influence upon attitudes towards drug users the public policy theories, particularly Advocacy Coalition, suggest that the outcomes from this reform, and indeed from most diversionary reforms, may be limited due to the failure to shift and challenge core values. Many evaluations from drug diversion schemes highlighted that in spite of strong conceptual support academics frequently questioned whether drug diversion, particularly the dominant model, was in fact making a significant impact (Bull 2005; Clancey & Howard 2006). The evidence-base on diversion programs was limited and generally provided mixed support. As Spooner et al. (2001, p. 291) noted “while key
informants generally supported these strategies, there has been insufficient evaluation research for firm conclusions to be made about their value.” From the perspective of the Advocacy Coalition programs it can be argued that while dissonance remains the impacts of the dominant diversionary models will continue to be limited. Even staunch opponents to drug law reform such as Brian Watters recognise the detrimental and powerful impact of the “criminal” label:

You can’t have a society where law and order and politicians go in a different direction, they beat that drum pretty loudly. Unfortunately rightly or wrongly it makes some of the perceptions of the drug using man a very negative concept.

Brian Watters – Former head of the ANCD – [10]

The current research therefore contends that dissonance will inherently reduce the capacity for effective reform. This is not to imply that the dominant diversionary model is ineffective. To the contrary, it provides a more adaptive response. Yet, the capacity for effective reform will remain limited unless the dissonance and hypocrisy is addressed. On this note, it was the capacity for paradigmatic change that was most advantageous in the Portuguese drug policy making.

Theoretical implications: Understanding drug policy reform

Despite different national contexts there were considerable similarities in the process of policy development in Portugal and Australia, particularly in policy formulation. This highlights that different opportunities may give rise to similar outcomes. There is therefore a need to study and learn from the process of policy formulation. The following section examines the adequacy of the theoretical frameworks for understanding drug policy development. It then re-assesses the drug policy developments outlined in Chapter Two in light of the theoretical frameworks.

Resonance of the theoretical frameworks

The thesis has shown that the public policy theories of Multiple Streams, Advocacy Coalition and Punctuated Equilibrium had considerable resonance to the drug policy developments in Portugal and Australia. The theories provided insight into not only how drug policy develops, but also how the process impacts upon the potential for and framing of reform. As highlighted in Chapter Seven, while the theory of Multiple Streams provided a useful distinction between and means of understanding problem and political opportunities for reform, the actions of policy actors were critical for understanding whether and how opportunities were capitalised upon, and thus the
framing and implications of the policy window. This suggests that the Multiple Streams theory which asserts policy implementation is primarily framed by the window for reform is too simplistic. Punctuated Equilibrium provides a more nuanced analysis of the process of policy formulation and its impacts upon policy development. The adoption and outcomes of decriminalisation and the IDDI were clearly facilitated by the methods and strength of strategic advocacy.

**Missing element: national beliefs and contexts**

The research highlighted that policy actors operate within a set of constraints and facilitators. These include the venue and types of policy windows. The role of national contexts, particularly past experience and cultural beliefs, is another important driver, one that is neglected by public policy theories.

This thesis highlighted that while the primary drivers of reform were problems, evidence, politicians and policy actors, what this thesis termed proximal factors, their actions were constrained or facilitated by a broader set of distal factors. The proximal factors determined the capacity and nature of policy making, who controlled policy making and whether the process was politicised, evidence-based or responsive to changing circumstances. However, the distal factors, including international conventions, structural arrangements, cultural beliefs and past paradigms, constrained or facilitated opportunities for reform and the range of possible solutions. This distinction was important since in studying drug policy researchers have tended to focus upon the proximal factors, particularly the relationship between politicians and evidence. It further appeared that some distal factors placed increased constraints upon potential reforms, particularly if community sentiment is against reforms.

The distinction was important in why decriminalisation was more likely in Portugal than Australia, and thus the national receptivity to a proposal. Given the historical emphasis in Portugal and Australian upon *de facto* decriminalisation and police diversion, both proposals “fit” the past experience. Further, both fit international conventions. Arguably, national context facilitated the chosen reforms, but would not have facilitated for example decriminalisation in Australia or indeed diversion in Portugal. This research thus contends that national contexts affect the type of responses that are likely to be deemed acceptable reforms.
A key national constraint or facilitator was the role of community beliefs and attitudes. The research suggests that while these can be a constraint upon reform, policy actors may also utilise or challenge community beliefs to enhance the likelihood of reform. This was particularly evident in Portugal where reform was facilitated by a challenge to community beliefs. Moreover, this research suggested that an understanding of national contexts could help explain why some strategies and means of advocacy were more powerful or more persuasive. Mass mobilisation was arguably more powerful than venue shifting with strategic mobilisation. It increased the potential to build a consensus and arguably reduced the potential for policy-based evidence. Mass mobilisation fundamentally increased the potential to challenge political views, and enhanced the power to persuade of the need for reform and the necessity of expert input and solutions. In contrast, one of the key challenges to the use of venue shifts, particularly to political venues, is that politicians are likely to be more constrained by community attitudes.

In spite of national differences the research suggests that the public policy theories particularly Punctuated Equilibrium have resonance to the understanding of drug policy reform. This is arguably because of the focus upon the role of policy actors. Differences therefore between nations might increase or decrease the potential for reform, but policy actors can utilise these to build strategic arguments. It appeared that national constraints, such as community beliefs could be influenced through in particular mass mobilisation. Alternatively, policy actors could wait for opportunities and build upon shifts in community mood. “Evidence” therefore of community support could be used as a persuasive tool for policy advocates to enhance the likelihood of reform. This research suggests that greater use of the theory of Punctuated Equilibrium may facilitate understanding of the actions of policy advocates and how, in particular, political windows are capitalised upon to produce pragmatic reforms.

Re-assessing the policy making process – images, venues and mobilisation

Chapter Two highlighted that the proposals for cannabis law reform in the Netherlands and Germany, USA and Australia and for supervised injecting facilities (SIFs) in Australia met with variable success. Many researchers attributed the failures to lack of political receptivity and particularly politicisation, but this research suggests that many of the successful reforms can be attributed to the type of images, venues
and mobilisation obtained. The following section re-assesses the policy developments through the new lens.

The two adopted reforms from Australia had similar features. The cannabis prohibition with civil penalties scheme (decriminalisation) in Western Australia and the Medically Supervised Injecting Centre (MSIC) in NSW involved pre-developed, evidence-based solutions, entrepreneurs, expert policy images and the mobilisation of key sectors. These factors were arguably vital to the evidence-based, non-politicised policy formulations. Another similar feature was that both involved Drug Summits which Advocacy Coalition and Punctuated Equilibrium respectively suggested were good venues for policy learning and for depoliticising policy discussions.

The persuasiveness of a strategic policy image was exemplified through the development of MSIC. As noted in Chapter Two medical images were common in the three SIF debates, but health professionals were most successful in NSW in obtaining access to policy formulation and thus depoliticising the discussions (Gunaratnam 2005; Wodak, Symonds & Richmond 2003). From the perspective of Punctuated Equilibrium, the enhanced role of the health professionals in NSW could be attributed to their ability to promote a more effective policy image and mobilise key supporters. In particular, the establishment of the temporary safe injecting room, the “Tolerance Room” served as a new venue from which to mobilise public and political attention and to facilitate medical input into policy formulation. It facilitated the framing of the debate in medical and humanistic terms. Those involved in the scheme highlighted that this was deliberate, since prior proposals for supervised injecting facilities had failed to be adopted (Wodak, Symonds & Richmond 2003). Mobilisation was assisted through the presence of multiple entrepreneurs including a politician (Ann Symonds) and health professionals (Dr Alex Wodak and Dr Ingrid Van Beek). The reform could also be attributed to the use of a visceral and emotive image which enhanced the capacity for a Downsian mobilisation of enthusiasm (Downs 1972) and consequently expert control over policy making. Other states arguably lacked the same visceral imagery and degree of mobilisation.

The Tolerance Room was a particularly good example of not only the benefits of a new venue, but also of how support could be facilitated through building upon shifts in community perceptions. The establishment and naming of the room as “tolerance” represented not only a means of mobilising and encouraging an evidence-based
response, but also building upon expert opposition to the federal climate of “zero tolerance.” Arguably, such an image succeeded since it capitalised upon the beliefs and attitudes of experts, rather than the broader community. This study suggests that even fleeting changes in community or sectoral sentiment might facilitate mobilisation and thus opportunities for reform.

In the proposed developments of cannabis decriminalisation in Victoria and Western Australia the critical difference between the successful and unsuccessful proposals could be attributed to the mobilisation of criminal justice support. The policy image of a law that failed to deter and was possibly harmful (Harvey 2003) encouraged both academic and criminal justice input. The mobilisation of both sectors was critical for the adoption of the reform. Lenton (2004) indicated that in Western Australia the push for decriminalisation was led by both academics, in the form of the National Drug Research Institute, and key criminal justice supporters, most notably the then Health Minister and former policeman Bob Kucera. In contrast, mobilisation of the criminal justice sector was not only absent in Victoria, but the majority were against the proposal. In retrospect, the proposal for decriminalisation in Victoria was unlikely to proceed since the Victoria Police had just devised and piloted drug diversion programs. While the decriminalisation in Western Australia also followed the introduction of diversion, the Victoria Police was considerably more enthusiastic about drug diversion. Further, the proposal in Western Australia built upon a shift in community perceptions which supported the notion of decriminalisation, something which appeared absent in Victoria.

There was thus considerable similarity between the successful reforms in Australia. The promotion of expert images, use of expansive venues, most notably Drug Summits, and mobilisation of key sectors were critical to obtaining expert input, and thus a more evidence-based and less politicised process. Further, the advocacy was led by a number of entrepreneurs and followed shifts in community perception. Arguably, the increased mass mobilisation and enthusiasm for the reforms, facilitated Government adoption of the proposals.

In the United States, the Netherlands and Germany it appeared that defining features in the successful proposals for cannabis law reform were the presence of sectoral and community support. Mobilisation of sectoral support appeared particularly critical for reforms developed through closed political arenas including the USA and the
Netherlands. DiChiara and Galliher (1994) noted that a critical difference between successful and non-successful proposals for cannabis decriminalisation in USA was the attitude of the criminal justice sector. Given the framing of the issue as one of criminal justice efficiency their voices were most needed for adoption. As predicted by Punctuated Equilibrium, jurisdictions where criminal justice support was less consensual were less likely to adopt cannabis decriminalisation. The proponents in the Netherlands and Germany advocated a different policy image, that drug use constituted non-problematic behaviour. Advocates in the Netherlands appeared more successful in obtaining expert input into their policy development, due arguably to their mobilisation of support from both social workers and the criminal justice sector (Scheerer 1978). In contrast, in Germany the health professionals were the primary opponents, followed swiftly by the criminal justice sector.

The successful reforms in USA and the Netherlands built upon shifts in community perception, something that was notably absent in Germany. The German image of drug use as a harmless behaviour directly opposed the national beliefs and community sentiment at the time on the importance of formal controls and drug-free living (Scheerer 1978). The lack of community support arguably facilitated counter-mobilisation to the German decriminalisation and the increase in penalties for drug users.

Clear differences were evident in successful and unsuccessful reform proposals. The type of image influenced whose voice was most important in agenda setting and policy formulation. This reinforced that to maximise the chances of atypical reform the promotion of new policy images must be accompanied by either mass or strategic mobilisation, and is most likely to succeed when it follows or facilitates a supportive shift in community perceptions. Political opportunities could be used to generate mass or strategic mobilisation, but strategic mobilisation was more dependent upon shifts in community perceptions. Punctuated Equilibrium therefore appeared to provide additional insight into why a number of reforms succeeded or failed. In particular, it indicated that reforms might be promoted but fail due to poor choice of image, venue or the lack of mobilisation of key sectors.
**Future areas for investigation**

While the theories resonated with the drug policy reforms, a number of queries remain. The theories appeared to be complementary yet had differing perspectives on the necessity of exogenous (uncontrollable) drivers of reform. Advocacy Coalition and Multiple Streams placed greater emphasis upon the need for exogenous events, such as the emergence and recognition of drug problems, or changes in leadership in order to obtain reform. Yet, for Punctuated Equilibrium exogenous events were of lesser importance, since policy actors have primary control over the likelihood and outcomes of reform. While this research indicated that policy formulation could influence the type of reform that emerged, it was unclear to what extent strategic advocacy could be utilised to obtain paradigmatic change, something that Advocacy Coalition argued necessitates a major exogenous event. Questions therefore remain as to what degree policy actors can influence the process of policy making, and the outcomes and likelihood of major reform. The interactions between the theories is an issue of considerable interest both for understanding the process of development and the potential for promoting atypical reform.

To what extent national peculiarities such as national beliefs or political reality constrain potential for reform needs clarification. The thesis suggests some societies may have increased opportunities for undertaking reform and in particular paradigmatic change. A key challenge is to determine the importance of cultural rationalities and to better understand how to facilitate reform. The common theme in the reforms, of either shifts in community attitudes or use of mass mobilisation, suggests that community beliefs are important in understanding receptivity. This indicates the importance of cross-national studies in discerning how and why policies develop, and in particular the degree to which community attitudes can be influenced.

Finally, it remains uncertain how differences in the mode of policy formulation affect the likelihood of and outcomes of reform. It appears that high levels of expert input increase the capacity for evidence-influenced implementation, even in political opportunities for reform. Both the MSIC and the prohibition with civil penalties schemes in Western Australia arose through political windows, yet were adopted through Drug Summits involving considerable expert input. At the time of writing both reforms have been characterised by a strong emphasis upon evidence, subject to considerable evaluation and evidence-based learning. This suggests that the venue of
policy formulation and type of mobilisation may be key factors in whether political opportunities give rise to more policy-based or evidence-based reforms. This however is in need of further investigation.

In conclusion, despite the differences in the nationality, temporality and type of reforms (cannabis decriminalisation, safe injecting rooms) the theories and findings from the present research appeared to resonate with other studies. This suggested that the theory of Punctuated Equilibrium should be generalisable to other studies of drug policy development. Application of PE clarified a number of the unresolved issues identified in Chapter Two, namely why some evidence-based reforms succeeded and others failed. It suggested that the actions and success of policy actors were of critical importance to whether reform was likely to occur. While further investigation is obviously needed into how the theories inter-relate, the level of controllability, and the impacts of differences in national factors and means of policy formulation upon the outcomes of reform, greater application of the theory of Punctuated Equilibrium appears warranted.

**Practical implications: Promoting atypical reform**

Policy advocates in Portugal and Australia faced the common and indeed worldwide issue of the need for improved drug policies. In particular, they faced the issue that existing drug policies were ineffective, inefficient and inhumane and thus in need of rectification. In short, the policies were in need of adaptation. It is evident that drug policies must adapt to problems in existing systems or contemporary changes in patterns of drug use. The challenge for policy advocates is not only what policies ought to be changed and what policies may be more adaptive, but how to promote and obtain reform and thus how to be strategic. As this thesis demonstrates, being strategic has rewards. Policy advocates in Australia used the ADCA forum to outline the types of challenges that would need to be overcome to obtain drug diversion and devise a strategy for obtaining reform. In so doing the major impediment – political opposition – was overcome, in spite of the politicised environment.

Policy actors clearly have considerable power over the potential for reform and likely outcomes. Understanding the intricacies of *strategic* advocacy is essential for more adaptive drug policies. The following sections examine the implications of this for
promoting atypical reform and highlights a number of strategies that have been used to facilitate atypical reform, and which may facilitate future reform.

New images – human rights
The promotion of a new image may help resolve the problem of current conflicting images. Further, it may facilitate increased advocacy and venue change. Optimal images will have emotive appeal, be simple, not conflict with the dominant image, connect to societal problems and reflect cultural beliefs. Further, they will be capable of manipulation to fit venues, particularly political venues. Issues such as drugs can be defined as individual issues or social problems, however defining a problem as the latter can galvanise government action.

Images and debates concerning human rights were used to facilitate mass mobilisation and support for new responses to drug users in both Portugal and Norway. The development of the Norway Supervised Injecting Facility through an evidence-based, non-politicised response can be attributed to the image of human rights. This was deemed crucial in encouraging expert input by social workers in the policy formulation, and in depoliticising the debate (Skretting 2006). This image was used to enhance the dignity of drug users and aid the establishment of the Safe Injecting Facility in Oslo. From the UK perspective the emphasis upon the rights of drug users was seen as particularly unusual, yet potentially a means of facilitating future reform:

It is particularly striking in the discussion on safe injecting rooms in Norway that a key element in the thinking on the part of parliamentarians was the degree to which such centres could enhance the dignity of drug users. This is a dimension which is rarely discussed in a UK drugs narrative which is predominantly concerned with either criminal justice or health related matters. And yet it is a dimension which is powerful in its own right. (McKeganey 2006, p. 2)

The major strength with the human rights image is the capacity to focus upon values and emphasise that drug users are citizens, not merely criminal or sick.

This particular case study was of particular interest since the human rights approach was utilised successfully in Norway in spite of national beliefs. Skretting (2006) contended that Denmark was the most likely of the Nordic countries to adopt a supervised injecting facility yet Denmark rejected such a proposal. The main reason he could attribute for the Norwegian willingness to accept a human rights perspective and adopt a supervised injecting facility was the prior introduction of needle syringe exchange. This suggested that not only could human rights images be utilised to
mobilise support, particularly mass mobilisation for reform, but that contemporary practices might also affect the willingness to reform.

New venues
Advocacy and mobilisation of supporters for reform could be facilitated by greater or better use of venues. As noted by Baumgartner and Jones (1993) the drug policy area has multiple competing institutions including police, immigration, schools, hospitals and private authorities. Since there are multiple venues there is considerable opportunity for venue shopping and avenues from which to promote new policy images. Societies such as Portugal and Australia where powers of governance are separated similarly have additional venues from which to advocate for reform. This primary risk with venue shifting is unsuccessful venue shifts might even attract more opposition (True, James, Jones & Baumgartner forthcoming).

Successful venue shifting requires knowledge of the benefits of particular venues, their rules and how to re-define issues. Particular venues confer advantages for different lobbyists. Yet, as noted by Pralle (2003) while incremental reform might result from limited access to alternate venues of power, it might also result from limited expertise of the lobbyist, lack of affiliation or preference for a desired image. There is a need to understand how to increase the chances of successful venue shifts, to map out what venues could be utilised, and to enhance the expertise or affiliations with such venues.

It appears that the potential for venue shifting may differ according to the level of politicisation. The historic problems in USA seeking alternate venues from which to advocate for drug policy reform have been clearly demonstrated by Sharp (1994). While Sharp predicted that the rise in alternate venues in USA increased the potential for venue shifting, the “war on drugs” and ipso facto drug users has remained dominant (Caulkins et al. 2005).

Greenaway (2003b) similarly demonstrated that venue shifting may have limited impact if there is a strong opposition. While the UK alcohol lobbyists successfully used new venues for some reforms, others were not possible due to counter-mobilisation by the alcohol lobby. This suggests that venue shifting to obtain reform may have constraints and benefits. However, venue shifting to increase support for
reform appears to be particularly worthwhile, and may enhance the likelihood of further venue shifting.

This was clearly evident in Australia in the development of the IDDI. Not only did the IDDI follow the venue shift to the Prime Minister’s Office but also the ADCA forum was used to mobilise Victoria Police interest in drug diversion. This in turn facilitated policy learning as exemplified by the following quote from Victoria Police Commissioner Neil Comrie:

I would have been one of those a few years ago who would have been a strong advocate of the prohibitionist solution…Having now thought a lot more deeply about the problem, I have realised that is not a total solution at all (cited in Ferguson, Mitchell & Cusworth 1999, p. 1)

This sector became a key advocate for the IDDI, which highlights the benefits of obtaining sectoral interest for reforms.

Venue shifting was utilised in a number of other drug policy developments. In the UK it was evident that the introduction of new venues facilitated opportunities for reform to alcohol policies (Greenaway 2003b). As noted previously the development of a new and temporary venue of the “Tolerance Room” appeared particularly successful in enhancing support for reform (Gunaratnam 2005; Wodak, Symonds & Richmond 2003). Without the establishment of the Tolerance Room, advocacy by health professionals was unlikely to have mobilised much support. Finally, both this development and the development of the prohibition with civil penalties scheme in Australia highlighted the importance of Drug Summits. The creation of these temporary venues expanded and facilitated expert and community input into political discussions and policy formulation, and thus the creation of more evidence-led reforms.

Mobilisation
As demonstrated by the reforms from Portugal and Australia mobilisation was essential to obtain reform. However, mass mobilisation appeared to have different strengths and weaknesses to venue shifting. Mass mobilisation was inherently more risky, but this research contends that it is particularly important for paradigmatic change. Politically-led mass mobilisation in USA has also demonstrated the power of an emotive campaign, something that can similarly be utilised by experts (Sharp 1994). The development of the Portuguese decriminalisation and the Supervised Injecting Facility in Norway similarly demonstrated the benefits of mass mobilisation,
where proposals challenged political and public beliefs and opened the way for a new response (Skretting 2006). Arguably, the use of human rights images of drug users encouraged a more enthusiastic response by the public and Government. This was facilitated by the arguments that the broader community would benefit through restoring dignity to people who use drugs.

However, as indicated by the failure of the ACT heroin trial and German proposal for cannabis legalisation this form of mobilisation also increased the potential for veto and counter-mobilisation. Mass mobilisation was particularly risky if community attitudes were not made more receptive prior to or during mobilisation. It was evident that the German strategic image of drug use as a harmless behaviour was destined to fail, since it directly opposed the national beliefs and community sentiment at the time on the importance of formal controls and drug-free living (Scheerer 1978). Both reforms had the unfortunate effect of producing a powerful counter-mobilisation and political response as exemplified through introduction of the “Tough on Drugs” strategy in Australia and increased penalties for drug users in Germany.

The lesson from failed efforts for mass mobilisation such as the ACT heroin trial is the need to ensure that the message of reform is clearly understood. The medical image in the promotion the ACT heroin trial came to symbolise drug law reform, which in turn increased community distrust. In retrospect, it was inevitable that Prime Minister John Howard failed to support the reform. Accordingly, Lawrence, Bammer and Chapman (2000, p. 254) attributed the failure to poor advocacy by the supporters of the heroin trial, in particular to “sending the wrong signal.” They contended that images themselves might be rejected if deemed to misappropriate particular solutions. Campbell noted that the apparent linkage between medical images and drug law reformers led to the rejection by Prime Minister John Howard of all medical solutions:

At present, disgust at scenes of self injection and the misrepresentation of legalisation to mean selling heroin alongside gin and cigarettes are enough to keep medical options off the agenda. (Campbell 1999, p. 15)

This suggests that health images may be tainted in Australia and hence the need for new images and/or better advocacy in Australia. The key challenge it appears is to draw a distinction between efforts for drug law reform, and efforts for a new conceptualisation or response to drug users.
Policy learning: The battle against dogma

The development of decriminalisation highlights that policy learning is critical to challenge dominant views or “dogma.” The power of and need for policy learning was evident in Portugal, whereby many of the entrepreneurs who advocated for reform originally thought policies were working. As noted by Alexandre Rosa:

These people are the openers of the minds, are openers of the minds. They opened up their own minds and willed the process of opened minds.

Alexandre Rosa – Former National Coordinator – [12]

Rodrigo Countinho was one such example, working in a treatment centre yet not aware that such centres were not the answer for all drug users. It was not until 1997 that his view changed through the operations in Casal Ventoso, but in doing so, he swiftly became a leading advocate for reform. Changing the minds of a few individuals in key positions can have a very powerful impact and lead to the mobilisation of society.

Without policy learning there could have been no reform. Policy learning thus was essential to increase the receptivity to new ideas. However, policy learning was facilitated not simply through evidence but through persuasion. Casal Ventoso was the key to policy learning in Portugal, but more importantly the entrepreneurs used this image and its emotiveness to enable the research and vicarious experience of the “failure of prohibition” to be heard. Similarly, in Australia evidence of the potential benefits of diversion was one driver, but the promotion of the emotive image, that drug diversion could “save lives,” was arguably critical in enhancing the receptivity to the proposal. Thus, policy learning was facilitated through the accumulation of evidence and expert environs, but also through vicarious experience, stories, images and values.

In conclusion, this research emphasised that to promote drug policy development strategic advocacy is essential. Emotive and visceral images, particularly human rights images and use of existing or creation of new venues may facilitate mobilisation of society and thus facilitate atypical reform, particularly if accompanied by enthusiastic advocacy. The pre-cursor to strategic advocacy is however policy learning, something that also requires strategy and persuasion, not just evidence.
Towards more effective drug policy

The thesis clarified a number of the dilemmas and queries raised in Chapter Two, concerning the relationship between politicians and evidence and the lack of understanding of why some evidence-based proposals succeeded and others failed. Researchers have tended to highlight the conflict between politicians and evidence. This research moves beyond this binary and demonstrates that the interaction of these factors is fundamentally influenced by the broader context, most notably the actions of policy actors, the structural opportunities for reform, the international conventions and cultural beliefs concerning how society ought to respond to drug users. The following section overviews the implications for better use of evidence and political venues and implications for more effective policy making.

Towards better use of political venues

Political venues do not inevitably lead to doctrinal solutions. Instead, outcomes appear dependent upon the level of input into political venues. Images and venues can therefore be used to facilitate input and maximise the potential for non-doctrinal responses. However, a number of dilemmas remain over the capacity to undertake reform and achieve effective reform through political venues.

The first dilemma is the capacity to undertake pragmatic reform. The research demonstrates that even in the presence of highly politicised environments, political venues can enable evidence-based reforms. It therefore moves beyond the contention of Zahariadis (2003) that political venues will lead to doctrinal solutions. However, advocating for reform through political venues, particularly through strategic venue shifts carries risk, most notably that politicians may be unreceptive to proposals. A key challenge and impediment to reform has been the perceived need of politicians to defend their policies:

The barrier is arguably built into the institutions of representative democracy where elected members are expected to retain control of decision making, and government officers are not permitted to make public political statements that bring these decisions into question. (Midgley, Winstanley, Gregory & Foote 2005, p. 4)

However, Punctuated Equilibriums highlights that political receptivity to proposals can be enhanced through enthusiastic mobilisation. Negative or critical mobilisation, through attacking the status quo is a far more risky means of policy making since proposals may be counter-mobilised or not adhered to. Thus, better use of political
venues demands greater attention to how to create new visions, proposals, ideas and enthusiastic mobilisation.

The second dilemma is the extent to which policy advocates can promote major reform – paradigmatic reform – through political venues. It is clear that given mass mobilisation politicians can be encouraged to undertake major reform, however mass mobilisation is not always desirable. Researchers have tended to suggest that strategic venue shifts will not produce major reform. Sharp (1994) noted that the inside-access model or strategic venue shifting tended to produce mainly technocratic changes in practices. She contended that for some issues, such as the push for cannabis decriminalisation, strategic venue shifting is less likely to succeed, due to reduced emphasis upon and potential for obtaining public consensus and hence mass mobilisation on an issue:

Efforts at policy change inevitably involved confrontations between expert judgements and public fears about a substance that had for many years been portrayed in highly negative terms. Successful policy change would have required forging a new public consensus. But unlike the mobilization model, the inside-access approach to policy formulation ignores the need for manipulation of the attitudes of the mass public. In short, …. it was a poor fit with the political imperatives of the marijuana decriminalization issue. (Sharp 1994, p. 45)

While the present research concurs on the necessity of public support, it disputes the insistence upon mass mobilisation.

Instead, the research contends that strategic venue shifting can be used to facilitate paradigmatic change. The prime example of undertaking paradigmatic change through a political venue was in the Netherlands where de facto decriminalisation emerged through a political venue (Boekhout van Solinge 1999). It appears that paradigmatic reforms of this nature are unlikely to occur unless they coincide with and utilise shifts in community values and beliefs. The key issue with political venues is therefore the level of input into policy formulation. This suggests a need to maximise input and positive advocacy, something that can be aided through the strategic tools of expert images and mobilisation, but also through the broader use of evidence.

Towards more effective use of evidence
The present thesis demonstrates that, due to political imperatives, evidence is not the only consideration in policy making. The reasons for the variable role of evidence are well documented, including differences in accountability of politicians (to the public) versus researchers (to the academic community). This has considerable implications
for how politicians and researchers assess the value of evidence. As Black (2001) noted the impact of evidence is dependent upon the relevance of information to politicians, level of consensus around evidence and factors such as whether the findings concur with the personal experience of politicians. Evidence is thus essential for policy learning and designing better responses that adapt to the constraints under which drug policy operates, but it is also essential to recognise that evidence is but one of the competing factors in policy making and often not the most persuasive.

It is now clear that politicians often are responsive to the evidence-base and expert recommendations. However, the political nature of policy making has a number of implications, which astute policy actors and researchers must recognise. Policy making is not rational and therefore evidence-based policy making or indeed evidence-based responses are unlikely to occur. Drug policy is therefore more likely to be evidence-influenced. Given the limited role of evidence and the need for negotiation and compromise, policies are likely to be adaptive rather than perfect solutions. Reforms therefore can enhance the adaptability of policies but ought to be viewed as part of a continuum of change and adaptation. That said the process of adaptation can enhance the humanity of responses and can have considerable impacts. Finally, the irrationality of policy making means that evidence particularly of “what works” ought to be viewed as one tool for obtaining reform.

The thesis indicates that the use of entrepreneurs, images and simple campaigns such as treatment works can increase the input and role of evidence in policy making. Images of drug users as citizens not criminals were vital to the reform in Portugal and increased not only the likelihood of reform, but of expert input. The key strength in the use of more emotive images is the power of persuasion. This is something that evidence can neglect and is a prime reason to incorporate both evidence and values in policy advocacy. Policy advocates in Portugal and Australia used a broad range of factors to build persuasive arguments, including values, ethics, community perceptions and models in Portugal and pilots and technical feasibility in Australia. Accordingly, neither reform can be deemed evidence-based, but instead evidence-influenced. That said the reform in Portugal was more influenced by the role of evidence, through in particular the partnership between experts and Government. This therefore suggests the need for expansive input into policy making and indeed policy learning.
The tools for strategic advocacy – a broader definition of evidence, entrepreneurs, images and persuasion – may increase the likelihood of reform. They may further increase the likelihood that evidence of anomalies or problems are addressed. Innvaer et al. (2002) found that the biggest facilitators of research by policy makers included personal contact, timeliness and relevance, which reinforces the importance of entrepreneurs. However, it is also evident that personal communication and indeed use of images and persuasion may increase the chance of selective use of research. This may lead to policy-based evidence, use of evidence that best suits the desired policy outcomes (Marmot 2006).

The observation above poses a quandary since it suggests that evidence is more likely to have an impact if it is broad and considers ethics, values, community and sectoral support and feasibility; however being strategic – in this case increasing persuasiveness of arguments – is unlikely to lead to “evidence-based” outcomes. This therefore suggests a need to reconceptualise the notion of “effective” reform. Evidence is primarily useful for determining whether something works, not looking at what problems are most in need of solving or how problems should be solved. Gibson (2003) notes that with difficult problems such as poverty or health consideration of values is arguably more important than consideration of evidence. This research concurs.

More effective drug policy making demands increased emphasis, not so much trying to rationalise policy making, but expanding attention to values. Effective reform is both evidence-based and value-based. The challenge is therefore to mesh evidence and values. As David Crosbie said, values have been a neglected area of drug policy. Values are not only important to politicians and thus to strategic drug policy making but also to more effective policy:

As they stand around a bbq on Sunday that is more likely to influence policy than a lot of research. People say that’s terrible, research should lead policy. I don’t know about that because research can actually be valueless and actually policy is made up of value, what people believe in, what they feel about things. I think we in some ways have missed that in drugs.

David Crosbie – Former CEO of ADCA – [4]

**Analytical reflection**

Given the application of the present research to two countries, the extent of generalisability of these findings to other nations or to other types of reforms remains
unclear. The re-examination of previous studies of policy development suggested the findings ought to have resonance, but this is something that needs to be tested. A major question that remains concerns the applicability of the multiple theories. Application to other nations may help clarify the conflict between the theories and indeed how differences in policy formulation impact upon implementation. The link between policy formulation and implementation remains hazy, due both to scarce data and to fundamental changes in the process of implementation. While this investigation of this link was never the primary focus of the research, it is a necessary area for future investigation.

The thesis necessitated the weaving together of selective stories. While informed by the policy actors and secondary sources, this was the interpretation of one story teller. From the outset it was acknowledged that my value position was informed by the harm minimisation approach and belief that criminal justice intervention for drug users has questionable benefits. It must therefore be recognised that another researcher or policy maker may have come to different conclusions or given a different interpretation of events. That said, through the provision of diverse views this research has endeavored to let policy makers tell their stories.
CHAPTER NINE: CONCLUSION

Adaptation is essential for effective drug policy in order to maximise the potential for more efficient, effective, just and humane responses to drug users. Yet, as shown in Chapters One and Two opportunities for evidence-based reforms are often constrained by international, political and community pressure for tough, punitive responses. While history clearly demonstrates that drug policy making has not been rational, there remained a dearth of theoretical or practical attention paid to the process of development. Many failed proposals were attributed to the actions of politicians, leading to the simplistic assertion that, due to the political nature of policy making, evidence-based reforms were unlikely. The current research moves beyond this.

Using the different but analogous atypical reforms of decriminalisation in Portugal and the Illicit Drug Diversion Initiative in Australia, the present thesis examined how and why atypical, particularly pragmatic drug policy reforms emerge. To guide this exploration several questions have been considered:

1. What are the primary drivers of national drug policy development?
2. How and why does atypical drug policy reform occur?
3. How does national drug policy formulation influence the mechanism and implementation of atypical reform?
4. How adequate are contemporary theoretical frameworks for explaining the process of national drug policy development?

The thesis concludes that opportunities for and outcomes from pragmatic drug policy reform are shaped by the process of policy making, particularly by the actions of policy advocates. Despite differences in national characteristics, histories and drug problems, drug policy development in both Portugal and Australia was driven by common factors. The most important and hence the primary drivers of atypical reform were crises, evidence, political receptivity and policy advocates. While the combination of such factors was essential for atypical reform, the inter-relationship particularly between evidence and politicians shaped the outcomes from reform.

The research demonstrates that atypical reform takes years to develop, following the accumulation of evidence and policy learning. Yet receptivity to problems, evidence
or advocacy for reforms requires the emergence of policy windows or agenda setting opportunities. While the convergence of the primary drivers – crises, evidence, political receptivity and policy advocates – creates policy windows, atypical reform occurs and is shaped by the subsequent capitalisation upon such opportunities. In converting opportunities into pragmatic responses, the primary driver is not the actions and beliefs of politicians, but instead policy actors and their ability to enhance political receptivity, input evidence into policy formulation and build persuasive arguments. Through the use of strategic advocacy policy actors can convert even doctrinal solutions into pragmatic drug policy reforms.

Given the importance of the policy formulation process it is concluded that while the three public policy theories – Multiple Streams, Advocacy Coalition and Punctuated Equilibrium – provide complementary insights into why atypical reform emerges, the theory of greatest application is Punctuated Equilibrium. By drawing attention to the process of policy formulation, Punctuated Equilibrium is best able to explain how pragmatic drug policy reforms emerge. Moreover, the thesis concludes that some processes of development increase the potential to shape the mechanism, implementation and potential outcomes from reform. In short, some processes of policy making are more effective than others. Ultimately, this is not because of the evidence, political stance or the venue of decision making per se, but because expert control over policy making proceeds from the promotion of a more persuasive argument.

To reach this conclusion the present thesis adopted a cross-national descriptive-analytical approach to examine the practical and theoretical basis for the development of decriminalisation and the IDDI. The largely qualitative approach, involving interviews with expert policy makers, secondary sources and publicly available data about the atypical reforms, provided in-depth insight into the complexity of drug policy making in Portugal and Australia, and the resonance of the theoretical frameworks. The choice of a cross-national research design posed logistical and methodological challenges. However, without learning Portuguese, establishing links with a relevant body – the Institute for Drugs and Drug Addiction – and securing funds for the international field study, this research may well have led to one-dimensional conclusions.
Examination of drug policy development in Portugal demonstrated the importance of windows of opportunity. The emergence of the problem window – the increasing severity and visibility of the public health and social crisis typified by Casal Ventoso – was essential for atypical reform. It was a tool to set the political agenda, increase expert control over policy making and challenge the prior dominance of the drug-free supporters. The problem window facilitated a public, concerted, pragmatic and bipartisan approach to policy making, one that was very different to the more ideological mode of incremental policy making. Examination of Portuguese drug policy development identified a very pragmatic and enthusiastic approach to drug policy making, characterised by the alliance between politicians and evidence. Yet the uniqueness of this approach and in particular the true cause of the pragmatic approach was only comprehended through comparison with the Australian reform.

While the development of the IDDI also highlighted the importance of windows of opportunity, it demonstrated a very different process of both incremental and atypical reform. Through the emergence of a political window, namely the perceived need by the Federal Coalition Government to respond to the increasing drug law reform movement the pre-developed but disregarded proposal of drug diversion became a more acceptable political compromise. Entrepreneurs capitalised upon the increased receptivity, through the use of a strategic venue shift and demonstration of the political and technical feasibility of the proposed solution. This resulted not only in the adoption of drug diversion, but also the conversion of a potentially doctrinal proposal by the Prime Minister’s Office into a more humane response.

Analysis of each national context on its own provided very different insight into how drug policy develops. However, the combination illustrated that there were considerable similarities in the drivers of the incremental and atypical reforms. Moreover, the emergence of similarly pragmatic reforms led to the conclusion that the reforms were not driven by the problem and political windows. Instead, they constituted tools used by the policy actors to build persuasive arguments.
Application of the different theoretical lenses reveals that despite the largely complementary insights, the public policy theories did not have equal application to the Portuguese and Australian reforms. Limitations in particular with Advocacy Coalition appeared a greater impediment, which led to the conclusion that it was the least applicable theory to the examination of drug policy development. In contrast, both Multiple Streams and Punctuated Equilibrium demonstrated considerable resonance, particularly the latter. The failure to consider the role of cultural beliefs was the major limitation apparent in Punctuated Equilibrium to date. Nevertheless, through incorporation of the cultural beliefs, Punctuated Equilibrium was able to clarify some of the confusion in previous studies over why some pragmatic reforms failed and others succeeded.

Examination of the process and outcomes from the reforms demonstrated that policy formulation had considerable influence on the mechanism and implementation of the reforms. Moreover, it led to the conclusion that decriminalisation involved a more effective form of advocacy. Due to the creation of an alliance between experts and politicians, policy advocates had a very powerful role in the development of decriminalisation, leading to a more evidence-influenced policy. In contrast, due to the perceived lack of community support political constraints were greater in Australia, contributing towards more policy-based or selective use of evidence. This had considerable impacts upon the framing of the responses, most notably that decriminalisation alone was framed as a humane response.

Due to the irrational nature of drug policy making tension between politicians and evidence will be inevitable. Yet, the inter-relationship depends upon the opportunities, constraints and facilitators and the advocacy by policy actors. Pragmatic reforms emerge through political venues, as a consequence of better use of evidence, or greater receptivity to evidence. Expert input and solutions can be facilitated through strategic use of evidence: more expansive definitions of evidence; use of other forms of persuasion, most notably values; and the generation of public or expert support. In particular, strategic venue shifts are most likely to facilitate effective reform if they capitalise upon shifts in community or expert beliefs and attitudes. Failure to generate community or expert support will inevitably reduce the potential for pragmatic reform.
Future Directions

The thesis takes the axiomatic position that adaptation is essential for effective drug policy making. Four major challenges need to be embraced if developments in policy understanding and policy adaptation are to take place. First, increasing knowledge of the strengths and limitations to various images, venues and means of mobilisation is essential to enhance the capacity for strategic advocacy. Second, this research demonstrates that countries may have variable capacity for atypical drug policy reform. Questions remain as to how and to what extent national factors and other distal factors constrain or facilitate the potential for atypical reform, and the extent to which strategic advocacy can be used to overcome these factors.

Third, much of this research has focused upon how and why atypical reform emerges. Greater attention is needed to how the process of capitalisation and different methods of advocacy impact upon the potential outcomes from reform. Fourth and finally, this research contends that the most effective reform will not only change practices, but change values – paradigmatic change – and therefore decrease inconsistency between values and practices. The extent to which policy actors can influence the capacity for paradigmatic reform, and hence more effective policy making, demands further attention.

While both the development of the decriminalisation and the IDDI heralded more adaptive and potentially effective responses to drug users, the present research concludes that policy making preceding the development of decriminalisation was fundamentally more effective, since it maximised the potential for paradigmatic change. The most important factor, the one that distinguished this reform from the Australian reform, and indeed from many atypical drug policy reforms, was the presence of a new vision. That vision, which Almeida Santos summarised as having the “same attitude” – to see and to treat drug users like other citizens – drove the alliance between politicians and experts and facilitated a more pragmatic approach.

More importantly, the vision contributed to the enthusiasm and belief in the new solution, and ultimately the political willpower to change paradigms and challenge even international critics. To achieve paradigmatic change, and hence to achieve what this thesis contends is more effective policy making, demands the promotion of not
only pragmatic responses, but a new conceptualisation of the drug user. Meshing pragmatism and ideals is therefore the next step:

The other legal framework was very bad…. To have a hypocritical attitude I think it is not a good place to go on. I think it is better to look this problem, because it is a great problem, it is not a problem in Portugal; it is a problem in the world. So I think that we must have, we in Portugal and politicians we have to have courage to implement new policies. Step by step OK if they want like this, because if they go to a radical position they can lose the election. So step by step OK but to go in front enough to have the same attitude [to all citizens], including people who are drug addicts.

Almeida Santos – Head of Lisbon CDT – [4-5]


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APPENDIX A: INTERVIEW SCHEDULE: PORTUGAL

1. What has been your involvement in Portuguese drug policy?

2. How would you summarise the current national drug policy?

3. Can you please describe the development of the national drug strategy?

4. What have been the major influences on Portuguese drug policy?

5. Can you please describe the development of decriminalisation in Portugal?

6. Were there any opponents to the strategy and legislative approach?

7. What are the main objectives of the strategy?

8. Have there been any difficulties in implementing the strategy? Policy, practice.

9. Has the meaning or emphasis upon harm reduction changed during the development and implementation of the drug strategy?

10. What are the effects of decriminalisation on drug users, use, crime, health?

11. Could the strategy have changed without decriminalisation?

12. What are the major differences between the response to drug consumption and possession today versus responses in the 1980s and 1990s?

13. What has been the main advantage of the drug strategy? For whom has it been most effective? Main disadvantage?

14. What do you think the future of Portuguese drug policy is?

15. Is there anything else you would like to tell me?
APPENDIX B: INTERVIEW SCHEDULE: AUSTRALIA

1. What does the term “Australian drug policy” mean to you?

2. What is the role of national drug policy?

3. What are the major influences on drug policy in Australia?

4. Can you describe the development of the 1998-99 to 2002-03 National Strategic Framework on Drugs?

5. What were the major changes between in Australian drug policy between 1998 and 2004? What factors influenced those changes?

6. Can you describe the development of the National Diversion Initiative? Why did it develop? Whose initiative was it? What does it signify? Diversion initiative = Law reform? What does it include/exclude? – drug courts, cautioning schemes

7. Can you describe the implementation of the National Diversion Initiative?

8. Following that National Diversion Initiative what is the role of criminal justice system in the response to drug consumption and possession? Role of legislation?

9. What is your view on harmonised drug laws?

10. What is the impact of politics on Australia drug policy?

11. What do you foresee as the future of Australian drug policy?

31 The National Diversion Initiative was another term used to describe the Illicit Drug Diversion Initiative.
# APPENDIX C: KEY INFORMANTS

Table 8: Portuguese key informants and positions

<table>
<thead>
<tr>
<th>Key informant</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitalino Canas</td>
<td>Former National Strategy Coordinator/ Socialist Party</td>
</tr>
<tr>
<td>Alexandre Rosa</td>
<td>Former National Coordinator/ Socialist Party</td>
</tr>
<tr>
<td>Elza Pais</td>
<td>Former National Coordinator/ Socialist Party</td>
</tr>
<tr>
<td>Sónia Furtuzinhos</td>
<td>Socialist Party</td>
</tr>
<tr>
<td>António Filipe Rodrigues</td>
<td>Portuguese Communist Party/ Former head of parliamentary committee</td>
</tr>
<tr>
<td>Bruno Dias</td>
<td>Portuguese Communist Party</td>
</tr>
<tr>
<td>André Beja</td>
<td>Left Block</td>
</tr>
<tr>
<td>Joaquim Rodrigues</td>
<td>Health Bureaucrat/ Former head of GPCCD and member of CNDS</td>
</tr>
<tr>
<td>Jorge Ribeiro</td>
<td>Health Bureaucrat</td>
</tr>
<tr>
<td>José Braz</td>
<td>Head of Criminal Police</td>
</tr>
<tr>
<td>Carlos Costa</td>
<td>Criminal Police</td>
</tr>
<tr>
<td>Graça Poças</td>
<td>Prison</td>
</tr>
<tr>
<td>GNR*</td>
<td>National Republican Guard</td>
</tr>
<tr>
<td>Maria António Almeida Santos</td>
<td>Head of Lisbon CDT</td>
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<tr>
<td>João Goulão</td>
<td>Health Professional/ Former head of SPTT and member of CNDS</td>
</tr>
<tr>
<td>Luís Patricio</td>
<td>Health Professional/ Former member of CNDS</td>
</tr>
<tr>
<td>Nuno Miguel</td>
<td>Health Professional/ Former member of CNDS</td>
</tr>
<tr>
<td>Rodrigo Coutinho</td>
<td>Health Professional</td>
</tr>
<tr>
<td>Prof. José Luis Castanheira</td>
<td>Health Professional/ Former head of SPTT</td>
</tr>
<tr>
<td>Maria José Campos,</td>
<td>Non-Government AIDS Organisation - Abraço</td>
</tr>
<tr>
<td>Luís Mendão</td>
<td>Political Lobbying Organisation - SOMA</td>
</tr>
<tr>
<td>Prof. Alexandre Tiedtke Quintaniha</td>
<td>Former head of CNDS</td>
</tr>
<tr>
<td>Prof. Jorge Negreiros</td>
<td>Academic</td>
</tr>
<tr>
<td>Prof. Carlos Alberto Poiares</td>
<td>Academic, Designer of CDTs</td>
</tr>
<tr>
<td>Danilo Balotta</td>
<td>EMCDDA</td>
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<tr>
<td>Brendan Hughes</td>
<td>EMCDDA</td>
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<tr>
<td>Anonymous*</td>
<td></td>
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<tr>
<td>Key informant</td>
<td>Position</td>
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<td>-------------------------------</td>
<td>---------------------------------------------------------</td>
</tr>
<tr>
<td>John Perrin</td>
<td>Prime Minister's Office</td>
</tr>
<tr>
<td>Stephen Vaughan</td>
<td>Senior Health Bureaucrat/ Former law enforcement officer</td>
</tr>
<tr>
<td>Marion Simmonds</td>
<td>Health Bureaucrat</td>
</tr>
<tr>
<td>Major Brian Watters A.O.</td>
<td>Former head of ANCD</td>
</tr>
<tr>
<td>Gino Vumbaca</td>
<td>ANCD</td>
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<tr>
<td>DC*</td>
<td>ANCD</td>
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<tr>
<td>Associate Prof. Robert Ali</td>
<td>ANCD/ Health Professional</td>
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<tr>
<td>Prof. Ian Webster A.O</td>
<td>ANCD/ Health Professional/ Former head of ADCA</td>
</tr>
<tr>
<td>David Crosbie</td>
<td>Non-Government Treatment Provider/ Former CEO of ADCA</td>
</tr>
<tr>
<td>PC*</td>
<td>Non-Government Organisation</td>
</tr>
<tr>
<td>Prof. John Saunders</td>
<td>Health Professional/ Academic</td>
</tr>
<tr>
<td>Dr. Alex Wodak</td>
<td>Health Professional/ Drug law reformer</td>
</tr>
<tr>
<td>Professor Nick Crofts</td>
<td>Health Professional</td>
</tr>
<tr>
<td>Superintendent Frank Hansen</td>
<td>Senior Drug Law Enforcement</td>
</tr>
<tr>
<td>Superintendent Paul Ditchburn</td>
<td>Victoria Police</td>
</tr>
<tr>
<td>K*</td>
<td>Victoria Police</td>
</tr>
<tr>
<td>Anonymous*</td>
<td></td>
</tr>
</tbody>
</table>
Plain Language Statement

Miss Caitlin Hughes (Principle investigator)
Department of Criminology
03 8344 9510

Dr Steve James (Principle investigator)
Department of Criminology
03 8344 9449

Cross-National Comparison of Drug Policy in Portugal and Australia

Background to the Project
Nations have few opportunities to experiment with multiple approaches to drug policy. Therefore, cross-national research can be of great benefit since it can highlight different approaches to and outcomes of drug policy, which have the potential to increase the effectiveness of national and global responses to drug issues. This research examines drug policy regarding drug usage in two UN signatories - Portugal and Australia. These countries have been chosen due to their common emphasis upon harm reduction and pragmatism and the considerable variation in their particular responses to drug consumption.

Introduction
You are invited to participate in the above research project, which is being conducted by Miss Caitlin Hughes and Dr Steve James of the Department of Criminology at The University of Melbourne. Your name and contact details have been obtained from the Instituto da Droga e da Toxicodependência / Australian National Council on Drugs. This project will form part of Miss Hughes’ PhD thesis, and has been approved by the Human Research Ethics Committee: number 040105.

Aims
The aim of this study is to explore how national characteristics affect both the creation and practice of drug policy. The focus of this research will be upon the policies and responses to personal drug use, and includes behaviours such as trafficking, possession and consumption of drugs for personal use. The research involves three objectives:
1. To evaluate drug policy regarding drug usage in Portugal and compare and contrast this with Australian drug policy.
2. To explore the impact of national characteristics upon the development, implementation and effectiveness of drug policies in Portugal and Australia.
3. To assess the transferability of harm reduction policies between these two countries.

What will I be asked to do?
Should you agree to participate, you would be asked to contribute through participation in an interview. The interview would take between 45 minutes and 1 hour, and would cover the areas of development of the drug strategy, harm reduction and the legal/administrative responses to drug use and drug related property offences. Interviews will also explore the process and challenges to coordination and implementation and finally, the perceived outcomes of the drug strategy. With your permission, the interview would be tape-recorded so that we can ensure that we make an accurate record of what you say. When the tape has been transcribed, you would be provided with a copy of the transcript, so that you can verify that the information is correct and/or request deletions. Interviews conducted in Portugal will also involve a translator if your primary language spoken is Portuguese.
Confidentiality
We would like to seek your permission to use your name in the final thesis. If you would prefer some comments to be made off the record, you could indicate this during the interview, or when you review the transcript of the interview. If for any reason you choose not to be named, we would refer to you by a pseudonym, and remove any contextual details that might reveal your identity. We would protect your anonymity to the fullest possible extent within the limits of the law; your name and contact details would be kept in a password-protected computer file, separate from any data that you supply. This would only be able to be linked to your responses by the researchers, for example, in order to know where to send your interview transcripts for checking. You should note, however, that since the number of potential interviewees is small, it might still be possible for someone to identify you.

Feedback
Once the thesis arising from this research has been completed, a brief summary of the findings will be available to you on application at the Department of Criminology, or the Instituto da Droga e da Toxicodependência. It is also possible that the results will be presented at academic conferences and published through academic journals. The data will be kept securely in the Department of Criminology for five years from the date of publication, before being destroyed.

Rights
Please be advised that participation in this study is completely voluntary. Should you wish to withdraw at any stage, or to withdraw unprocessed data you have supplied, you are free to do so without prejudice.

Further information
Should you require any further information, or have any concerns, please do not hesitate to contact either of the researchers; Dr Steve James: 03 8344 9449 or Miss Caitlin Hughes: 03 8344 9510. Alternatively you may contact the Portuguese supervisor, Senhora Maria Moreira, from the Instituto de Droga e da Toxicodependência in Lisbon: 351 21 310 4126. Should you have any concerns about the conduct of the project, you are welcome to contact the Executive Officer, Human Research Ethics, The University of Melbourne, on ph: 03 8344 7507 or fax: 03 9347 6739.

Participation
If you would like to participate, please indicate that you have read and understood this information by signing the accompanying consent form and returning it in the envelope provided. The researchers will then contact you to arrange a mutually convenient time for you to undertake the interview.
Consent form for persons participating in research projects

PROJECT TITLE: Cross-National Comparison of Drug Policy in Portugal and Australia

HREC Project Number: 040105

Name of participant:
Name of investigator(s): Miss Caitlin Hughes, Dr Steve James

I agree to take part in the above University of Melbourne research project. I have had the project explained to me, and I have read the Explanatory statement, including details of the interview procedure. A written copy of the information has been given to me to keep.

I understand that agreeing to take part means that I am willing to:

- be interviewed by the researcher and her assistant
- allow the interview to be audiotaped

The possible effects of the interview have been explained to me to my satisfaction.

I understand that my participation is voluntary and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.

I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements. Due to the small size of the sample, there may be the possibility that you will be identifiable.

I understand that I will be given a transcript of data concerning me for my approval before it is included in the write up of the research.

Please tick the appropriate box:

- [ ] I agree that the research data provided by me during the project may be included in a thesis, presented at conferences and published in journals on the condition that I am referred to only by pseudonym.
- [ ] I give permission to use my name in any publications arising from this research.

Signature Date

( Participant)
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Hughes, Caitlin Elizabeth

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