



James Dunne

The Role of Research in Driving Progressive Drug Policy Advocacy: Reconsidering Our Approach

In late September I attended the second annual Hep C Community Summitⁱ in Lisbon and participated on a panel where we considered the question: how can we increase the relevance of research on policy and practice? At first glance, it seems straight forward – we need to ask the right questions to get the right answers. However, a deeper consideration of this question reveals critical issues for us to explore as advocates for progressive drug policy while also illuminating the nature of politics and power.

The medical and public health fields are blessed with huge amounts of research and data, and there is no shortage of sources to inform our policy and practice decisions. In the case of hepatitis C, for example, virological research explains the way that new Direct Acting Anti-viral treatments work at the biological level; epidemiological tools helps us understand who is most affected by hepatitis C and why; and research from the sociological schools bring in critical social factors that shape the expression of the virus. These data sources work together to enable decisions about patient care and policy direction.

But in the context of policy, and advocacy for policy change, the generation of data and the formation of new knowledge is only half the challenge.

Despite statements from our governments that “evidence-based policy” is a priority, “evidence” is often selectively used, or, as is regularly the case with illicit drug policy, ignored all together.

Consider the case of Drug Consumption Rooms and the “War on Drugs” more broadly. If evidence on its own was enough to create policy change we would see a Drug Consumption Room in every city and town, given the consistently positive public outcomes that these services provide and which research elucidates.ⁱⁱ If evidence on its own was enough to create policy change we would see an end to the “War on Drugs”, given how often research demonstrates it as a costly failure that negatively impacts on individuals and communities.ⁱⁱⁱ

So why do governments persist with ineffective policies in the face of evidence that says otherwise? One perspective is that this is due to the nature of power and its expression within policy discourse.

When thinking about power, researcher Peter Morriss^{iv} understands power not as the ability of one person or institution to *control* another, but instead the ability of a person or institution to *affect particular outcomes*. He builds upon the work of Stephen Lukes who, in his 1974 seminal book *Power, A Radical View*^v, sees power as the ability to create a latent conflict, where the expression of power enables certain questions and perspectives to lie dormant and unconsidered. In a policy context, these perspectives may be “out of scope” for discussion and remain as glaring silences within policy documents.

The way this power operates can be seen when policy documents are examined more closely. Returning to hepatitis C, the Australian hepatitis C response provides a useful example of the intersection of policy and power. Australia is often considered a global leader in responding to the virus^{vi}. Direct Acting Anti-virals are inexpensive within the Australian context and in many cases prescribed in community settings by local General Practitioners. Despite this environment, however, the numbers of people initiating treatment are plateauing and new approaches are required to ensure hepatitis C elimination can be achieved.^{vii}

Yet an analysis of policy documents illustrates that with the exception of the introduction of Direct Acting Anti-virals, Australia’s response has been consistently framed in the same way over the course of four national strategies. The policy responses focuses, for the most part, on individual behaviour change and enhancing pathways to care. Discussion on structural factors that contribute to hepatitis C are largely absent.

The HIV experience tell us, however, that laws operate as structural factors in HIV transmission, and play a significant role in creating vulnerability, hindering access to prevention and treatment tools and exacerbating stigma and social inequalities that make people more vulnerable to transmission.^{viii} Despite this research and the reality that hepatitis C is almost entirely concentrated amongst people who inject drugs, the role of illicit drug laws and their relationship to hepatitis C barely rates a mention within Australian national hepatitis C policy, let alone any action or law reform. Here public health research and knowledge becomes silenced and the power of governments to determine particular policy outcomes is demonstrated – namely, that the maintenance of drug prohibition sits at higher priority than public health goals.

The above examples illustrate that the data and knowledge generated through high quality research does not create policy change on its own. Power plays a critical role in why certain decisions are made and why certain research is ignored. Therefore, our question is not so much how we can make research more *relevant* to our achieving our goals, but how can we *more effectively* use the research we have.

This involves reconsidering the way that research is used as part of our advocacy process and the value it provides. Research can help us develop cohesive responses that challenge existing policy narratives and amplify the critical silences that are excluded from discussion. It can be a tool that helps uncover our own blind spots and illuminate new ways of looking at old issues. And perhaps most critically, research can help organise coalitions of practitioners, community members and researchers that want to see more progressive illicit drug policies.

If we want progressive drug policy to be the norm rather than the exception, we must see research as just one important tool in our response. Progressive drug policies will be realised through the building of coalitions that challenge powerful positions. And it is this data and knowledge that is generated through research which forms the platform on which these coalitions can be built and which change can occur.

For more than 10 years, James has worked in a variety of government and non-government public health policy and planning roles, and most recently with Australia's peak peer-based organisation that promotes the health and rights of people who use drugs. He has completed a Masters of Human Rights with a dissertation focusing on hepatitis C policy in Australia. James is currently working as a freelance public health consultant in Europe.

ⁱ The full program for the *Hep C Community Summit* can be found at <https://hepatitiscommunitysummit.eu/programme-2018/>. The Summit was held in conjunction with the 7th Annual Symposium on Hepatitis C in Substance Users. The program and presentations from the Symposium can be found at <http://www.inhsu2018.com/>

ⁱⁱ The European Monitoring Centre for Drugs and Drug Addiction provides a comprehensive review of research on Drug Consumption Rooms. The review can be found at http://www.emcdda.europa.eu/topics/pods/drug-consumption-rooms_en

ⁱⁱⁱ For example, see the Global Commission on Drug Policy's *War on Drugs* report at <http://www.globalcommissionondrugs.org/reports/the-war-on-drugs/>

^{iv} Morriss, P. (2006). Steven Lukes on the Concept of Power. *Political Studies Review*, 4(2), 124-135.

^v Lukes, S. (1974). *Power, a radical view*. London: Macmillan.

^{vi} Dore, G. (2017, July 31). Australia leads the world in hepatitis C treatment - what's behind the success? *The Conversation*. Retrieved from <https://theconversation.com/australia-leads-the-world-in-hepatitis-c-treatment-whats-behind-its-success-81760>.

^{vii} The Kirby Institute. (2017). Monitoring hepatitis C treatment uptake in Australia (Issue 8). Retrieved from https://kirby.unsw.edu.au/sites/default/files/kirby/report/Monitoring-hep-C-treatment-uptake-in-Australia_Iss8-DEC17.pdf

^{viii} Global Commission on HIV and the Law (2012). *Risk, Rights and the Law*. Retrieved from <https://hivlawcommission.org/wp-content/uploads/2017/06/FinalReport-RisksRightsHealth-EN.pdf>