G. Wardlaw

Final Report: Illicit Drug Reporting System. Consultant's Report to the Commonwealth Department of Human Services and Health

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The IDRS has been a product of many hands and minds over a decade. The IDRS was originally developed at the National Drug and Alcohol Research Centre (NDARC) by Julie Hando, Wayne Hall, Lisa Maher and Shane Darke.

Professor Darke ran the IDRS until 2001, and Libby Topp trialled the initial three-State pilot of the EDRS in 2000-2001. Louisa Degenhardt took oversight of the IDRS from 2002, and expanded the EDRS to a national system in 2003.

A succession of researchers at NDARC has contributed to the smooth coordination of the projects, and they are: Rebecca McKetin, Libby Topp, Courtney Breen, Jenny Stafford, Susannah O'Brien, Matthew Dunn and Emma Black.

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Foreword

In 1995 the Australian National Drug and Alcohol Research Centre (NDARC) was commissioned to design a relatively inexpensive way of monitoring trends in illicit drug use that minimised the effects of these challenges. The architect of the Illicit Drug Reporting System (IDRS) was a criminologist, Dr Grant Wardlaw, who ran an Illicit Drug Indicators project in 1990 and 1991. This predecessor version of the IDRS proved to be too slow and cumbersome to produce timely reports on illicit drug trends largely because it relied on existing indicator data collections (e.g. numbers seeking treatment, school surveys of drug use), which varied between States and were typically reported 1-2 years after their collection. This early monitoring system was abandoned in 1992 after two iterations.

Dr Wardlaw was then commissioned by the Commonwealth Government to review methods for monitoring illicit drug trends and to design a new system for doing so in Australia. In 1995, NDARC was funded to develop and test an Illicit Drug Reporting System that met Wardlaw's specifications. The IDRS was to provide coordinated monitoring of: trends in the price, purity and availability of major illicit drugs; patterns of use (frequency, routes of administration); and characteristics of the users of the major illicit drug classes of concern to health and law enforcement, namely, the opioids, cocaine, amphetamines and cannabis. The intention was to provide an *earlier* warning of emerging drug use trends than the number of arrests, treatment entrants, blood-borne viral infection (BBVI) notifications, and drug overdose deaths.

The IDRS became a national monitoring system by increments. The first report was published in 1996, and in 1997 and 1998 it was expanded from Sydney to Melbourne, Victoria and Adelaide, South Australia. In 1999 the full IDRS was conducted in these capital cities, but only the key expert (KE; formerly referred to as key informant, or KI) interviews and indicators were used in the remaining states and territories. From 2000 onwards a full set of IDRS information (KE, injecting drug user, or IDU, interviews and indicators) has been collected from the capital cities of every state and territory in Australia.

We believe that rationality is the outcome of a social process in which the validity and interpretation of data are tested by discussion and debate among experts who are knowledgeable

about the limitations of the data and their possible implications. When interpretation is uncertain, the aim of the discussion is to identify further research that needs to be done to resolve the uncertainties. Confidence has grown over time as a result of these experiences and as we have been able to retrospectively validate the findings of earlier iterations of the IDRS against information from lagging indicators. Alternative explanations generated in the meetings and reports have also been tested by looking at additional data sets or by including additional questions in later iterations of the IDRS, or in other studies of illicit drug use that were in the field.

Over the 12 years that it has operated the IDRS has proven to be a relatively inexpensive system for monitoring trends in the types of illicit drug use that cause the most harm to the community, namely, heroin and pharmaceutical opioids, benzodiazepines, and the stimulants, methamphetamine and cocaine. It has detected major changes in the availability, use and harms caused by these drugs in Australia over the past decade. Details of the projects and results of the work – bulletins, reports and publications - can be found on the NDARC website[1].

The current report is a reprinted version of the original report submitted by Dr Wardlaw to the Australian Government Department of Health Ageing. We feel that it provides important contextual information on the historical origins of the system that helps to understand the current operation of the IDRS, and its sister project that monitors trends in ecstasy and related drug markets – the EDRS.

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[1] http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/page/Drug%20Trends

FINAL REPORT

ILLICIT DRUG REPORTING SYSTEM

CONSULTANT'S REPORT TO THE COMMONWEALTH DEPARTMENT OF HUMAN SERVICES AND HEALTH

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August 1994

BACKGROUND

1. In March 1989, the Ministerial Council on Drug Strategy (MCDS) agreed to the implementation of an illicit drugs reporting system (IDRS) which was to provide a co-ordinated approach to the monitoring of data associated with the use of opiates, cocaine, amphetamines and cannabis. The IDRS was the source of data used to produce a number of Illicit Drugs Situation Reports for MCDS between 1989 and 1992. The *Illicit Drugs Situation Report. January to December* 1991, dated April 1992, was the final in the series. The reports were presented to the Senior Committee of Officials (SCO) six-monthly and to MCDS annually.

2. The aim of the IDRS was to collect and integrate information from a number of sources to reveal trend data which could serve as an early warning indicator of the availability and use of, and subsequent health problems associated with, major illicit drugs. On the basis of this information, it was hoped that jurisdictions would be able to put in place specific prevention and early intervention programs before problems arose or assumed significant proportions.

3. The *Illicit Drugs Situation Reports* were compiled from two major sources:

   - quantitative and qualitative data relating to health and welfare aspects of drug use. These data were supplied by each jurisdiction through the National Drug Abuse Data System (NDADS). The data included:

     - drug related morbidity, i.e. the number of clients at residential treatment agencies (both government and non-government) admitted during the collection period for treatment of problems associated with one of the major illicit drugs groups;

     - qualitative reports from health professionals, i.e. anecdotal information from 'key informants' having direct contact with drug users in non-residential agencies. Key informants provided estimates of current levels of illicit drug use, the severity of health or personal problems associated with illicit drug use, and the availability of illicit drugs;

- the number of telephone enquiries to specified health and welfare agencies regarding major illicit drugs.

- law enforcement data supplied by the Australian Bureau of Criminal Intelligence (ABCI). The ABCI supplied law enforcement data in the form of a *'Major Drugs Report'* which was prepared on a six-monthly basis for the Australasian Police Ministers' Council (APMC). These reports incorporated data collected from State and Territory police, the Australian Federal Police (AFP), the Australian Customs Service (ACS) and the National Crime Authority (NCA). The information contained in the report included numbers of arrests/seizures for each illicit drug group and police estimates of availability of the drugs.

4. The 1989 *Illicit Drug Situation Report* was regarded as being deficient because the aggregation of data at the State/Territory and national levels could mask the trends in specific localities, thus reducing the value of the system as a basis for planning interventions to respond to local problems as they arose. To remedy this deficiency, MCDS agreed in June 1990 that, where possible, regional reporting would -be incorporated into future reports. As a result, the key informant network was extended to incorporate reports from 57 regional areas. These regions were distributed as follows: New South Wales, 14 regions; Victoria, 8 regions; Queensland, 10 regions; South Australia, 9 regions; Western Australia, 8 regions; Northern Territory, 4 regions, Tasmania, 3 regions; and the Australian Capital Territory, 1 region.

5. Modifications to the IDRS were unable to overcome problems which had become apparent to both data producers and consumers. In particular, the anecdotal nature of the reporting system led to criticism of the reliability of the information supplied by the key informants. A number of other data limitations and problems also became apparent.

AIM OF THE CONSULTANCY

6. In view of the above problems, the Commonwealth Department of Human Services and Health commissioned this consultant's report to consider the options for designing an improved IDRS. According to the Consultant's Brief, the aim of the consultancy was "to develop an Illicit Drug Reporting System that will act as an efficient early warning indicator of the use, availability and severity of subsequent health problems associated with major illicit drugs on a regional basis. Law enforcement indicators will also need to betaken into account."

CONSULTANCY OBJECTIVES

7. The main objectives of the consultancy were to:

- examine the current Illicit Drugs Reporting System in order to determine whether this system is an appropriate and efficient collection vehicle;

- develop a methodology (either based on the current system, or if necessary, on a new and more efficient method of collecting these data) to collect and report on data regarding indicators of illicit drug use on a regional basis throughout Australia;

- identify appropriate contacts in each state/territory/ region who are able to provide informed data on the illicit drug scene in their area on a quarterly basis. Information required should include:

    - the level of **individual's illicit drug use**;

    - the **severity of health and social problems** associated with the use of illicit drugs;

    - the general **availability** of illicit drugs; and

    - the **main illicit drugs used**, ranked in order of prevalence;

- identify regional variations in illicit drug using habits so that regions at risk of potential drug related problems may be highlighted; and

- develop appropriate guidelines for incorporating law enforcement data.

8. Further consultation with the Department of Human Services and Health determined that additional issues to be considered in the consultancy were to include:

    - further clarification of the role of an early warning system, especially its link to policy action and the justification for putting such a system in place for illicit drugs as opposed to licit ones;

    - an assessment of the outcomes (costs and benefits) associated with an early warning system;

    - an assessment of the implications of an early warning system concentrating on illicit drug related harm rather than areas such as production, sales and usage;

    - an examination of how the need to provide timely feedback to jurisdictions could be met within the available resources; and

    - examination of some specific measures, such as the use of hospital morbidity data and improved methodologies involving key informants.

THE FORMAT AND CONTENT OF REPORTS FROM THE ORIGINAL IDRS

9. The *Illicit Drugs Situation Reports* which were generated from the original IDRS contained tabular and graphical summaries of admissions to government and non-government drug treatment centres (in the 1991 *Illicit Drugs Situation Report* these data were available for all jurisdictions except Tasmania and the ACI'), numbers of enquiries to drug information

telephone enquiry lines (in the 1991 report, for NSW, VIC, SA, and WA), and qualitative information supplied by key informants at treatment facilities regarding availability of supplies, individual use and severity of health problems associated with the use of illicit drugs. Qualitative data were given for each State and Territory and for each of the major drug types surveyed (heroin, cocaine, amphetamines, and cannabis). In addition to tables and graphs, the reports presented a brief commentary on trends for the major drug types by jurisdiction and for Australia as a whole. The information given was very general in nature, attempted to give a regional picture within each jurisdiction, and included dot point summaries of major key informant comments. Such comments did little more than state views about the relative frequency of use of the drugs under review.

OPERATIONAL LIMITATIONS OF THE ORIGINAL IDRS

10. The operation of the original IDRS, which reported trends for 1990 and 1991, revealed a number of significant problems which severely limited its potential as an early warning system. These included:

- the adequacy of the coverage by the key informants. This was particularly the case with some of the non-metropolitan regional key informants, due to the limited data at their disposal upon which to base judgements. Regional key informants were senior personnel situated at health/ welfare agencies in each reporting region. They were selected because of their knowledge of clients and the illicit drug scene in their areas and were also expected to consult with other appropriate sources to arrive at their six-monthly estimate of trends. Although key informants in capital cities had access to more detailed data sources, some of the same limitations were still evident. In particular, there was uncertainty about how representative the sources were of the general drug-using population, as opposed to those having contact with health/welfare agencies.

- variability in the suitability of regional key informants. It proved difficult to identify key informants in some regions who had access to the range of sources necessary for informed .estimates of illicit drug use trends. Nevertheless, in order to gain the desired level of regional coverage, informants were appointed even though their knowledge of the local illicit drug scene or access to a wide range of data may have been limited. The reports from these informants had equal status with those from better informed ones in other regions. There was no indication in the *Illicit Drugs Situation Report* which allowed the reader to judge the basis for the judgements contained in it.

- variability in the identity of key informants. Because many of the assessments used were subjective judgements, changes in key informants (due, for example, to staff turnover) meant that it was impossible to judge the extent to which reported changes reflected actual ones or merely different individuals' perceptions of the situation.

- the absence of a standardised methodology for data collection and thus no basis for estimating the reliability, validity or extent of coverage of the data submitted;

- the inability of all jurisdictions to supply regional information in a consistent and timely manner;

- the lack of a consistent reporting format and significant differences between jurisdictions in the degree to which the reports relied on qualitative data;

- the fact that the categories contained in the forms on which qualitative reports from health professionals in regions were submitted for collation were too general, subject to considerable individual interpretation and were responded to in many cases on the basis of subjective judgements. The forms asked for information for each of the major drug types in the following areas:

- individual use: estimate whether the number of individuals contacting non-residential agencies and claiming current use of each illicit drug have risen, fallen or remained steady since the beginning of the reporting period;

- severity of health or personal problems: estimate whether the severity of health or personal problems resulting from use of each illicit drug has risen, fallen or remained steady since the beginning of the collection period;

- availability of illicit drugs: estimate whether the availability of each illicit drug has risen, fallen or remained steady since the beginning of the reporting period;

- prevalence of use: rank, in order of highest prevalence of use, the illicit drugs used in the region during the collection period; and

- comment on trends: provide any comments about the illicit drug scene in the area, particularly changes in drug using behaviour, availability and severity of problems.

As is apparent from the way in which questions seeking this information were framed, reports were returned for collation containing qualitative judgements about the matters being assessed. They were often backed up with no quantitative evidence and there was no basis for deciding on the adequacy of the information upon which the judgements were made. Furthermore, just as MCDS recognised that regional trends are likely to become lost in State/Territory and national aggregations of data, so local trends are likely to be masked by regional aggregations. The extremely broad impressionistic generalisations contained in the regional reports provided no basis for determining local trends which may have been able to be acted upon or which might have acted as specific indicators which needed to be monitored more closely.

- difficulties in interpreting the qualitative data because different regions had different · baseline' rates of drug usage. Thus, numerically similar rises and falls in cases reported might be interpreted differently by the key informants when reporting against broad criteria such as "risen a lot" and "risen a little".

- lack of credibility for estimates of availability, given that many of the key informants had to rely on a limited range of contacts, mostly clients in a treatment setting, from whom to gather this information;

- questions concerning the interpretation of the information from telephone enquiries to drug information "hotlines". There are different data collection protocols for different telephone services, all data items are not always able to be collected for each caller, identification of precise local trends is made difficult because callers do not always give their location or those that do may represent a biased type of user or problem, biases are introduced into the data by the fact that a significant proportion of callers are not themselves drug users but are calling about the drug use of a relative or friend, there is an unknown number of callers who use the service more or less regularly, and the flow and nature of calls to the services is affected not only by trends in drug use themselves but by such factors as the presence or absence of major government campaigns concerning particular drugs and media treatment of particular drugs or drug-related incidents;

- lack of sufficient detail in the law enforcement data and delays in its provision;

- timeliness of reporting and collation. There were significant delays in reporting of some data to the National Drug Abuse Information Centre (NDAIC) in Canberra, which collated the information and produced the *Illicit Drugs Situation Reports.*

This undermined the usefulness of the system as a source of early warning of trends requiring policy or planning action.

- incompleteness and inadequate validation of key informants' assessments of major changes in the drug scene in their regions and their explanations for them. Some informants had no comments to make at all. Those that did varied widely in the amount of detail provided and the proportion of judgements accompanied by corroborating evidence. In essence, many of these judgements were unsubstantiated guesses and estimates.

11. In summary, the original IDRS was inadequate as an early warning system because it did not deliver timely information, was cumbersome to operate, lacked precision, used data whose reliability and validity were suspect and relied too heavily on subjective judgements made against imprecise criteria.

THE CONCEPTUAL LIMITATIONS OF THE ORIGINAL IDRS

12. In addition to the operational limitations discussed above, the original IDRS also suffered from a lack of conceptual clarity. This was most evident in the lack of clear aims for the IDRS and no articulation of how trends which were uncovered could be translated into policy or program action. In other words, there was no obvious link between the provision of warning and subsequent remedial or preventive action.

13. A number of other problems were also evident. These included:

- insufficient consideration given to the relevance of law enforcement data to the system;

- lack of clarity concerning the purpose of providing regional reporting. As noted above, regional reporting is just as likely to obscure local trends as national aggregation is to obscure regional ones. A clear decision has to be made on the level and detail of data required and how they are intended to contribute to policy and service provision decisions. In the case of the original IDRS, the decision to attempt comprehensive regional

coverage led to the collection of data of a quality and detail which were inadequate for decision-making at either regional, State/Territory or national levels.

- insufficient attention was paid to the integration of the IDRS data with reporting from other sources in order to allow for interpretation and analysis of the trends as a basis for decision making. This appears to be a major limitation of data systems in other countries also. As Haaga and Reuter (1991) point out in relation to Federal drug data in the United States: "The need is less for increasing the budget and scope of data collection activities than for ensuring that a variety of these activities be carried out in a manner that enables the data to be integrated into policy decisions" (p. 4).[2]

- insufficient attention was paid to the problem of timeliness. Simple and often impressionistic data collected as much as a year or more previous to the reporting to MCDS cannot be claimed to be an early warning system.

- the data requirements were not linked directly to addressing the major aims of the National Drug Strategy (NDS), especially harm minimisation.

- the system aimed to be too comprehensive rather than concentrate on high quality data selected because of their demonstrated reliability and validity and their usefulness to decision-making.

THE CONCEPTUAL BASIS FOR A NEW IDRS

14. It is evident from the limitations discussed above that the foundation for an improved IDRS must be a clear conceptual basis for its existence and a clear statement of purpose. The first characteristic of the IDRS is that it is intended to serve an early warning function. This immediately distinguishes it from a wide range of other National Drug Strategy data collections whose primary purposes are the comprehensive description of drug using populations and the monitoring and evaluation of strategies and programs.

[2] Haaga, J. and R.euler, P. (1991). *Improving Data for Federal Policy Decisions*. RAND Drug Policy Research Center, Santa Monica, CA.

15. Data required for understanding the nature, extent and consequences of illicit drug use and for evaluation purposes must be comprehensive, detailed and in-depth. They must ensure representative coverage of the population of interest if they are to be useful for policy making or accurate planning of service provision.

16. Data required for early warning purposes need to be comprehensive also. But their comprehensiveness comes in their coverage, rather than in their depth. Coverage, however, may be achieved by determining key indicators, a change in which would alert the policy-maker to the need to seek more detailed information about the nature of the underlying phenomenon before deciding how to respond.

17. In order to decide what are the appropriate indicators, it is necessary first to have a clear idea of who the client for the warning system is and how the client is able to respond to the warning. There are a number of possible clients for early warning systems and a number of possible levels of warning. In order to design a functional system, it is necessary to be clear on the uses of the system. In general, it is possible to distinguish between systems designed to provide tactical warning and those designed to provide strategic warning. (There are obvious parallels with tactical and strategic warning in the intelligence field.)

18. Tactical early warning applies to situations that require immediate response. It is usually short-term, often of a relatively localised nature, and often does not involve changes to policy (because of the short timeframe involved) but, rather, requires the immediate mobilisation of urgent response mechanisms. An example would be indications of the availability of heroin with levels of purity (either high or adulterated) capable of causing death to users. This might trigger public warnings or extra provision being made by ambulance and hospital accident and emergency departments in a particular region, but would not engender any major policy changes in the way heroin use is handled overall.

19. **Strategic early warning** is any type of warning issued early enough to permit decision-makers to undertake counter-measures. This may involve policy changes designed to affect the situation unfolding in a way which is consistent with the decision-makers' goals. Ideally, strategic warning provides sufficient time to take preventive measures which either forestall or (more realistically) lessen the size of the phenomenon in question or minimise its impact. An example would be information about major shifts in populations using a particular drug or the emergence of a new drug or method of administration. Such information might trigger the development of new preventive measures, a change in targeting of current ones or consideration of policy or strategy changes designed to have an impact on the emerging problem.

20. A national IDRS should be designed to provide strategic early warning. The system is intended to inform the MCDS and the National Drug Strategy Committee (NDSC). These bodies are charged with the formulation of national drug strategy. By definition, their work involves longer time periods and policy and strategic decision-making. If reports are to be considered by these bodies before action is taken, they cannot be viewed as demanding urgent action. (Especially since MCDS only meets once a year, so that some data will necessarily be a year or more old before they are reported to MCDS.) For the most part, urgent action will be a more localised matter and will be the responsibility of local or State/Territory health and law enforcement authorities. This implies that the data needs of the IDRS should be driven by the fact that the client is MCDS/NDSC and the level of warning required is strategic. Ideally, there would also be a series of local IDRSs whose clients are local authorities and whose data needs are driven by a focus on tactical warning. But it is important to note that because of the nature of the different levels of warning and different clients, a strategic IDRS is more than merely the collation of the products of a number of tactical IDRSs.

21. This conclusion has major implications for the level of coverage of the IDRS. If the purpose of the IDRS is to serve national strategic ends then it is not necessary to include detailed local or regional reporting in the system. This would be appropriate for local or State/Territory-based systems which might be established to serve both tactical and strategic warning functions at a sub-national level. Consideration of this issue

brings us back again to the purpose of the system. If the major purpose is to be early warning, the system must produce information capable of being acted upon. Emerging problems demanding urgent action will almost invariably be of a local or regional nature. The data which trigger such action will most often come from local sources which should be being constantly and widely monitored, rather than from a national IDRS in which local trends may be lost in the process of aggregation. In addition, local IDRSs will concentrate on the collection of data which indicate the need for immediate practical action, rather than the need to collect further detailed data for consideration in a major policy decision.

22. The time factor is crucial in determining the data requirements for a national IDRS. The strategic nature of the system means that data need only be of the type that indicate that significant changes are taking place in patterns of illicit drug production, distribution and use and in the consequences of these changes. Essentially, the data alert the system to the existence of emerging problems. They do not have to describe the phenomena in detail. That should be done on the basis of research commissioned for that purpose. Such research may involve the collection of new information tailored to the emerging situation or may involve the re-analysis of existing data collections.

23. This is an important point. If the national IDRS is to be capable of acting as a strategic early warning system, it must involve a mechanism for using the initial indicators to trigger the collection of more detailed data which will allow proper formulation of policy. The obvious mechanism is to have IDRS reports presented to meetings of the NDSC and for that body to consider them and, when necessary, commission further in-depth research for presentation to MCDS when they come to debate the issue[3] . In this way, the function of the IDRS is kept clear: It is to

[3] An obvious difficulty in ensuring timely deliberation of and action on reports from the IDRS is the fact that Nose itself does not meet regularly. Often there are more than six months between meetings. Given the argument presented above that a national IDRS of the type proposed cannot be expected to function as a trigger for immediate action, this delay is not necessarily critical. However, to be effective, each meeting of the NDSC should be in a position to make a decision at that meeting about the commissioning of any follow-up research or analysis. In the absence of such timely decision making much of the potential value of the IDRS would be lost. This may mean that some preliminary decisions, and certainly some discussion of the issues raised and possible avenues of investigation, will need to be made out of session.

alert policy-makers to the existence of emerging problems and to suggest areas for more detailed data collection. It does not itself need to be detailed. This has clear implications for the design of the system and the level of complexity of its operation.

24. The design of the IDRS must also be informed by a clear appreciation of the relationship between each data element and the sort of decision it is intended to drive. The major flaw in the old IDRS was that there was no obvious linkage between the data collected and possible decision-making. For example, the impressionistic reports used to generate estimates of availability in the 1991 *Illicit Drugs Situation Report* led to the presentation of graphs showing steady availability of three of the four major drug types with only one jurisdiction in each case showing increased availability. There was no indication of the extent of this availability and no way of telling whether or not this was merely a transitory observation. It is difficult to see how information at this level of generality could be used to prompt further study. The type of data collected and the manner of its aggregation meant that it was practically useless as an indication of emerging problems.

REQUIREMENTS FOR AN EFFECTIVE NATIONAL IDRS

25. A system which monitors key data sources in order to provide strategic early warning of significant changes in illicit drug use and its consequences is capable of performing a key service for decision-makers. It allows decision-makers to be warned of emerging issues which will require policy attention or the re-allocation of prevention, treatment or law enforcement resources in order to cope most effectively with emerging situations. In order to perform this function properly, a strategic IDRS must:

- **provide data in a timely manner**. As noted above, a strategic IDRS does not depend on having near real-time data which enables immediate corrective action to be taken. Such data are characteristic of a tactical IDRS. Rather, it requires indicative data which point to trends of national significance. However, in order to feed into the longer time-frames required by major policy-making processes, the data need to be collected, collated,

analysed and disseminated to appropriate bodies such as NDSC and MCDS in a timely manner. Without attention to timing issues, the data are not likely to be able to contribute to effective strategic counter-measures.

- **collect comprehensive data nationwide**. A critical requirement of a national strategic IDRS is the ability to provide data nationally on a range of indicators which are capable of alerting policy-makers to the existence of changes in the illicit drug environment. The changes monitored should be those likely to produce negative consequences whose management will demand the fashioning of new policies and strategies. The most obvious types of changes are those such as the emergence of new drug using groups (types of users or changes in the age structure of users), the availability of new drugs whose use is judged to have damaging consequences, new patterns of drug administration (eg, a change to injecting drug use), and new patterns of drug trafficking which may increase availability, change user preferences for particular drugs (eg, because a drug is more readily available in a different form) or increase the amount of violence in the drug distribution system.

- ensure that the data collected are comparable. 1£ the data are to be a basis for policy deliberation, the policy-makers *must* have confidence that data collected from all sites conform to the same standards of reliability and are collected according to common definitions or criteria.

- **be as simple to operate as possible**. In order to be able to keep to a regular reporting schedule (probably quarterly to NDSC and annually to MCDS) the system should not become administratively complex. This should be achieved by careful selection of data elements and collection sites to be included and keeping analysis, especially for the quarterly reports, to a minimum. This can be achieved if it is accepted that the purpose of the IDRS is to indicate trends that require further indepth analysis, rather than attempt detailed examination of the issues raised. At the same time, the data must be of

sufficient precision to ensure that decisions to order more detailed work can be made with confidence.

- **linked to a mechanism which can quickly commission the collection of more detailed data in order to further investigate the trends reported by the IDRS**. This report has argued that the detailed data which should inform policy-making should come from a system other than the IDRS. Once the IDRS has reported a trend which raises concerns for policy-makers, a need will exist for an in-depth examination of the phenomenon under discussion. This should be commissioned by NDSC or MCDS and should include the collection of targeted, comprehensive and in-depth data, synthesis with other datasets and analysis of the policy implications. In some cases, sufficient information may be gained by further detailed analysis of other major data collections such as the National Household Surveyor the Australian Criminal Intelligence Database (ACID)[4]. Whatever the method used, the IDRS should trigger further study of problematic trends that it identifies.

- **cost effective**. The system must not be costly to operate. This should be possible to achieve if the principle is accepted that the IDRS has a national strategic focus and that it will not itself be undertaking detailed analysis. The system is designed to identify emerging problems, not describe the nature and extent of the drug scene. That is the job of other collection and analysis efforts.

  It also suggests a major refocus from that emerging under the original IDRS. Any system that attempts to cover a wide range of regional centres individually will be costly and cumbersome to manage if data are collected in sufficient detail to be of practical value to national decision-makers. In the original IDRS, regional data were collected in an attempt to be able to describe the drug scene in Australia comprehensively and to

[4] The ABCI has expressed concern that detailed analyses of the ACID database may have funding implications depending on the detail required in the analysis. It will be necessary to properly resource additional analyses of any databases if their full potential is to be realised.

note major challenges. But the system was not capable of identifying trends of national importance. There was a confusion between the tactical and strategic levels of warning. Consequently, data were collected at a level of generality which was too vague to drive either further detailed research or to inform immediate practical action or major decision-making. At the same time, the attempt to provide comprehensive coverage produced a mass of data which proved difficult to collate in a timely manner and report meaningfully. An improved IDRS would seek to select a small number of key indicators, collect data of sufficient detail to justify confidence in the trends being reported and have a national focus which recognises that it does not seek for comprehensive national description but, rather, the identification of changes in the illicit drug environment which are likely to have significant implications for national drug policy and the strategies that flow from it.

MEASURES TO BE INCLUDED IN A NATIONAL IDRS

26. A wide range of datasets have been suggested as potential contributors to a national IDRS. Many of these exist in some form already in Australia. Examples are the many routine collections maintained by health and welfare and law enforcement agencies. Others have existed in some form in the past and could be reconstructed to avoid the limitations which led to their abandonment. Examples are specialised collections such as the National Drug Poisoning Case Reporting System (NDPCRS) and the National Forensic Case Reporting System (NFCRS)[5]. Finally, there are suggestions that new collections be established to tap new sources of

[5] For comments on the nature of these collections and analysis of the problems inherent in them see Pedic, F. (undated), *A Review of the National Drug Poisonings Case Reporting System,* National Drug and Alcohol Research Centre Technical Report Number 4, NDARC, Sydney; Pedic, F. and Flaherty, B. (undated), *Early Warning Indicators of Changes in Drug Use: A New South Wales Perspective,* National Drug and Alcohol Research Centre Technical Report Number 5, NDARC, Sydney: Thompson, J. (1993), *The National Drug Strategy Data System.* (Consultants Report to the Drugs of Dependence Branch, Commonwealth Department of Health, Housing and Community Services), Canberra.

information. A number of such suggestions have come recently from the law enforcement sector[6].

27. Each of the major existing and proposed collections were examined for this consultancy. Where the collections do not exist in Australia, the experience with the comparable systems in other countries (principally the United States) was assessed. In addition-use was made of previous reports which have reviewed the composition and usefulness of various illicit drug datasets[7]. The following types of data collection were considered for inclusion in the IDRS:

    - general population surveys, such as the National Campaign Against Drug Abuse (NCADA) Household Survey;

    - special population surveys, ie, purpose-designed surveys of specific groups thought to be more likely to display higher levels of problem illicit drug use or to suffer or cause more severe harm as a result of such use;

[6] An example is the suggestion from the New South Wales Police that Australia establish a Drug Use Forecasting (DUF) program based on a similar program in the United States which involves interviewing and urine testing of a sample of arrestees. See, comments by Bronwyn Say and Frank Hansen in G. Bammer (ed), *Australian Drug Markets Research: What Are We Doing? Where Are We Going? What Are the Gaps?,* Feasibility Research into the Controlled Availability of Opioids Stage 2, Working Paper Number 2. National Centre for Epidemiology and Population Health, The Australian National University and Australian Institute of Criminology, Canberra.

[7] Particularly useful were Collins, J.J. and Zawitz, M.W. (1990), *Federal Drug Data for National Policy,* US Department of Justice, Bureau of Justice Statistics, Washington, D.C.; Haaga and Reuter, op cit; Hartnoll, R, Lewis, R Daviaud, E., and Mitcheson, M. *(1985), Drug Problems: Assessing Local Needs. A Practical Manual for Assessing the Nature and Extent of Proble11lltic Drug Use in.the Community.* Drug Indicators Project, London; Jones, R and McAllister, I. (1986), *The Establishment of a National Drug Related Data Collection System: A Report to the Commonwealth Department of Health.* Canberra; New South Wales Directorate of the Drug Offensive (no date), *Discussion Paper on Data Accessed by the Directorate and Relevant to the Detection and Description of the Population of Intravenous Drug Users,* internal Directorate paper; New South Wales Directorate of the Drug Offensive (no date), *Discussion Paper on Data Sources for Area and Region Based Drug Indicators,* internal Directorate paper; Pedic, op cit; Pedic and Flaherty, op cit; Retka, RL. (1978), "Patterns of new drug detection in the Drug Abuse Warning Network", *British Journal of Addiction,* 73, 155-165; Reuter, P. (1993), ·Prevalence estimation and policy formulation", *Journal of Drug Issues,* 23 (2), 167-184; Rootman, I. (1988), "Epidemiologic methods and indicators", in J.C. Blackwell and P.G. Erikson (eds), *Illicit Drugs in Canada.* Nelson Canada, Scarborough, Ontario, pp. 213-219; United States, National Institute of Justice, *Techniques for the Estil11lltion of Illicit Drug-Use Prl!lJl1lence: An Overview of Rell!lJl1nt Issues.* US Department of Justice, Washington, D.C.;

- key informant studies on drug availability, patterns of use and severity of health, social, economic, law enforcement and other consequences;

- observational studies involving the direct observation and recording of behaviours of interest;

- drug-related treatment admissions;

- calls to drug information and counselling telephone services;

- drug poisoning case reports;

- drug-related accident and emergency department visits;

- hospital morbidity data;

- coronial examination of drug-related deaths;

- urinalysis of arrestees;

- data on drug arrestees;

- data on price and purity of illicit drugs offered for sale;

- data on seizures of illicit drugs;

- law enforcement intelligence information on availability of illicit drugs;

- ambulance service reports of calls involving illicit drug use; and

- data on use of needle exchanges.

28. Detailed examination of the "manner in which many of these datasets are assembled, the purposes for which they were (or would be)

created, and experience with their reporting and analysis reveal that most are unsuitable for full inclusion in an early warning system. The purpose of many is the detailed description of drug using populations. This information is essential for policy-making and necessarily describes trends in drug use and its consequences. However, it does not reveal trends within a timeframe that is required for the data to serve a warning purpose. The NDS Household Survey results, in particular, are available only a considerable period after the survey is actually conducted. Other datasets simply contain too much information to be analysed and presented in a regular summary designed to alert policy-makers to important changes in the drug environment. Still others are either very expensive to assemble on a continuous national scale or are beset by problems of coverage and interpretation.

29. In order to serve early warning functions, data should identify specific trends which, if they continue, will require new measures (policies, strategies, programs) to be implemented to change the direction or speed of the trends or mitigate their negative impact. The required data should be able to track changes in:

- drugs of choice (or form of the drugs of choice);
- routes of administration;
- populations using the drugs (ie, the types of users, rather than the numbers);
- problems emerging with new patterns of use (changes in demand for services, overdoses, changes in the type and seriousness of drug-related crime);
- the manufacture and distribution of illicit drugs (new groups involved, new marketing methods);
- price and purity; and
- market and illicit drug consumer reactions to government strategies (especially in law enforcement).

Some of these data are not readily available at present and special arrangements will need to be made to collect them or to produce the appropriate analyses from existing collections. For example, law enforcement data on changes in the type and seriousness of drug-related crime are not at present systematically collected and analysed.

30. The justification for each of these data elements is that changes in them can lead directly to the identification of further detailed data collection or analysis designed to better understand the phenomena and changes in question. In some cases the data may be sufficient themselves to indicate the need for an immediate policy or strategy change or the provision of new, altered or expanded services.

31. Attempts to measure changes in drug use incidence and prevalence are not very useful as short-term policy drivers. As the old IDRS measures on usage levels demonstrated, the data that can be collected on a quarterly basis are not such as to provide information of sufficient detail and quality to be of practical use to policy-makers[8]. Such data can only come from longer-term and larger-scale efforts such as the National Household Survey. For this reason estimates of changes in gross levels of drug use have not been suggested as part of the new IDRS. This information should be available routinely from the National Household survey and other purpose-designed or population-specific surveys. Rather, the IDRS should focus on changes in patterns and types of use to alert officials to emerging problems (and to indicate where interventions may be being successful).

32. Proposals to add other data elements to the IDRS should be judged against the criteria that they indicate changes in the occurrence or severity of harms caused by illicit drug use, that vulnerable populations are more at risk, that there is evidence of a risk of significant spread of use (generally or of a specific type), and that the information is likely to be of sufficient quality as to justify consideration of the trends by national policy-makers.

[8] Prevalence estimates can play an important role in drug policy formulation, but this does not generally extend to an immediate warning role. For further discussion of the contribution of prevalence estimation see Reuter, P. (1993), "Prevalence estimation and policy formulation", *Journal of Drug Issues;* 23 (2), 167-184.

THE PROPOSED ORGANISATION OF THE NATIONAL IDRS

33. The key requirements of the national IDRS are that it be able to identify changes in the drug environment which should be brought to the attention of NDSC and MCDS and that the system is simple enough to allow the regular reporting of indicators (preferably every quarter to NDSC and annually to MCDS). The data need to be indicative of problems and help define the requirements for more detailed research. They should not themselves be detailed. They need not involve reporting individually from a large number of regional centres. Since the IDRS is intended for national policy purposes, it needs only to be able to detect changes of national importance. State/Territory and local needs should be catered for by a system of tactical IDRSs organised at the Sate/Territory or local level. As with the national IDRS, these systems should be kept as simple as possible.

34. On the basis of the examination of data collection systems undertaken for this consultancy, it is suggested that the IDRS should be organised around two major activities -a redesigned set of key informant groups and National Drug Trend Indicator Meetings. These activities are described in the following paragraphs. It is also suggested that the NDSC and MCDS establish a mechanism (see following paragraph) to ensure that matters identified through the IDRS as issues of concern are subjected to further detailed examination. This could be either by the commissioning of in-depth research on the specific topics or undertaking detailed monitoring or analysis of existing major datasets (such as national surveys or treatment statistics).

35. It is important in collating and analysing the information gathered by the IDRS that both health and law enforcement perspectives are included in reports that go forward for consideration by NDSC and MCDS. Accordingly, it is recommended that the processing of IDRS data for submission to NDSC/MCDS be a joint responsibility of DAPEAS and the ABCI. This arrangement will ensure that the ABCI is able to feed its own data into the process to complement that received from the key informant groups and that coming to DAPEAS from health sources.

36. The original concept of using key informant groups to detect important changes in the illicit drug environment was a sound one. The implementation was flawed, however, by:

- the inclusion of a large number of regional reports in an attempt to provide comprehensive national coverage. The system failed to account for the different requirements of tactical and strategic warning.

- failure to identify key indicators that could lead to policy or practical outcomes; and

- failure to recruit appropriately knowledgeable and representative key informants for all the regions included in the system.

37. The new IDRS should recruit key informant groups in each capital city only. The justifications for this are twofold -to keep the system simple in order to manage the amount and timing of data delivered and because most trends of national importance will be detected reliably in the capital cities. This is not to say that regional and local trends are not important. But such trends will more likely require more immediate attention and should be detected through local warning systems. Such local IDRSs need not be complex. They require the same coverage as the national IDRS, but using local data sources.

38. The key informant groups should be recruited primarily from people who are part of the drug scene, rather than from officials whose major contact with it comes from dealing with clients at treatment centres or through access to official data collections. Special attempts should be made to recruit members of National Drug Strategy (NDS) priority groups such as young people, people from non-English-speaking backgrounds, and injecting drug users. Other groups of interest are those who have only recently come into contact with the drug scene, casual users who have not experienced any problems with illegal drug use, and regular and problem users who have no desire to approach official agencies.

39. Key informants should be tasked to provide information about the issues listed in paragraph.

40. Because of the need to access groups that normally have little to do with official agencies, it is recommended that a university (or other externally-based) research group be used in each State/Territory to organise the key informant groups and to report the results to their appropriate State/Territory authority and to DAPEAS each quarter. A number of such organisations have already demonstrated a capacity to gain entry to the required communities[9].

41. The use of key informant groups of this composition in order to monitor trends is a major innovation. It is recommended that one of the major research centres be asked to trial the concept for one year to allow MCDS to evaluate the utility of the data produced by such a system before extending it to all jurisdictions.

42. The second major activity proposed for a new IDRS is the organisation of six-monthly or annual National Drug Trend Indicator Meetings. This concept has been operating successfully for 17 years in the United States under the name of the Community Epidemiology Work Group (CEWG) sponsored by the National Institute on Drug Abuse. The CEWG is a "network of researchers from major metropolitan areas of the United States and from selected foreign countries. The primary objective of the Group is to provide ongoing community-level surveillance of drug use and abuse, principally through the collection and analysis of epidemiological and ethnographic research data. Through this program, the CEWG provides current descriptive and analytical information regarding the nature and patterns of drug abuse, emerging trends, and characteristics of vulnerable populations"[10].

[9] Leading examples are the National Drug and Alcohol Research Centre, the National Centre for Research into the Prevention of Drug Abuse, and the Drug Research Group at the Department of Community Medicine at the University of Melbourne.

[10] United States. National Institutes of Health, National Institute on Drug Abuse, *(1993), Epidemiologic Trends in Drug Abuse. Proceedings of the Community Epidemiology Work Group, June* 1993, NIDA, Rockville, MD, piii.

43. This concept has already been successfully trialed in Australia. In 1988 and 1990 the NCADA-funded ACT, Drug Indicators Project ran National Drug Indicator Conferences which provided an opportunity for health and law enforcement officials and drug researchers to share the most up-to-date knowledge about trends in illicit drug use in Australia and to discuss how better to collect and analyse data for drug policy purposes[11].

44. In the context of an improved national IDRS, the National Drug Trend Indicator Meetings would provide an opportunity for State/Territory representatives to share more detailed information about trends in illicit drug use. The purpose of the meetings would be to identify from the reports the trends which need further specific investigation and to prepare a draft "request for research" document for the consideration of NDSC or MCDS. This document should specify the details of the further collection or analysis tasks required and the policy/ program needs which they would address. If approved by MCDS, the document could be the basis for the commissioning of research designed to provide the detailed information required for national drug policy decisions to be taken. The type of research which would come from this process would normally be able to be completed within one year (and often sooner)[12].

45. Meeting attendees should include representatives of Commonwealth and State/Territory health and law enforcement agencies (including the AFP, NCA, ABCI and the Office of Strategic Crime Assessments (OSCA) of the Commonwealth Law Enforcement Board (CLEB)) and the research bodies contracted to organise the key informant groups. As with the key informant groups, they would be tasked to provide information about the issues listed in paragraph 29, but on the basis of official datasets such as the surveys or routine agency collections discussed in paragraph 27.

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[11] See Wardlaw, G. (ed), (1989), *Epidemiology of Illegal Drug Use in Australia 1988,* ACT Drug Indicators Project, Australian Institute of Criminology, Canberra; Wardlaw, G. *(1991), Epidemiology of Illegal Drug Use in Australia 1990,* ACT Drug Indicators Project, Australian Institute of Criminology, Canberra.

[12] Examples of the type of research envisioned are examinations of drug use in particular areas or groups. See, eg, Hando, J. and Hall, W. (1993), *Amphetamine Use Among Young Adults in Sydney, Australia,* Research Grant Report Series B93/2, NSW Drug and Alcohol Directorate, Sydney; Ross, J., Cohen, J., Darke, S., Hando, J., and Hall, W., *(1994), Transitions Between Routes of Administration and Correlates of Injecting Amongst Regular Amphetamine Users in Sydney,* NDARC Monograph No. 18, National Drug and Alcohol Research Centre, Sydney.

CONCLUSIONS AND RECOMMENDATIONS

46. Policy makers need to have in place some system to alert them to significant changes taking place within the illicit drug environment. Local and regional decision-makers need access to local and regional level information primarily to be able to respond to immediate concerns of health and safety. National decision-makers need information about trends which are more long-term and affect national policy considerations. There is therefore a need for two levels of IDRS - tactical IDRSs with a local/regional focus and a strategic IDRS with a national focus. The tactical IDRSs should be established by State/Territory authorities to meet local and regional needs. **It is recommended that MCDS establish a national strategic IDRS whose function is to provide warning of trends in the illicit drug environment which require national policy attention.**

47. The previous IDRS attempted to provide data which covered too many specific locations at a level of generality and on matters which led to no obvious policy deliberation. **It is recommended that the new IDRS be dearly focused on data items which stimulate a policy debate. The data should be simple to collect and should be used primarily to determine the requirement for further specific research and analysis to underpin policy deliberations**.

48. **It is recommended that the IDRS should be organised around two major activities - a redesigned set of key informant groups and National Drug Trend Indicator Meetings.**

49. **It is recommended that the key informant groups be recruited in each capital city only and that they be organised by university or other research groups.**

50. **It is recommended that one of the major research centres be asked to trial the concept of key informant groups for one year to allow MCDS to evaluate the utility of the data produced by such a system before extending it to all jurisdictions.**

51. **It is recommended that the National Drug Trend Indicator Meetings provide data on the same issues as the key Informant groups, but on the basis of analysis of official data collections.**

52. **It is recommended that NDSC or MCDS establish a mechanism to ensure that matters identified through the IDRS as issues of concern are subjected to further detailed examination. The processing of IDRS data for submission to NDSC/MCDS should be a joint responsibility of DAPEAS and the ABCI.**

53. **It is recommended that where further examination of issues identified through the IDRS involve substantial law enforcement input or have major implications for law enforcement such examination should be co-ordinated through APMC. This will ensure the proper degree of law enforcement input and contribute to the effectiveness of any measures which may be put in place as a consequence of the examination.**

IMPLEMENTATION ISSUES

54. A number of implementation issues flow from the above recommendations. The most significant of these are:

- the organisation of the key informant groups (how they should be recruited, how to maintain stability over time);
- the data elements to be included in the key informant monitoring;
- the collation and analysis of the data from key informant monitoring;
- the organisation of the National Drug Trend Indicator meetings; and
- the funding implications.

55. The precise composition of the key informant groups need not be specified in detail. The objective is to ensure coverage of the data elements which will serve to alert us to significant changes in the drug environment. The groups or individuals who are capable of providing the information will vary from time to time and in different cities. One of the purposes of recommending that a trial of this concept be carried out for a year in one city is to allow experimentation with different data sources and methods of collection.

56. The consultant believes that this trial period is of considerable importance, since a system of key informant groups established for this type of strategic early warning has not, as far as is known-been established elsewhere from which practical lessons can be drawn. The major guideline is that the principal contributors to the groups should be drawn from people who have direct access to the drug scene. Consideration should be given to participants from drug referral centres, youth drop in centres, drug treatment centres, academics conducting drug research at street level, drug user organisations, needle exchanges, drug squads and patrol police from selected stations, ambulance service, etc. The actual organisations supplying members will vary according to the city, but every effort must be made to include as wide a range of organisations as possible and to ensure that the representatives actually have contact with users.

57. An important part of the trial should be to attempt to have the key informant group actually meet on (say) a monthly basis to report on trends in their area of knowledge and to use the discussion as an opportunity to cross-check the information provided by individual participants[13].

58. Regardless of whether the groups meet physically, each contributor should be required to provide substantiation of their assessments. In some cases, this will involve the production of data from records (eg, ambulance overdose data, police intelligence, results of surveys undertaken among user groups or groups at risk). In others, the contributor should be required to at least outline the basis for the assessment (source of data, extent of coverage, factors having implications for the generalisability of the information, etc).

[13] It may be necessary to exclude police from these meetings in order not to inhibit the contribution of some participants. However, part of the trial should involve assessing whether or not police do in fact inhibit discussion.

59. A problem identified in the old IDRS was the variability in the identity of key informants and the subjective' nature of many of their judgements. As far as possible, the organisers should strive to maintain a consistent membership of the key informant groups over time. This will allow the expertise of the group to build up, especially if group meetings are used to cross-check and justify the assessments coming forward. Changeover of personnel representing particular organisations or expertise will, however, be less important in the new IDRS because of the increased emphasis on verification of data and justification of individual assessments. Nevertheless, a consistent membership should be encouraged by ensuring, for example, that the results of the meetings are fed back to the participants for their own use and that groups are informed of and, where appropriate, involved in subsequent follow-up investigations. Such feedback and involvement should make participation in the group a more rewarding experience for individual participants and, thus, maximise the probability of their continued participation.

60. It could be argued that the key informant groups suggested here are little improvement on the earlier system. There are important differences, however. These include:

- emphasis on a different type of information (ie, data which indicate major shifts in patterns of consumption, drugs of choice, methods of administration, populations of users, etc versus data on availability and prevalence of use) to provide strategic warning;

- emphasis on participants with direct contact with users and more reliance on other than official sources (nevertheless including street level input from official agencies such as patrol police, ambulance services, etc);

- emphasis on verification and cross-checking of trends, especially through regular meetings of and discussion by the key informant groups; and

- emphasis on adequate collation and analysis of the data from the groups in the form of quarterly reports from each State/Territory organiser and the central collation and analysis for policy and planning implications by DAPEAS/ABCI for submission to NDSC/MCDS.

61. Paragraph 29 suggested that data would be required to track changes in:

- drugs of choice (or form of the drugs of choice);

- routes of administration;

- populations using the drugs (ie, the types of users, rather than the numbers);

- problems emerging with new patterns of use (changes in demand for services, overdoses, changes in the type and seriousness of drug-related crime);

- the manufacture and distribution of illicit drugs (new groups involved, new marketing methods);

- price and purity; and

- market and illicit drug consumer reactions to government strategies (especially in law enforcement).

62. The American experience with the CEWG system is that it is not necessary to specify in great detail the actual data items which need to be collected to meet the requirement. There is need for some flexibility, especially in view of the different resources and types of collections available in each jurisdiction. Previous attempts to apply strict common definitions and data categories have foundered in the complex negotiations which are necessary to reach agreement. The time and effort spent in trying to negotiate standard formats for the now-defunct National Drug Abuse Data System (NDADS) are instructive in this regard. Such standardisation is desirable for collections such as surveys conducted in different jurisdictions if the results are to be used for comparative purposes. However, the data to be used do not need to be so standardised for strategic warning purposes.

63. The difficulties with non-standardisation are dealt with in two ways. First, by making the list of changes being monitored (as in paragraph 61) the standard, rather than the data items which address them. Second, by the meeting process, during which participants will be required to substantiate and argue the case for their proposition that a significant trend is being reported. The usefulness of the resulting report will depend on the ability of the organising agency to draw conclusions from the meetings and place degrees of certainty on the conclusions eventually presented after analysis of all the information submitted each reporting period.

64. There will certainly be room for refinement of the list presented above. It is suggested that further work be undertaken on the list by a working party comprising representatives of the centre chosen to trial the key informant groups, DAPEAS and ABCI. However, the consultant believes that the list

given in this report would provide a satisfactory basis for initial attempts to organise a key informant group.

65. As stated in paragraph 40, the consultant believes that university (or other externally-based) research organisations are best placed by virtue of their contacts, analytical expertise and perceived distance from official agencies to organise and report on the key informant groups. It is suggested that the research organisation would recruit the key informants, arrange the periodic meetings, analyse the input to the meetings and report (say) quarterly to both their own State/Territory health and law enforcement authorities and to DAPEAS/ABCI. The role of the latter would be to collate and analyse the State/Territory reports and to produce a national report for NDSC/MCDS which identifies trends of national importance and suggests what additional data collection and/or analysis should be undertaken to monitor or better understand the trends in question. In producing the reports for NDSC/MCDS, DAPEAS/ABCI would incorporate information from the National Drug Trend Indicator meetings. In essence, these meetings are the official agency complement to the key informant meetings.

66. If funding allows, it would be desirable for the National Drug Trend Indicators meetings to take place once every six months. As noted above, the American experience with the comparable CEWG meetings is that it is not necessary to precisely define the data collections which individual jurisdictions are expected to bring to the meetings. However, there is a tendency for comparability to increase over time[14]. As with the key informant groups, the list of changes to be monitored should be standard for each meeting. In addition, though, the meetings provide an ideal opportunity for jurisdictions to table their latest general drug use-related statistics. The Proceedings from the two meetings organised by the ACT Drug Indicators Project should serve as a model for the type of report that should result from these meetings. In addition, both the Australian and American meetings found it useful to use them as a forum for discussing methodological issues in drug research.

67. In order for these proposals to be effective, both the key informant network and the National Drug Trend Indicator meetings need to be properly resourced. The latter require little more than a conference organising and publishing capacity. DAPEAS/ABCI could act as the organisers or the work could be contracted out to one of the participating research centres. The experience of the meetings organised by the ACT Drug Indicators Project was that most of the organising could be done by a person at AS03/4 level under

[14] Personal communication, Mr Nick Kozol, epidemiologist and organiser of the CEWG meetings, National Institute on Drug Abuse, Rockville, MD, USA.

the supervision of a researcher. If the meetings were every six months, it is estimated that a half-time AS03/4 position would be required for conference organisation and production of proceedings. A small budget for venue hire, some travel subsidies, and publication of proceedings would be necessary.

68. It is estimated that the key informant group network would require a half-time research assistant under the supervision of a senior researcher in each jurisdiction and a half-time SOG C position from each of DAPEAS and the ABCI to facilitate national coordination, collate and analyse the State/Territory reports, and compile the reports and recommendations for NDSC/MCDS.