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Research paper

Examining the construction and representation of drugs as a policy problem in Australia's National Drug Strategy documents 1985–2010

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ABSTRACT

Background: National drug policies are often regarded as inconsequential, rhetorical documents, however this belies the subtlety with which such documents generate discourse and produce (and re-produce) policy issues over time. Critically analysing the ways in which policy language *constructs* and *represents* policy problems is important as these discursive constructions have implications for how we are invoked to think about (and justify) possible policy responses.
Methods: Taking the case of Australia's National Drug Strategies, this paper used an approach informed by critical discourse analysis theory and aspects of Bacchi's (2009) 'What's the Problem Represented to be' framework to critically explore how drug policy problems are constructed and represented through the language of drug policy documents over time.
Results: Our analysis demonstrated shifts in the ways that drugs have been 'problematised' in Australia's National Drug Strategies. Central to these evolving constructions was the increasing reliance on evidence as a way of 'knowing the problem'. Furthermore, by analysing the stated aims of the policies, this case demonstrates how constructing drug problems in terms of 'drug-related harms' or alternately 'drug use' can affect what is perceived to be an appropriate set of policy responses. The gradual shift to constructing drug *use* as the policy problem altered the concept of harm minimisation and influenced the development of the concepts of demand- and harm-reduction over time.
Conclusions: These findings have implications for how we understand policy development, and challenge us to critically consider how the construction and representation of drug problems serve to justify what are perceived to be acceptable responses to policy problems. These constructions are produced subtly, and become embedded slowly over decades of policy development. National drug policies should not merely be taken at face value; appreciation of the construction and representation of drug problems, and of how these 'problematisations' are produced, is essential.

Introduction

Approaches to drug policy vary across nations, and are reflective of unique social, cultural and political contexts (Babor et al., 2010). The formal documentation of national drug strategies has become ubiquitous. Tools such as the International Drug Policy Consortium's (2012) 'Drug Policy Guide' have even been published to assist their development. National drug policies are often regarded as inconsequential, rhetorical documents, especially when they are seen to maintain the status quo. However this belies the subtlety with which such documents generate discourse and produce (and re-produce) policy issues over time. Sometimes a shift away from previous approaches is made explicit by policy-makers. For example the Obama Administration's inaugural National Drug Control Strategy emphasised a "new direction in drug policy – one based on common sense, sound science, and practical experience" (Office of National Drug Control Policy, 2010, p. iii). The UK's 2010 Drug Strategy similarly emphasised a departure from "those that have gone before" by shifting focus from drug related-harms to promoting 'recovery' (HM Government, 2010, p. 2). Rarely are such discursive shifts (or their implications) made so explicit. More often, shifts are produced over time through subtle, but powerful, underlying assumptions and conceptual logics.

It has been suggested that explaining the development of drug policy should be a central concern for drug policy researchers. Such understanding can help researchers (and advocates) recognise that future change is possible and that drug policy is situated within a wider social and political context (Seddon, 2011). Furthermore, we contend that critically analysing the ways in which policy language *constructs* and *represents* policy problems over time is important

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as these discursive constructions have implications for how we are invoked to think about (and justify) possible policy responses (Bacchi, 2009). Fundamentally, "policies are constrained by the ways in which they represent the problem" (Bacchi, 2009, p. 13). By critically analysing the ways that 'problematisations' are produced (and re-produced) through the language of drug policy, we also begin to see how policy problems can be reframed and thought about differently, because policy problems are not fixed, objective ideas. As Fraser and Moore (2011, p. 505) argue, "once we recognise that policy produces problems rather than merely addressing them, and that these acts of production are subtle, complex and sometimes paradoxical, we find before us a new, compelling agenda for drug policy research".

Taking the case of Australia's National Drug Strategies, in this study we aim to delve beyond the surface of national drug policy documents. In doing so, we seek to develop better understandings of how drug policy problems are constructed and represented through the language of drug policy over time.

The Australian context

The multiple iterations of Australia's National Drug Strategy have for over twenty-five years provided an overarching framework (and a shared language) for alcohol, tobacco and other drugs policy in Australia. Attempts have been made to characterise an 'Australian approach' to drug policy, which has been said to be underpinned by principles such as harm minimisation, balance, partnerships, and a commitment to evidence-informed policy (Fitzgerald & Sewards, 2002; Single & Rohl, 1997). By the Australian Government's (2012) own account, the National Drug Strategy has been operating since 1985 as a "cooperative venture" with "bipartisan political support". Notably, throughout the process of evaluation and renewal of the National Drug Strategies, there has been a desire for the 'Australian approach' to be understood as comprehensive and consistent since its inception.

Contrary to this narrative of the 'Australian approach', it has been suggested by several commentators that Australia's drug policy has changed significantly over time as a result of political and ideological contestation. It has been argued that the social conservatism of the 'Howard Years' in Australian politics led to a shift in drug policy from the late 1990s onwards, away from harm minimisation and towards zero tolerance (Bessant, 2008; Macintosh, 2006; Mendes, 2001, 2007; Rowe & Mendes, 2004). Commentators have focused on the successive 'Tough on Drugs' statements (e.g. Howard, 1997, 1998; Liberal Party, 2001) made throughout the Howard Liberal-National Coalition's four terms in government (from 1996 to 2007) as evidence of this shift (Bessant, 2008; Mendes, 2001; Penington, 2010; Rowe & Mendes, 2004). They argue that 'Tough on Drugs' "overturned" (Bessant, 2008, p. 212) the harm minimisation framework which had previously characterised Australian drug policy. Bessant's (2008) analysis of the use of metaphor and moralising discourse in Australian drug policy compares the zero tolerance rhetoric used by the Howard Government, with the language of harm minimisation. Bessant (2008, p. 212) concludes that the Liberal Party's zero tolerance position "became official in the late 1990s", thereby 'replacing' harm minimisation. However, the consistency with which formal National Drug Strategy documents continued to reiterate harm minimisation as the overarching framework for Australia's drug policy throughout this period (and subsequently) sits uneasily with this assessment. Bessant's study focuses on the political rhetoric of the Howard Government, but does not include analysis of the 'formal' National Drug Strategy documents generated throughout this period. Mendes (2001, pp. 11–12) notes that despite the political statements put forward, the government paid "lipservice to the notion of harm minimisation" and did not seek to overturn its "formal commitment to harm minimisation goals and objectives". While Bessant (2008), Mendes (2001, 2007, 2004), Fraser and Moore (2011), Bacchi (2009), Keane (2009) and others have examined the discursive construction of Australian drug policy by focusing on particular aspects of Australia's drug strategy, during specific stages of development, comprehensive analysis of the Australian National Drug Strategy documents from 1985 to the present has not been undertaken.

Methods

This paper explores the hypothesis that there has been a discursive shift in the way that drug policy problems have been constructed and represented through Australia's National Drug Strategy documents over time. We analyse each iteration of the National Drug Strategy since 1985, using an approach informed by critical discourse analysis theory and aspects of Bacchi's (2009) 'What's the Problem Represented to be' framework (an approach which focuses on problematisation).

Approach

The notion that "language has meaning beyond mere words" (Aldrich, Zwi, & Short, 2007, p. 125) and fundamentally shapes and constructs the very nature of social life has been the subject of an extensive literature. The language of public policy is no exception. In recent years, the study of public policy discourse has emerged as an important research area in policy studies (see Fischer, 2003; Marston, 2004). This approach to policy analysis takes the view that "public policy is not only expressed in words, it is literally 'constructed' through the language(s) in which it is described" (Fischer, 2003, p. 43). That is, "public policy is *made* of language" (Majone, 1989, p. 1, emphasis added). From this perspective, the role of the policy analyst is to scrutinise the way policy problems themselves are constructed and represented ('problematised') (Bacchi, 2009), rather than regarding policy as a logical response to an empirically-known, predefined problem.

Critical discourse analysis (see Fairclough, 1995; van Dijk, 1993) has emerged from critical theory as a multidisciplinary, socio-political approach to discourse analysis, concerned primarily with "pressing social issues" (van Dijk, 1993, p. 252). The critical discourse analysis approach is a useful tool for policy analysis because, at its core, it aims to examine (and question) the underlying assumptions which are treated as accepted or normal within established discourses (Teo, 2000). By going beyond mere description of language and content, this approach seeks to "drill down into the ordinary use of language to derive meaning from the possibly incidental use of words or expressions" (Aldrich et al., 2007, p. 134). A critical approach to discourse analysis takes the position that policy documents, for example, are not simply objective government publications (Young & McGrath, 2011) but rather texts which contain contested meanings and values, privileging certain positions, whilst silencing others. The critical discourse analysis approach has been used previously to examine policy documents and political discourse (e.g. Aldrich et al., 2007; Smith et al., 2009; Taylor, 2007; Young & McGrath, 2011), whilst aspects of Bacchi's approach have recently been applied to drug policy in an examination of amphetamine-type stimulant policy in Australia (Fraser & Moore, 2011).

Our approach was informed by critical discourse analysis theory and the first two of Bacchi's (2009) six questions for policy analysis: (i) what's the problem represented to be in a specific policy and (ii) what presuppositions or assumptions underlie this representation of the problem? Using these analytic tools, following Smith et al. (2009, p. 220), we asked two questions to frame our analysis: (i)

Table 1
National Drug Strategy documents analysed ($n = 5$).

Year	Title of National Drug Strategy document	Document length	Stated authorship
1985	National Campaign Against Drug Abuse 1985–1992	10 pages	"Campaign document issued following the Special Premiers' Conference, Canberra, 2 April 1985."
1993	National Drug Strategic Plan 1993–1997	22 pages	"This document has been developed by the National Drug Strategy Committee for the Ministerial Council on Drug Strategy. The document was produced with the cooperation of health and law enforcement jurisdictions representing the Commonwealth and all States and Territories."
1998	National Drug Strategic Framework 1998–1999 to 2002–2003 Building Partnerships	54 pages	"This document was endorsed by the Ministerial Council on Drug Strategy at its meeting in Sydney on 19 November 1998. The document was prepared for the Ministerial Council by a joint steering committee of the Intergovernmental Committee on Drugs and the Australian National Council on Drugs."
2004	The National Drug Strategy: Australia's Integrated Framework 2004–2009	26 pages	"This document was endorsed by the Ministerial Council on Drug Strategy at its meeting in Sydney on 20 May 2004. The document was prepared for the Ministerial Council by a joint working group of the Intergovernmental Committee on Drugs and the Australian National Council on Drugs."
2011	The National Drug Strategy 2010–2015: A framework for action on alcohol, tobacco and other drugs	26 pages	"This document was approved by the Ministerial Council on Drug Strategy at its meeting held in Perth on 25 February 2011."

For full publications see: Australian National Council on Drugs (2012).

how are drugs constructed as a policy problem, that is, 'what's the problem represented to be?' and (ii) how do the policy documents represent the causes of and solutions to drug problems, and what are the values and assumptions which underlie these claims? (The second of these questions is separated into two parts – causes and solutions – below.)

Documents for analysis

We chose to analyse official National Drug Strategy documents, based on the rationale that such formal statements of public policy "are a distinctive kind of text which frame the nature of public policy problems, shape the boundaries of possible responses and act as points of reference for a wide variety of actors to justify subsequent actions" (Smith et al., 2009, p. 219). Such analysis contributes to our understanding of the policy process because policy documents represent consensus positions at particular points in the ongoing, contested policy decision-making process, revealing the values, ideas and interests which dominate policy debates (Iannantuono & Eyles, 1997). As such, these endorsed, formal documents exist as marker points along an evolving policy continuum.

All National Drug Strategies from 1985 to the present were collated ($n = 5$), sourced from the Australian National Council on Drugs (2012) database (see Table 1). The National Campaign Against Drug Abuse (NCADA, 1985) was chosen as the starting point for analysis, as this was the first time the federal government had formally documented a comprehensive approach to drug policy in Australia. The analysis focused only on national overarching drug policy documents, not State and Territory policies or documents with a focus on specific drugs (such as the alcohol, cannabis or amphetamine-type stimulant strategies which sit underneath the overarching National Drug Strategy framework).

Results

How are drugs constructed and represented as a policy problem?

By stating that drug problems "do not lend themselves to a short-term solution" (p. 1) and "will never disappear entirely" (p. 3), NCADA (1985) represented the problem of drugs as an ongoing, intractable problem. However, by 1993 this representation of drugs as a problem not easily 'solved' was revised: "some objectives will only be achieved over many years. *Others can, with intensive effort, be achieved sooner*" (p. 6, emphasis added). The 1993 National Drug Strategic Plan represented the problem of drugs as a costly, quantifiable, community-wide problem in need of careful management. The problem was constructed by being 'measured' and 'known', within a technical-rational framework, in contrast to the more emotive and less bureaucratic discourse of NCADA. The implication of this characterisation was that if a problem was measureable, then it was also manageable, and to some extent solvable. The National Drug Strategic Plan employed managerial and bureaucratic discourse to assert the authority of the state over the 'problem', by quantifying dollar-value costs and drawing on indicator data and expert knowledge. As such, the National Drug Strategic Plan sought not merely to respond to drug issues (as was the case in NCADA), but rather respond to what was represented to be an empirically understood problem in a strategic, effective and efficient way.

It is in this way that we begin to see the significant role that evidence, expert opinion and data play in constructing and representing the problem of drugs in these policy documents. In 1985 NCADA noted that "there is no authoritative collection of data upon which reliable estimates of the size of the problems associated with illegal drug use can be based" (p. 3). Data collection was regarded as central to the long term development of the strategy. Over time, each of the iterations relied on evidence in a different way, and as such 'problematised' drugs slightly differently. For example, by relying extensively on data, the 1998 National Drug Strategic Framework constructed drugs as a problem which was empirically understood and monitored consistently by those with expertise and authority. The data were regarded as reliable, collected through authoritative institutions. The 2004 National Drug Strategy also noted that "monitoring trends in drug use and drug-related harms is important" (p. 5). This suggests that the ongoing monitoring of the 'problem' was essential to responding to it, thereby constructing and representing the problem again as seemingly quantifiable and empirically understood (but nonetheless 'challenging').

The economically quantifiable cost of the problem of drugs was emphasised in the opening paragraph of the 2004 National Drug Strategy, by citing economic research. In keeping with the previous two iterations, drugs were represented as a health, economic and social issue, as well as a law and order problem:

> "Drug use contributes to significant illness and disease, injury, workplace concerns, violence, crime and breakdown in families and relationships in Australia. Collins and Lapsley (2002)

Table 2
Mission or aim of each National Drug Strategy document.

Title of National Drug Strategy document	Mission or Aim
National Campaign Against Drug Abuse 1985–1992	"to minimise the harmful effects of drugs on Australian society"
National Drug Strategic Plan 1993–1997	"to minimise the harmful effects of drugs and drug use in Australian society"
National Drug Strategic Framework 1998–1999 to 2002–2003 Building Partnerships	"to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society"
The National Drug Strategy: Australia's Integrated Framework 2004–2009	"to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society"
The National Drug Strategy 2010–2015: A framework for action on alcohol, tobacco and other drugs	"to build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities"

> estimated the economic costs associated with licit and illicit drug use in 1998-99 amounted to $34.5 billion, of which tobacco accounted for 60%, alcohol 22%, and illicit drugs 17%" (p. 1).

By 2010, the reliance on evidence was such that the policy problem could be constructed seemingly unequivocally: "The harms to individuals, families, communities and Australian society as a whole from alcohol, tobacco and other drugs are *well known*" (p. ii, emphasis added). Health and social harms were again quantified in dollar-terms, rather than being constructed in terms of social goods or quality of life:

> "the cost to Australian society of alcohol, tobacco and other drug misuse in the financial year 2004-05 was estimated at $56.1 billion" (p. ii).

This suggests that the policy problem, over time, came to be represented primarily in terms of the economic costs of drugs to society, rather than social outcomes (that is, health and social harms were perceived to be problematic *because* they were economically costly). The focus on the health system, workplace productivity, road accidents and crime is also notable in the 2010 document, and contrasts with earlier iterations such as NCADA (1985), where the costs listed included "illness" and "social misery" or the National Drug Strategic Plan (1993) which included "*less readily quantifiable costs* such as family breakdown", "pain and suffering" and "AIDS deaths" (p. 2, emphasis added).

Data also contributed to the way the policies constructed the problem of drugs in terms of drug *use* or *harms*. The changing emphasis on either drug *use* per se or drug-related *harms* altered how the problem of drugs was represented over time and, ultimately, the orientation of the policy framework. The changing language of the stated aims or missions of the policy iterations is notable in this regard (see Table 2). NCADA's (1985) aim was: "to minimise the *harmful effects* of drugs on Australian society" (p. 2, emphasis added). The problem of drugs was not represented to be drug use per se, but rather the associated harms which were described in social and medical terms: "waste of human potential... illness, disruption to production and social misery" (p. 1). The differing use of the terms 'use' and 'abuse' throughout this document allowed latitude to contemplate how drugs could be 'used' in society without necessarily resulting in 'abuse' or negative social outcomes. However by 1993, the aim changed: "to minimise the *harmful effects* of drugs and *drug use* in Australian society" (p. 6, emphasis added); with drug use specifically mentioned alongside the harmful effects of drugs.

The role of evidence in producing the concepts of 'use' and 'harm' is particularly notable in the 1998 document. Although reducing the harms caused by drugs was said to be the focus of the strategy, by drawing extensively on epidemiological data collected through the National Drug Strategy Household Survey and other sources, the extent of drug *use* in society (and not 'abuse' or 'misuse') became central to the way the policy problem was constructed. Not until page 8 of the strategy, after the problem of drug use was thoroughly documented, were indicators of harm discussed. An expert understanding of the 'problem' was implied throughout, drawing on scientific and medical discourses, with extensive referencing. Not until page 19 was the mission of the policy stated: "to improve health, social and economic outcomes by *preventing the uptake of harmful drug use* and *reducing the harmful effects* of licit and illicit drugs in Australian society" (p. 19, emphasis added). In its new expanded form, this was a significant departure from earlier iterations. Notably, it was expressed in positive terms (i.e. to 'improve' not just 'minimise harmful effects'), and prevention of initiation to drug use was explicitly included. This language was retained and expressed identically in 2004.

In 2010, reference to prevention and 'drug use' was removed from the overarching aim of the strategy: "to build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities" (p. ii). Like the previous iteration, the strategy aimed to more than minimise harms; but rather also 'build safe and healthy communities'. The concept of harm minimisation, therefore, was constructed not as a value-neutral aim but as connected to other aspirational goals. In doing so, alcohol, tobacco and drugs were represented to be un-safe and un-healthy.

How do the policy documents represent the causes of drug problems, and what are the values and assumptions which underlie these claims?

Very little was said (at least explicitly) in NCADA (1985) about the 'causes' of drug problems but some were implied. For example, the aim of education responses was said to be "to reduce underlying causes of drug use by helping people make informed responsible decisions about drug abuse and promoting self-help and positive alternatives to drug use" (p. 4). Here the cause of drug 'abuse' was represented as a lack of knowledge, which could be ameliorated through education thus empowering the individual to make choices. This construction of the 'cause' assumed that the individual had agency and that if people had access to information and knowledge, then a rational choice would be available to them. By 1993, although the costs and consequences of the problem of drugs were outlined in detail, still very little about the causes of the problem was defined. It was implied that further data collection, monitoring and evaluation would contribute further to understandings of the problem and the effectiveness of responses – therefore, the causes of the problem were represented to be quantifiable and empirically understandable with the aid of data. Within the 'Policy Approach' section of the National Drug Strategic Plan (1993), social justice and health inequalities were emphasised, the implication being that the problem of drugs was partly caused by these factors. As such, the document situated drug problems (or at least 'risk' or vulnerability') within certain categories of people, particularly "the socio-economically disadvantaged, remote communities and homeless people" as well as "Aboriginal Australians and Torres Strait islanders, prisoners, women, people of non-English speaking background, young people and injecting drug users" (p. 4).

The National Drug Strategic Framework (1998) was a departure from previous iterations and represented the causes of drug problems as empirically understood, by drawing extensively on data and research evidence. It was "factors underlying drug *use*" (p. 6, emphasis added) that were represented as the cause of the policy problem. These factors were categorised as social and cultural factors, psychological factors, health factors, market factors, and economic and geographic factors (pp. 6–7). These causes were represented as "broad and complex" (p. 6). This authoritative representation continued in 2004:

> "It has become clear that drug use is but one of a number of social and health problems that can share common determinants, and that these problems tend to cluster in vulnerable individuals and population groups" (p. 6).

Underlying these claims was the value placed on empirical knowledge, but also by representing the causes of drug problems in this way a sense of coordinated management and authority over 'vulnerable' groups who needed 'help' or 'intervention' from the state was produced. This continued in 2010 with the representation of the causes of drug problems as 'multiple and complex' (e.g. "Drug use is influenced by a complex interaction of physical, social and economic factors", p. 9). This was said to require "broad-based, multidisciplinary and flexible strategies [. . .] to meet the varied needs of individuals and communities" (p. 9).

The 2010 strategy represented the causes of drug problems in terms of social determinants, drawing upon the binary notions of 'risk' and 'protective factors':

> "There is strong evidence of an association between social determinants–such as unemployment, homelessness, poverty, and family breakdown–and drug use. . . Family factors – including poor parent-child relationships, family disorganisation, chaos and stress and family conflict and marital discord with verbal, physical or sexual abuse – also have a strong association with drug use" (p. 6).

In this iteration, concepts were represented normatively (this document is less referenced yet draws extensively on data and research). By representing these concepts normatively, there was no sense of contested understanding or limited knowledge of the causes of drug problems: "drinking during pregnancy can cause birth defects and disability"; "illegal drugs not only have dangerous health impacts but they are a significant contributor to crime" (p. 2); "it is well recognised that people are at greater risk of harm from drugs at points of life transition" (p. 5). In this way, over time, the causes of drug problems were constructed and represented increasingly technically and authoritatively.

How do the policy documents represent the solutions to drug problems, and what are the values and assumptions which underlie these claims?

One way to analyse the representation of solutions to the problem of drugs is by examining the overarching concept of harm minimisation used throughout these policy documents. Although it has been said that harm minimisation has formed the overarching framework for drug policy in Australia since 1985 (Single & Rohl, 1997), the term 'harm minimisation' was not used explicitly in NCADA. The term 'harm minimisation' was first used in the 1993 National Drug Strategic Plan, defined as:

> "an approach that aims to reduce the adverse health, social and economic consequences of alcohol and other drugs by minimising or limiting the harms and hazards of drug use for both the community and the individual without necessarily eliminating use" (p. 4).

In 1993, the key policy goals within the harm minimisation strategy focused on minimising health harms, minimising harm from drug-related crime, and minimising economic costs associated with "inappropriate use of alcohol and other drugs" (p. 6).

However, by 1998 a new definition emerged:

> "Harm minimisation aims to improve the health, social and economic outcomes for both the community and the individual and encompasses a wide range of approaches including: supply-reduction strategies designed to disrupt the production and supply of illicit drugs; demand-reduction strategies designed to prevent the uptake of harmful drug use, including abstinence-oriented strategies to reduce drug use; a range of targeted harm-reduction strategies designed to reduce drug-related harm for individuals and communities" (p. 1).

Although the concept of supply-reduction remained relatively constant through the various iterations, the use of the concepts of demand-reduction and harm-reduction changed. 'Harm-reduction' as a discrete concept was newly introduced in 1998, defined as a sub-set of harm minimisation rather than as synonymous with the approach. This may be because of the new way the concept of demand-reduction was used. In 1998, demand-reduction also included 'abstinence-oriented strategies' and so a separate concept of harm-reduction was required to cover interventions not concerned with reducing the prevalence of drug use per se. This was a significant departure from the 1993 definition of harm minimisation which aimed to limit harms "*without necessarily eliminating use*" (p. 4, emphasis added). Moreover, in 1998, harm-reduction was said to be "designed to reduce drug-related harm for *particular* individuals and communities" (p. 15, emphasis added). Whereas supply- and demand-reduction were constructed as having universal reach, harm-reduction was not. The separation of harm-reduction as its own discrete category sitting within harm minimisation, rather than as synonymous with it, arguably reflected a shift in the political rationalities underlying drug policy at the time.

Harm minimisation was represented in the 1998 National Drug Strategic Framework not only as a proposed solution, but as a 'successful' strategy. This assessment of 'success' was based on the evaluation of the National Drug Strategic Plan commissioned by the Ministerial Council on Drug Strategy (Single & Rohl, 1997) which is cited throughout. In this way, harm minimisation as a solution to drug problems was represented as 'justified' because it had been empirically assessed by those with 'expert' skills and knowledge. The success of the solution was said to be based on four features: the principle of harm minimisation, the comprehensiveness of the approach, the promotion of partnerships, and a balanced approach between supply-reduction, demand-reduction and harm-reduction. Many of these concepts were not explicitly expressed in previous iterations, but rather were produced through the process of evaluation. A narrative or 'historical' view of 'an Australian approach' to drug policy was thus formed.

More than a strategy or policy, harm minimisation was also described in 1998 as a "principle" (p. 1), implying a philosophical rationality which required a "shared vision"; that is, imbued with implicit ideological value beyond the technocratic implementation of policy interventions. However, confusion over the meaning of the term 'harm minimisation' in the wider community was noted (p. 21). Increasing "the community's understanding and acceptance of the broad range of prevention, treatment and harm-reduction programs and services" (p. 21) was listed as a first priority.

The 2004 document reemphasised the notion of 'an Australian approach'; harm minimisation had "formed the basis of successive phases of Australia's National Drug Strategy since its inception in 1985" (p. 2). Nonetheless, the definition altered again:

> "Harm minimisation *does not condone drug use*, rather it refers to policies and programs aimed at reducing drug-related harm. It aims to improve health, social and economic outcomes for both the community and the individual, and encompasses a wide range of approaches, including abstinence oriented strategies" (p. 2, emphasis added).

The nature of harm minimisation was further redefined by saying it focused on both "*preventing anticipated* harm and *reducing actual* harm" (p. 2). Harm minimisation was also no longer represented as a 'fixed' concept, as implied in the previous iteration through its construction as a 'principle'. Instead, it was said that "[h]arm minimisation approaches will vary according to the nature of the problem, the population group, the time and the locality" (p. 11).

The 2010 Strategy reaffirmed the historical narrative of consistency in Australia's response to drug problems: "The overarching approach of harm minimisation, which has guided the National Drug Strategy since its inception in 1985, will continue" (p. ii). Placing solutions in a rational frame, rather than being defined as a principle, harm minimisation was described simply as being made of its constituent parts: "the three equally important pillars of demand-reduction, supply-reduction and harm-reduction being applied together in a balanced way" (p. 2). It was also said that "prevention is an integral theme across the pillars" (p. 1). By 2010, harm minimisation was represented as a seemingly uncontested, rational and value-neutral concept. Although the overarching mission statement focused on minimising drug-related harms, an emphasis on prevention and reduction of drug use permeated the description of the three pillars said to constitute harm minimisation. For example, demand-reduction meant "strategies to prevent the uptake and/or delay the onset of *use* of alcohol, tobacco and other drugs", and harm-reduction meant "strategies and actions that primarily reduce the adverse health, social and economic consequences of the *use* of drugs" (p. 2, emphasis added).

Discussion

In this paper we have explored the hypothesis that there has been a discursive shift in the way that drug policy problems have been constructed and represented over time through Australia's National Drug Strategies. In doing so, we have sought to develop better understandings of the ways that 'problematisations' are produced through (i.e. 'made' in) the language of drug policy. These findings have implications for how we understand policy development over time, and challenge us to critically consider how the construction and representation of drug problems serve to justify what are perceived to be acceptable responses to policy problems.

Our analysis of Australia's National Drug Strategy documents demonstrated shifts in the way that drugs have been 'problematised' over time. In particular, we identified a shift from 1985 when the problem of drugs was represented to be an intractable problem to a representation of drugs as a quantifiable problem, which could be subject to a successful management strategy. Central to these evolving constructions of drugs as a policy problem was the increasing reliance on data and research evidence as a way of 'knowing the problem,' thereby constructing it within a rational framework. This shift accords with the rise of the evidence-based policy paradigm in the late 1990's, and is reflective of modern governments' desire for rational, effective and efficient solutions to complex policy problems (Head, 2008).

By analysing the stated aims of the policies, we identified shifts in the orientation of the policy framework, which were driven by the representation of drug problems either in terms of drug-related *harms* or drug *use* per se. This case demonstrates how constructing drug policy problems in terms of 'harms' or alternately 'use' can affect what is perceived to be an appropriate set of policy responses. Construction of drug use per se as the policy problem over time led to representations of the causes of drug problems as resting within individual drug-using subjects (i.e. 'determinants' which placed individuals at risk of use). The problematisation of drug *use* meant that the policy focus became the authoritative management of individuals' drug using behaviour (i.e. through prevention of initiation to use altogether, or medical treatment, or limiting access through supply control, or harm reduction interventions for particular 'at risk' groups). In turn, acceptable solutions came to be constructed as top-down in nature, rather than being generated at the community level (as NCADA in 1985 had contemplated). Moreover, the gradual shift to focus on drug *use* as the policy problem ultimately altered the concept of harm minimisation (initially aimed at limiting harms, without necessarily eliminating use), and within that, influenced the development of the concepts of demand- and harm-reduction over time.

The construction of drug-related harms (and not use) as the policy problem, arguably leads to different policy solutions. The problematisation of 'harms' leads not to the management of the individual 'drug-using' subject necessarily, but rather to addressing the structures around the subject to reduce harms which may be experienced by both the individual and the community. This is because the notion of 'harm' extends beyond the individual, whilst drug use per se, by nature, rests only within individual behaviour. This analysis demonstrates that what may to some appear to be an inconsequential distinction between the language of 'drug use' and 'drug-related harms' has important implications for the orientation of drug policy responses, and ultimately the lived effects produced by these two alternate representations of the problem of drugs.

This analysis also demonstrates that these different constructions are produced very subtly, through the possibly incidental use of language, and that these constructions become embedded slowly over decades of policy development. The findings challenge the normative characterisation of 'the Australian approach' to drug policy as being consistent since 1985. Moreover, they lead us to question whether the shifts identified were simply driven by the conservative agenda of the 'Howard Years' in Australian politics, as commentators have argued (Bessant, 2008; Mendes, 2001, 2007; Rowe & Mendes, 2004). The shifts we have identified have been produced subtly through policy, not simply by 'replacing' harm minimisation with a zero tolerance framework. Macintosh (2006, p. 1) argues that "[w]hile the rationale behind harm minimisation is compelling and the concept has received wide-spread support both domestically and abroad, there has been vigorous debate about how this objective should be pursued". We contend that evidence of this vigorous debate, and contestation of interests, agendas and political rationalities within the ongoing policy process, is manifested in the changing constructions of the drug policy problem, how its causes are represented and, accordingly, what emerge as appropriate responses. However we cannot conclude, based on this study, to what extent these discursive shifts are unique to drug policy or simply reflective of broader shifts in social policy (see Stewart, 2007). For example, to what extent is the focus on quantifying the economic costs of the problem of drugs identified in this analysis reflective of the way the 'costs' of health issues have increasingly been framed in economic terms? Further research is required to more closely examine the policy context, and, in particular, the

influence of new public management, evidence-informed policy discourse, and conceptualisations of the neo-liberal subject more broadly, both in Australia and internationally.

Despite the comprehensive analysis presented here, there are many interesting aspects of the National Drug Strategies which have not been examined in detail but which require further consideration. For example, what are the assumptions underlying the 2004 National Drug Strategy reference to "drug-related fear" (p. 7)? Why does the 2010 document make a distinction between the notions of 'evidence-based' and 'evidence-informed' policy and practice? What are the implications, in light of recent debate, of the first use of the term 'recovery'? All these elements could be subject to further analysis.

In delimiting texts for analysis and focusing only on the overarching National Drug Strategies, we have not taken into account the broader discursive framework of drug policy in Australia. Moreover, we cannot, using this method, draw conclusions about how the drug policy documents have been implemented in practice or the implications of these shifts for the 'affected community'. Wodak (2004, p. 1) argues that "to find out what governments are really doing, as opposed to what they say they are doing, we have to look at their actions rather than just their words". An assessment of how the discursive shifts we identified have influenced policy practice requires future research. Finally, we concur with Young and McGrath (2011, pp. 375–376) that "enculturation can make it extremely difficult to see pathways out of naturalised understandings. Overwhelmed by the dominant focus of the documents analysed, as analysts it became difficult to imagine how it might be possible to encompass an alternate approach". This is the challenge for researchers embedded within a normative framework, and a challenge for us (the authors) in producing this analysis. Such analysis nonetheless requires us to question normative frameworks of understanding, to better understand how 'problematisations' are produced through the language of drug policy, and, importantly reminds us that "things could have developed quite differently" (Bacchi, 2009, p. 10).

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