

**Towards a National Strategy for the Development
of Research on Tobacco, Alcohol,
Other Drugs and Gambling**

Strategy Advisory Document

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Disclaimer

The views expressed in this document evolved from the collective efforts of a stakeholder committee that included researchers, research provider organisations, treatment providers and government agencies. Although financial support originally came from the Mental Health Research and Development Strategy, the views in this document do not necessarily represent the views and positions of the Ministry of Health directorates and committees, Mental Health Commission or Health Research Council.

Executive Summary

This document presents a strategy for improving New Zealand's capacity to generate good quality applied research on tobacco, alcohol, other drugs and gambling.

The strategy has been developed over a two-and-a-half year period, beginning with the circulation of an ideas paper identifying perennial difficulties in developing research in this sector. Following this, an Advisory Group was formed made up of key researchers, end-users and other stake holders from within the sector. This group oversaw the compilation of a discussion document reviewing the current scene and outlining issues and opportunities for the future. Approximately 400 copies of the discussion document were distributed to key individuals and organisations along with a request for feedback or comment. Some submissions were received but several key organisations did not respond and interviews were therefore conducted with representatives from a selection of these organisations. Responses from the submissions and the interviews provided a foundation for the Advisory Group to prepare the present document.

The Advisory Group observes that the tobacco, alcohol, other drugs and gambling research sector is facing the following key challenges:

- it lacks a sizeable body of researchers dedicated specifically to investigating the harms associated with tobacco, alcohol, other drugs and gambling;
- funding opportunities are, on the whole, limited to one-off short or medium term project contracts, with little guarantee of continuity;
- trained researchers in the sector are forced into diversifying, or working on projects in other areas, or even leaving this sector of research altogether;
- new researchers have difficulties entering the sector for the first time, particularly Maori, Pacific and more recently Asian researchers;
- researchers tend to operate in isolated groups within sub-sectors and have little opportunity to build networks across the whole sector;
- end-users have difficulties accessing research outputs and expertise, and
- there is little consensus between researchers, end-users, funders or government agencies on the direction and priorities for research.

To begin addressing these key infrastructural issues and challenges, the Advisory Group considers two critical steps need to be taken:

Step One: Collective Engagement

This aims to foster greater interaction and integration across the sector by bringing together researchers and other stakeholders from each of the four sub-sectors in order to explore the viability of developing a common identity and collective purpose. A steering group would organise regular forums such as regional meetings and symposia that enable researchers to share their work.

Step Two: Development Projects

This step builds on the relationships formed in the first step in order to initiate a range of projects targeting key areas of infrastructural development. A project working group would oversee a range of development projects that aim to improve funding mechanisms, workforce development and communication/dissemination.

The following ten projects are recommended:

1. End-User Needs Assessment
2. International Review of Funding Models
3. Research Priority Setting
4. Research Workforce Development Strategy
5. Support for Trainee and New Researchers
6. Whole Sector Research Stock-take
7. End-User Technology Transfer
8. Regular Forums
9. Website Dissemination
10. Researcher Networking

It is unclear how structures will evolve after these two steps have been taken. However, one possibility, consistent with the majority of views expressed in the Advisory Group, would be the formation of a national coordinating committee to provide ongoing support for infrastructural development, to advance sub-sector strategies and to advise government agencies on sector development. This committee would comprise representatives from the four sub-sectors (tobacco, alcohol, other drugs, gambling) and would stand outside – but be in a strong relationship with – government sector agencies. The committee would ensure that sub-sector research strategies are formulated and maintained, and would be included in government planning processes.

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Introduction

Aotearoa New Zealand has significant health and social problems arising out of, and linked to, the widespread availability and use of tobacco, alcohol, other drugs¹ and gambling. Achieving a better understanding of the complex origins of these problems, and identifying and evaluating interventions to counter them that are appropriate to New Zealand conditions, requires a robust infrastructure for planning, undertaking and disseminating relevant, good quality research in these areas.

In New Zealand, a range of organisations and people fund and undertake research aimed at better understanding and responding to the spectrum of health and social problems arising from, or underlying, the use of tobacco, alcohol, other drugs and gambling. However, to date very little concerted attention has been given to examining how well this research effort is organised or ways it could be improved.

Towards the end of 1999, Dr Peter Adams was commissioned by the Mental Health Research and Development Strategy Steering Committee² to undertake a process aimed at generating a national strategy for the development of research in these areas. The main emphasis of the strategy would be the development of research capacity and infrastructure, rather than the identification of information gaps and research priorities.

Dr Adams had previously signalled an interest in fostering such a process, having presented papers highlighting the need for a strategy at various conferences and workshops. Over this time he had come to realise that there were a number of good reasons to examine the research arrangements for tobacco, alcohol, other drugs and gambling together in a single, over-arching consultation process:

- Tobacco, alcohol, and other drugs, like cannabis, are all psychoactive substances used recreationally (or due to dependence) by New Zealanders, sometimes in combination.
- Many of the broader social conditions thought to influence the problematic use of these substances and activities are similar. For instance, people experiencing significant adversity in their lives, or alienated from support networks, may be more likely to gamble, or use tobacco, alcohol or other drugs, in ways that may be considered harmful to themselves or others.
- Alcohol and other drug intervention services frequently treat people with problems linked to poly-substance use as well as co-existing mental health and /or gambling problems.
- Especially in the case of tobacco, alcohol and gambling research, there is a common concern with the role of commercial interests in promoting and marketing these substances and activities. There is also a common interest in the role of government in controlling the demand and supply of these substances through measures such as taxation, licensing and law enforcement.

¹ Other drugs refers to all other mood altering substances besides tobacco and alcohol. This includes illicit drugs such as opiates, and misuse and abuse of drugs such as minor tranquillisers and solvents.

² The Mental Health Research and Development Strategy Steering Committee include Consumer, Māori, Pacific, alcohol and drug, and District Health Board expertise, and representatives from the Ministry of Health (Mental Health Directorate), Mental Health Commission, and Health Research Council. In 1999 the Strategy was funded through the Health Funding Authority. Funding is now provided through the Ministry of Health.

Forming an Advisory Group

As a first step in the strategy development process, Dr Adams convened a Strategy Advisory Group made up of representatives from a range of different New Zealand organisations that either provide, purchase or use tobacco, alcohol, other drugs or gambling research. The Advisory Group met on several occasions during 2001 and 2002.

Discussion Document for Consultation

A major task of the Advisory Group during 2001 was assisting Dr Adams with the preparation of a discussion document: *Towards a National Strategy for the development of Research on Tobacco, Alcohol, Other Drugs and Gambling*. This document presented an assessment of the strengths and weaknesses of New Zealand's current infrastructure and capacity for undertaking research on tobacco, alcohol, other drugs and gambling, based on evidence and impressions offered by participants at meetings of the Advisory Group.

Key observations made in the document were as follows:³

- New Zealand lacks a sizeable body of researchers dedicated specifically to investigating the harms associated with tobacco, alcohol, other drugs and gambling. In part this is a result of the comparatively modest levels of funding earmarked specifically for work in these areas, and its unpredictability.
- Most funding for harm-reduction research in recent years has been secured in direct competition with other research areas, or by way of the commissioned research system, which on the whole offers only one-off short or medium term project contracts, with little guarantee of continuity.
- Hardly any substantial funding has been provided to support extended programmes of research specifically within the alcohol or other drugs areas, and none, or virtually none, for tobacco or gambling. As a result, in recent years many researchers with an interest and training in tobacco, alcohol, other drugs or gambling issues have had to diversify and undertake research projects in other areas, or even leave research altogether.
- Barriers restricting the development of specialist research careers are impacting in turn on new graduates and other researchers entering these areas of research for the first time, limiting their opportunities for on-the-job training and mentoring by more experienced researchers. This is particularly significant in the case of Māori and Pacific researchers. Research aimed at reducing the harms associated with tobacco, alcohol, other drugs and gambling needs to effectively address and respond to the perspectives of Māori and Pacific peoples, using methods and approaches that are culturally appropriate and safe. Central to this should be the development of a dedicated Māori and Pacific research capacity.
- In conjunction with the above, it is also necessary to consider ways to effectively support the development of Masters and PhD students who demonstrate the enthusiasm and ability to pursue a research career in tobacco, alcohol, other drugs or gambling.
- There is a need to develop resources and mechanisms to better support the sharing and dissemination of research expertise and data. This includes developing systems that enable data from previous studies to be made available for further study.
- New approaches need to be devised, such as regular forums or roundtable meetings, to promote more face-to-face discussion and networking between research funding agencies,

³ Appendix A provides a detailed summary of the contents of the January 2002 Discussion Document.

research end-users and researchers with an interest in reducing the harms associated with tobacco, alcohol, other drugs and gambling.

- Agreeing on priority topics for future New Zealand tobacco, alcohol, other drugs and gambling research may help to better align and focus the efforts of research providers and research purchasing agencies, in the interests of making the best use of the limited resources available. However, the identification of priority topics will need to be based on wide consultation with a broad range of research funding agencies, researchers and research end-users.

The discussion document ended by suggesting two possible strategies for beginning the work of addressing these research capacity and infrastructure issues:

- Establishing a high-level advisory committee with a clear mandate to regularly review and make recommendations on ways to further develop New Zealand's workforce and infrastructure for tobacco, alcohol, other drugs and gambling research.
- Creating a dedicated research development fund earmarked specifically for investment in research projects and other targeted initiatives aimed at strengthening New Zealand's infrastructure and capacity for undertaking tobacco, alcohol, other drugs and gambling harm minimisation research.

Key Informant Interviews

The Discussion Document was circulated widely to over 300 individuals and organisations early in 2002. A range of submissions was received but several key people and organisations did not comment. In order to capture a greater range of viewpoints, an independent evaluator was commissioned to supplement the submissions with a set of 16 key informant interviews. Informants were approached from each of the four sub-sectors and included health policy makers, research funders, research providers and end-users. They were interviewed for their ideas on the development of research in the sub-sectors with which they were familiar.

Appendix B contains a summary of the main observations, comments and suggestions arising out of the key informant interviews and written submissions. Key issues covered include coordination, research quality, funding mechanisms, workforce development, and communication and dissemination.

Strategy Advisory Document

In the final stage of the project, completed midway through 2003, the information, comments and suggestions gathered during the consultation process were used as a basis for developing the present Strategy Advisory Document. The current document outlines a recommended strategy, or set of key actions, for strengthening New Zealand's infrastructure for research on the harms associated with tobacco, alcohol, other drugs and gambling. The recommended actions build on, and as much as possible, attempt to reconcile and synthesise the wide range of perspectives and opinions expressed during the consultation process and meetings of the Strategy Advisory Group.

A Way Forward

This section outlines a set of key actions for strengthening the New Zealand infrastructure for research on the harms associated with tobacco, alcohol, other drugs and gambling. The actions as much as possible reflect and build on the wide range of ideas offered by participants in the consultation process and meetings of the Strategy Advisory Group.

Coordination

During the consultation process and meetings of the Strategy Advisory Group, a major theme for discussion was the issue of coordination. Some individuals advocated strongly for greater integration and collective working between the different agencies and individuals with a stake in tobacco, alcohol, other drugs and gambling research. This “cross sub-sectoral” approach was argued to be the key to addressing the infrastructural issues common to all four sub-sectors, providing the necessary momentum for sustained progress in the long-term. Infrastructural issues thought to be amenable to this kind of collective approach included:

1. funding processes (developing appropriate funding models, improving funder coordination, defining priorities for research funding);
2. enhancing research quality (building methods support services, improving standards of application and publication, introducing quality incentives);
3. research workforce development (recruiting, training and retaining a researcher skill base), and
4. communication and dissemination (building researcher networks, enhancing academic vitality).

Other participants in the consultation process were less inclined to accept that greater coordination between the four sub-sectors would necessarily be appropriate or beneficial for addressing these issues. However, most did agree that coordination could potentially have advantages if it was done appropriately and well.

Key Principles for Promoting Coordination

Participants in the consultation process expressed a range of opinions about the best strategies to use to promote greater coordination between the four sub-sectors. However, it was generally agreed that any process or structure instituted to promote this coordination should be developed according to the following core principles.

1. Research coordination processes are most likely to be effective if they are led or managed by research practitioners themselves, rather than by funding agencies such as government departments or ministries.
 - Researchers in the four sub-sectors are likely to have longer-term interests in this type of research than people working in government sector agencies.
 - Each government sector agency tends to focus on specific aspects of issues associated with the consumption of these products. For example, the Ministry of Justice will focus on crime, and the Ministry of Health on contribution to disease. This concern only with specific issues connected to the use and misuse of tobacco, alcohol and other drugs and gambling makes it difficult for a single government agency to embrace and appreciate the full complexity of the research issues confronting the sector, which span the molecular to the macro-social and global levels.

- Government sector agencies are subject to changes in political focus and orientation and may therefore have difficulty setting long-term objectives.
- Government sector agencies, particularly those involved in research funding, may encounter difficulties talking through strategies when the discussions could result in setting strong funding expectations with participants.

That said, it is important that key government sector agencies (e.g. the Ministries of Health and Social Development, the Alcohol Advisory Council [ALAC], the Health Research Council (HRC), and the Police) maintain a strong involvement in any future coordination processes. This could be achieved by representatives of government sector agencies regularly attending key meetings but limiting their role to advice and support and not attending as formal members.

2. Maintain a long-term focus.

The effort involved in setting up mechanisms for greater coordination between the four sub-sectors will only be worthwhile if they remain in place for a long period; a matter of decades rather than years. Research infrastructures take considerable time to develop (as an entry qualification for researchers, PhD graduates take years to recruit and train) and major research programmes similarly take a long time to formulate, implement and mature into useful applications. The relationships required for realising successful inter-disciplinary and multi-site collaborations also take a long time to build.

3. Involve all four sub-sectors.

During the consultation process and meetings of the Advisory Group there was a degree of ongoing debate about the appropriateness of including the tobacco and gambling sub-sectors in any future research strategy coordination processes. Tobacco research has to date built up its service and research base largely independently of the other sub-sectors, and concerns were expressed about the viability and usefulness of joining with the other sub-sectors to promote the interests of tobacco research. The absence of an addictive substance led some to question why gambling should be included with the other three sub-sectors. As well, the gambling research sub-sector is just emerging in New Zealand and for this reason its needs are not very well understood or appreciated by those in the other sub-sectors.

By the end of the consultation process and Advisory Group meetings most participants accepted there were several good reasons why the four sub-sectors should attempt to work more closely together to advance their common interests. These reasons included:

- All four sub-sectors have a focus on potentially addictive substances or products that are being commercially produced and distributed throughout New Zealand (three using legal distribution networks, and one using illegal networks).
- All four sub-sectors share the principles of harm minimisation as a basis for policy and strategy.
- As a small nation, New Zealand lacks the resource base to support separate coordination of research in each of the four sub-sectors.
- Efficiencies could be gained in servicing the diversity of research interests and methodologies within each sector. For example an epidemiologist or a pharmacologist could be active in two or more of the sub-sectors.
- The long-term development and updating of sub-sector strategies is unlikely to be adequately resourced and maintained in separate sub-sectors.

- The sub-sectors are more likely to achieve an effective voice in policy environments by working collectively.

4. Coordination should span both public health and treatment research.

Some participants in the consultation process argued that the infrastructure for public health research on tobacco, alcohol, other drugs and gambling should be addressed and developed quite separately from the infrastructure for treatment research in these areas. However, most were supportive of a single, unified coordinating process incorporating both public health and treatment research. It was acknowledged by many that to date the rigid separation of treatment and public health has not been beneficial to sub-sector development as a whole. It was also noted that increasingly the methodologies and perspectives of public health and treatment orientated service providers and researchers are overlapping and integrating.

5. Coordination processes should develop gradually, in a stepwise fashion.

Feedback from participants in meetings of the Advisory Group made it clear that the development of any future coordination processes or structures would need to evolve slowly and carefully. At present those involved in research in each of the four sub-sectors tend not to intermingle with people from outside their sector and therefore do not have a good understanding of the work they do. There is even perhaps some suspicion of those involved in other sub-sectors. In addition, efforts to obtain funding to support the development of new coordinating processes will take time and are unlikely to attract significant resources in the short-term. Linked to this, researchers in particular need to be reassured that funding for coordination will not come at the cost of funding for future research projects.

Stepping Forward

Given the principles just outlined, the following is a recommended way forward from here. It consists of two initial steps – (1) collective engagement and (2) development projects – followed by a possible third step that could be taken in the longer term should support emerge for it. Table 1 summarises key aspects of these three steps.

Table 1. Summary of multi-phase implementation.

	Purpose	Coordination	Activities	Time-frame
Step 1	Collective Engagement	Steering Group	Forums (e.g. symposia, conferences, networking)	2004/2005
Step 2	Development Projects	Project Working Group	Priority projects (workforce, funding, communication)	2005/2006
Future	Ongoing intersectorial coordination	High Level Coordination Committee	Committee active in policy, project, advocacy and ongoing planning	2006/2008

The first step – Collective Engagement – aims to foster greater interaction and integration across the four sub-sectors by bringing together researchers and other stakeholders from each sub-sector in order to explore the viability of developing a collective or common identity.

The second step – Development Projects – builds on the relationships formed in the first step in order to initiate a range of projects targeting key areas of infrastructural development such as workforce and funding processes.

It is unclear how structures will evolve best from here, but one possibility, consistent with the majority of recommendations from the consultation process, would be the formation of an ongoing permanent national coordinating committee for New Zealand research on tobacco, alcohol, other drugs and gambling. This committee would be made up of representatives from the four sub-sectors and would stand outside – but be in a strong relationship with – government sector agencies.

Step One: Collective Engagement

The consultation process identified a need for some form of overall coordination that provided support for the development of each of the four sub-sectors. However, during discussions it became readily apparent that researchers and other key stakeholders in each sub-sector tended not to associate strongly across sub-sectors (with the exception of strong ties between those involved in alcohol and other drug treatment services). In the absence of interchange, people in one sub-sector tend to have an under-developed appreciation of the similarities of focus and content they share with people in the other sub-sectors. This lack of interchange has contributed to levels of misunderstanding between members of each sub-sector. A guided process is required, based around the running of research symposia, which enables people from all four sub-sectors to interact more closely and begin exploring commonalities in purpose and focus. Events that enable people to meet and discuss ideas and activities will help both in building a common sense of identity and in facilitating the exploration of inter-sector activities and the combining of coordination.

Aim of this step

Development of greater links and communications between researchers, end-users, consumers and government agencies within and across the four sub-sectors.

Key Activities

1. Formation of a steering group.

A steering group will be required to initiate and organise the symposia. Interested members of the current Advisory Group could form the initial membership. The steering group will actively seek members from each of the four sub-sectors.

2. Organisation of regional symposia.

These could consist initially of presentations of current research within each region. The symposia will also provide a forum for discussion of sub-sector and whole sector development issues.

3. Organisation of a national conference.

A national conference will enable presentation of key developments in research, and assist in linking government sector, researchers and service providers.

4. Review progress.

It will be important to evaluate the success of this initial step and gauge how much support there is for moving to the second step centred on the completion of Development Projects (see below).

Sub-sector Engagement

The advantages to each of the four sub-sectors of the activities associated with this first step will take time to become apparent, particularly with long histories of separate development. However, there are clear benefits possible for each sub-sector.

Tobacco

During 2002 the tobacco sub-sector formed a research strategy committee. This strategy committee formally released its research strategy document in May 2003. The strategy is now well advanced and the tobacco research sub-sector is now seeking to engage in further dialogue with and secure support from government agencies. The strategy recommends the formation of a tobacco control research strategy steering group to oversee the implementation of the strategy. The opportunities for networking and discussion provided during the first step – collective engagement – could provide tobacco researchers with additional support in furthering their strategic goals.

Alcohol

ALAC has provided leadership on research strategy in this sector in the past. Although ALAC has remained primarily focused on alcohol, it has contributed to the development of responses to other drugs and gambling when they relate to the provision of alcohol. This is most obvious with treatment research. It is anticipated ALAC will continue to contribute to the development of an alcohol-related research strategy. ALAC has moved to a specific end of activity and its research interest is more oriented to public health. Other organisations with a critical interest in alcohol-related research, such as the Drug Foundation, Social Health Outcome Research and Evaluation (SHORE), the National Addiction Centre (NAC) and Alcohol Healthwatch, will be seeking input into the sub-sector strategy. The views of these organisations may or may not align with those of ALAC.

Other Drugs

The “other drugs” sub-sector is the least advantaged in terms of organisational support and strategy. The Drug Foundation has advocated for improvements to the research base on other drugs, but the Foundation lacks sufficient resources to develop these improvements on its own. Most of the research to date has been oriented towards treatment. The networking and forums in this first step could explore whether there is interest in developing a clearer definition of this sub-sectors research needs.

Gambling

Early forms of a gambling research strategy have been articulated particularly by the Centre for Gambling Studies at the University of Auckland. The HRC is also developing its role in the sector, and the Ministry of Health is preparing for its service-funding role once the Gambling Act 2003 is fully enacted. Accordingly, it is an opportune time to bring researchers together and begin exploring future directions. The networking and forums at this stage could assist in planning for the gambling sub-sector and building its recognition and support from the three other sub-sectors.

Step Two: Development Projects

If Step One goes well, and providing there is a consensus and support for further work, then the next step should be to undertake a series of well defined and planned development projects intended to benefit the four sub-sectors. At some juncture, the setting-up of these projects will require the creation of a formal or quasi-formal project working group made up of representatives from the four sub-sectors. The resources required to manage these projects will be included in the budgets for each project. Overall coordination could evolve in the process of managing these projects.

Aim of this step

Build a series of development projects that contribute to priority objectives for the whole sector.

Key Activities

1. Formation of project working group.

In order to support a range of projects, the original steering group will need to be reformed as a project working group capable of overseeing the management of multiple projects. The management of individual projects could occur within already existing institutions such as service or research units. But the overall progress of the various projects would need to be coordinated and monitored by one project group.

2. Project funding applications.

Implementation of projects will be dependent on accessing funding support from relevant agencies to advance infrastructural development. This funding will be sought in terms of specific project areas.

3. Promotion of cooperation between sub-sectors.

The progress made in bringing researchers and other stakeholders together in Step One will require further consolidation by continuing to provide events such as symposia and conferences where research activity is shared and developed.

4. Reviewing progress.

The project working group will need to monitor its own progress and assess whether additional coordinating structures and project development processes are required. As projects are funded, expected outcomes or outputs would need to be carefully defined and progress regularly evaluated.

Development Projects

The consultation process identified three critical areas for infrastructural development during Step Two. These were: funding mechanisms; research workforce development; and communication / dissemination. Ten development projects were proposed to address these critical areas. The projects were as follows:

Funding Mechanisms

Project 1: End-user Needs Assessment

The term “end-users” refers to a broad range of groups that include the general public, politicians, policy makers, government agencies, students, managers, advocates and service

users. This project would conduct individual and focus group interviews that assist in identifying perceived future needs for research information and knowledge.

Project 2: International Review of Funding Models

This project aims to review strategies used in other countries for funding research in the tobacco, alcohol, other drugs and gambling sectors. It could also look into the different ways in which multiple funding bodies coordinate their efforts for funding research in these areas. The information could form the basis of identifying a limited set of scenarios that use different purchasing strategies. These scenarios could form the basis of discussions with the various New Zealand funding bodies.

Project 3: Research Priority Setting

This project would undertake a pilot process for identifying research priorities in one of the sub-sectors. The process and output would be evaluated as to its suitability for defining priorities in other sub-sectors. The identified research priorities would form the basis for advice and discussion with government sector agencies.

Research Workforce Development

Project 4: Research Workforce Development Strategy

This project would work alongside the government's Health Workforce Advisory Committee and other workforce development initiatives to outline a strategy for recruitment, training and retention of a research workforce. It would begin by collecting detailed information on the status of the current research workforce, identifying key needs and, in consultation with key stakeholders, identifying opportunities for improvement.

Project 5: Support for Trainee and New Researchers

The working group could take responsibility for seminar and networking opportunities aimed at fostering the development of young researchers in the field. This might also include the introduction of scholarships such as junior scholarships, PhD scholarships, post-doctoral fellowships and possibly re-patriation scholarships.

Communication and Dissemination

Project 6: Whole Sector Research Stock-take

This project would combine all available databases on New Zealand research in the sector and searches for published and unpublished material for parts of the sector that have been missed out. The resultant database could be made available on the Internet.

Project 7: End-user Technology Transfer

This pilot project would tackle the issue of engaging health practitioners in acting on the outcome of research. For example, the focus could be on training strategies that get pharmacists or physicians to adopt new practices that have been shown by research to be more effective and/or efficient, such as the implementation of early and brief intervention strategies.

Project 8: Regular Forums

The working group could begin by organising regional symposia that bring together researchers and others interested in research to present work and share issues. These meetings would provide a foundation upon which to organise a first national conference, with the aim of the conference becoming a regular annual event.

Project 9: Website Dissemination

The construction of a whole-of-sector research website, incorporating New Zealand tobacco, alcohol, other drugs and gambling research of all kinds, could provide an important one-stop reference point for people to access information not just about the new and completed research projects, but also research infrastructure development issues. As well the website will be an important resource for many of the other projects (such as conferences, meetings etc).

Project 10: Researcher Networking

Future steering and coordinating committees could foster regional networks that enable communication and interaction between researchers within and across each sub-sector.

Sub-sector Support

Progress with each of these whole-of-sector initiatives is intended to support improvements in the four sub-sectors. Since the sub-sectors are at different developmental stages, each development project will vary in importance to each sub-sector. The main potential benefits these development projects will have for each sub-sector are briefly highlighted below.

Tobacco

In the wake of the release of *A Tobacco Control Research Strategy for New Zealand*⁴ the tobacco sub-sector will benefit from the following:

- improved networking within and between sub-sectors;
- closer definition of the perceived needs of those active in the sub-sector, and
- support for improved and better targeted funding, such as resources for a tobacco control research centre.

Alcohol

ALAC has provided ongoing support for research in the alcohol sub-sector for many years. The Step Two development projects could provide the following additional benefits:

- improved communication of the diversity of viewpoints within the sub-sector;
- improved networking between public health and treatment dimensions of the sub-sector;
- transfer of research knowledge into practice, and
- improved career development for alcohol-related researchers.

Other Drugs

As the least resourced of the four research sub-sectors, the development of the other drugs sub-sector is at an early stage. Its needs span all 10 development projects, but particularly the following:

- improved networking and communication of researchers and others involved in the sub-sector;
- development of a database of current and past New Zealand research on other drugs;

⁴ *A Tobacco Control Research Strategy for New Zealand*. Prepared by staff from the Department of Public Health, Wellington School of Medicine, University of Otago, in conjunction with the Health Sponsorship Council, the Cancer Society, Āparangi Tautoko Auhai Kore (ATAK), the Smokefree Coalition and the Quit Group.

- initial planning and consultation for the drafting of a national Other Drugs Research Strategy, and
- closer definition of the other drug sub-sector's key needs and research priorities.

Gambling

The contribution of gambling research is just beginning to attract some recognition. As funding becomes available this sub-sector would benefit from the Step Two development projects in the following ways:

- improved specification of the unmet information needs of New Zealand's gambling research end-users;
- increased recruitment of researchers into gambling research;
- improved networking leading to the formation of collaborative teams, and
- preparation of an initial statement of gambling research priorities.

A Permanent National Coordinating Committee

In response to the proposals in the January 2002 *Discussion Document* regarding the nature of coordination, subsequent discussions centred on the viability of establishing a permanent national coordinating committee to provide a focal point for the overall development of research in the four sub-sectors. Ideally this committee would have equal representation from the four sub-sectors and work in close collaboration with relevant government agencies.

The Advisory Group acknowledged that the realisation of such a committee would require time and resources and should be attempted in discrete stages. The following description of the committee is intended as an outline of the eventual form such a committee could take. However, its structure and processes may take a different form during the course of its actual formation.

Once project activity has attained sufficient participation and impetus, a base will have been created to set up a national coordinating committee. The committee and its operations will require funding support on an ongoing basis. Initial funding could be sought from government sources with additional funding as an overhead cost to contracted projects.

Purpose

The three primary goals of such a committee will be to:

1. identify and implement improvements to the research infrastructure of the four sub-sectors;
2. advance the formulation and delivery of sub-sector strategies, and
3. advise agencies of government on sub-sector and whole-of-sector development.

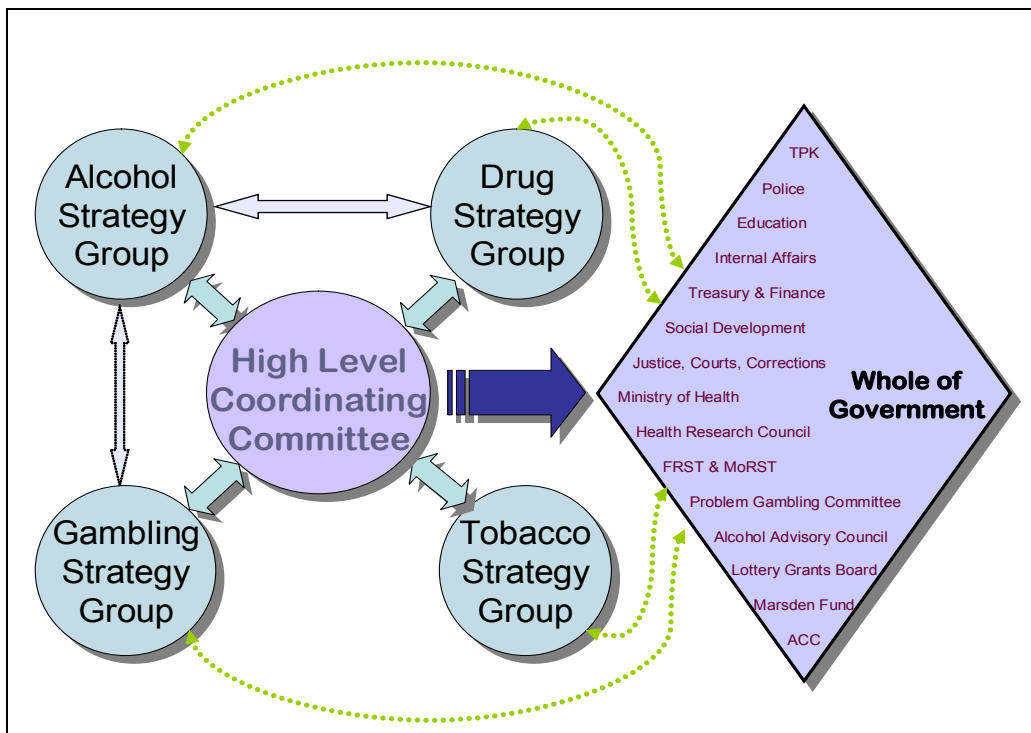
Details on the key actions in the formation of such a committee will need to wait until a clearer idea of suitable structures emerges from the two previous steps.

Relationship to Government Agencies

A major challenge for research into tobacco, alcohol, other drugs and gambling is that the sub-sectors' relationships to government agencies span the whole government sector. For example, alcohol-related research has relevance to government agencies concerned with health, justice, corrections, courts, finance, economic development, youth development, education,

social development, Māori development, and Police. Not only this, but a number of quasi government agencies have specific interests in the sector, these include ALAC, HRC, the Foundation for Research, Science and Technology (FRST), the Accident Compensation Corporation (ACC) and the Mental Health Commission (MHC). For each sub-sector, the task of maintaining relationships across all relevant government agencies creates enormous difficulties. The formation of a high level coordinating committee, consisting of a collection of experts and key stakeholders with a critical interest in the development of research in this sector, could provide the sector with a means by which relationships with government agencies could be built up on an ongoing basis (see Figure 1).

Figure 1.



During consultation, the general consensus was that government agencies would have difficulty both managing the committee and implementing research policy. For this reason it is envisaged that the committee stands outside government agencies. It is not intended that the committee will have responsibility for developing research funding policies or allocating research funds. The relationship is intended more as a partnership, with representatives of key government agencies (e.g. the Inter-agency Committee on Drugs and the HRC) in attendance at committee meetings, but not serving as actual members of the committee.

The committee will be in the position to offer assistance to government agencies in the following ways:

- assist government agencies to identify sub-sector research priorities;
- participate in infrastructure planning and development for the whole sector, and
- facilitate communication between research funders, research providers, provider organisations, policy makers and other end-users.

Relationship to Sub-sector Groups

The consultation process highlighted how each sub-sector is at a different stage of development, with different needs and different clusters of relationships. For example, gambling research is at a very early stage while alcohol-related research has had a longer time to refine its focus. The needs in each sub-sector vary according to the nature of the product and the social context of its use. For example, the physically addictive nature of tobacco requires different responses than more socially embedded products such as alcohol and gambling. Some overall issues (such as research workforce development and funding mechanisms) would be best handled at the combined level, but certain other initiatives, such as identifying future research priorities, need to take place mainly at the sub-sector level

A key role of the coordinating committee will be to ensure that development, implementation and updating of key sub-sector strategies continue to occur. For example, the coordinating committee could provide support to the recently released *Tobacco Control Research Strategy*⁵, assisting with its ongoing promotion to relevant government and non-government agencies and helping with any future revisions to the strategy document. Other forms of support the coordinating committee could provide to the sub-sectors include:

- advocating to government agencies for resources to advance research infrastructure development in accordance with sub-sector strategies;
- compiling and maintaining a web-based central register of completed and ongoing New Zealand research activities, and
- assisting in organising research symposia, training workshops, conferences and other forums.

Membership

As the coordinating committee will be primarily answerable to its sub-sector groups, membership of the committee should consist of an equal balance of representatives from each of the four sub-sectors. Two members from each sub-sector would provide a manageable group of eight committee members. Relevant government agencies could have input into the selection process and could attend and provide input into meetings of the committee on a regular basis. Additional experts could be co-opted to the committee for limited terms as required. The committee could meet initially every two to three months.

Operations

The activities of the committee will require an operational and resource base. At first all that may be needed may be the facility to organise and hold meetings. However, as projects develop, it will be necessary to develop some administrative capacity to manage projects and negotiate funding. In time, if the work of the committee extends to several projects, it may be necessary to appoint a director and possibly a small secretariat to provide administrative support for the committee and to action key developments.

⁵ See footnote 4.

Sub-sector Coordination

The work of the committee could have the following benefits for each of the four sub-sectors:

Tobacco

The committee could provide ongoing support for reviewing and updating the *Tobacco Control Research Strategy*. It could also assist the tobacco sub-sector's advocacy work with government agencies, as well as encourage and facilitate research collaborations with members of the other three sub-sectors.

Alcohol

The coordinating committee would provide a forum for alcohol-related research stakeholder groups to connect both within and across sub-sectors. It could also seek improvements to the level of recognition, quality and the shape of the workforce involved in alcohol-related research.

Other Drugs

The coordination of research on other drugs suffers from the lack of a clear strategy. The coordinating committee could assist in supporting the first steps in devising a research development strategy for this sector. It could put together a working group of key individuals and organisations with a critical interest in other drugs, and assist the group in the development of a strategy with clearly identified objectives and priorities.

Gambling

The coordinating committee could assist by supporting the formation of a working group to formulate an integrated research strategy for gambling. It could also assist by working to raise awareness of the issues that gambling research has in common with the other three sub-sectors, especially the alcohol-related research sub-sector.

Appendix A: Summary of January 2002 Discussion Document

Introduction

The following is a summary of the January 2002 Discussion Document, which described and evaluated New Zealand's infrastructure for tobacco, alcohol, other drugs and gambling research.⁶ The document was circulated widely for comment and feedback on it served as an important foundation for the preparation of the present Strategy Advisory Document.

The focus of the discussion document was on research aimed at understanding and responding to the various health and social problems arising from, or underlying, the use of tobacco, alcohol, other drugs and gambling. This included research concerned with the harms connected with recreational use, as well as research concerned with the origins and treatment of addiction or dependence, whether at the level of the individual or whole populations.

The document was divided into separate sections to covering each of the four harm-reduction research "sub-sectors" – tobacco, alcohol, other drugs, and gambling.⁷ While this was something of an artificial division, it offered the advantage of making it easier for readers to identify what was special and distinctive about each of the four sub-sectors, as well as what they had in common.

The document did not aim to address research capacity and infrastructure issues in any detail specifically from the point of view of Māori. After discussions with Māori who participated in meetings of the Advisory Group, it was decided that the way should be left open for Māori researchers and end-users of research, such as iwi, to embark on their own parallel process for considering these issues.

In various places in the document, examples were given of past and present studies. These were provided primarily to help readers get a sense of the scope and flavour of the research undertaken in recent years. The examples were not intended to be exhaustive, nor were they intended to be seen as a judgement on the quality or otherwise of studies not included.

The final section of the document drew upon the material from the previous sections and highlighted a core set of key development issues facing the four sub-sectors. It then proposed two initial steps that could be taken to begin strengthening New Zealand's overall research capacity in these areas.

Tobacco

In New Zealand, as in many other countries, a prime impetus for undertaking harm-reduction research on tobacco (otherwise known as tobacco control research) is the scale of the human costs attributed to cigarette smoking. About one in four adult New Zealanders are cigarette

⁶ Readers should note that some of the information about the New Zealand research infrastructure given in this summary of the original January 2002 Discussion Document may now be out of date.

⁷ Alistair Woodward and George Thomson contributed to the writing of the Tobacco section. Sally Casswell, Sally Jackman and Simon Adamson contributed to the writing of the Alcohol section. Sally Jackman, Simon Adamson and Justin Pulford contributed to the writing of the Other Drugs section. Peter Adams and Robert Brown contributed to the writing of the Gambling section.

smokers and 4,700 New Zealanders are estimated to die each year due the direct health effects of smoking. A further 388 are estimated to die as a result of second-hand tobacco smoke (Ministry of Health 2001).

Existing Research Arrangements

Tobacco control research covers many disciplines, including policy-related, biomedical, behavioural and public health fields. Currently the main providers of tobacco control research are the universities (including the departments of community health and public health at the Universities of Auckland and Otago), Māori health research groups, the Institute of Environmental Science and Research (ESR), independent researchers, and private consulting firms.

Research training is provided by the universities, through the usual undergraduate and postgraduate programmes. In the past the HRC has had an important role through its training fellowships scheme. This scheme has been available to Māori and Pacific researchers, and to people in the biomedical, clinical and public health areas.

While there has been no systematic study of the range, nature and funding of tobacco research in New Zealand, the most common funding sources appear to be:

- Ministry of Health;
- Health Sponsorship Council;
- the Quit Group;
- the Universities;
- HRC;
- Cancer Society;
- National Heart Foundation, and
- other health research funders such as the Lottery Grants Board and medical research foundations.

Commissioned research is likely to make up the greatest part of the total. Researcher-initiated projects funded from miscellaneous sources (such as work carried out in universities by students and staff with no outside funding) would come next, followed by investigator-initiated research supported directly by the HRC and other research agencies.

The HRC makes provision for tobacco-related research under lifestyle determinants in the Determinants of Health Research Portfolio. In addition, the Council acknowledges the *New Zealand Health Strategy* (Ministry of Health, 2000) and gives priority to research addressing the major causes of disease burden in New Zealand, health inequalities and health issues for the HRC's priority populations (i.e. Māori, Pacific peoples, children and young people, older adults and people with disabilities).

Commissioned research is most commonly arranged by direct contacts (for smaller projects) or a formal Request for Proposal (RFP) process. Priorities for this category of tobacco research are determined by the individual agencies. These tend to be influenced mostly by operational issues such as the need for evaluation of discrete, short-term projects.

Communication and Dissemination

Many government and voluntary agencies are (or potentially will be) involved in the tobacco control field, all requiring research information. They include, beyond the core health sector, the Health Sponsorship Council, Occupational Safety and Health (OSH), Treasury (economic costs, taxation and cost-of-life policy guidelines), Te Puni Kokiri; and the Ministries of Youth Affairs, Women's Affairs, and Social Development (e.g. social disparities in smoking and policy solutions). Non-government organisations (NGOs) include the Heart Foundation (and Te Hotu Manawa Māori), the Cancer Society, and the specialist advocacy groups, Action on Smoking and Health (ASH) and the Smokefree Coalition. Te Hotu Manawa Māori and the Cancer Society are involved as major providers, especially within the Quit Group, running the Quitline and Quit Campaign.

Tobacco control research is typically published in refereed journals or as technical reports. The electronic newsletter, *New Zealand Smokefree eNews*⁸, distributes news, research abstracts and information about tobacco policy. National Smokefree conferences provide an opportunity once every two years for service providers to meet researchers and policy analysts. The Public Health Association (PHA), the Health Promotion Forum and the New Zealand branch of the Australasian Epidemiology Association also hold meetings, publish journals and organise conferences that include tobacco research.

Examples of Past Studies

Landmark pieces of tobacco research in New Zealand include:

- the regular reports on smoking prevalence, based on the national census data collected in this country in 1976, 1981 and 1996;
- studies on the effects of advertising and prices on consumption, and
- investigations of the health risks due to smoking, especially those relating to cardiovascular diseases and cot death.

The Department of Health (during 1985-1990) and the Public Health Commission (PHC, 1993-1995) generated a considerable level of policy research (e.g. the 1989 *Toxic Substances Board report on tobacco advertising*, the 1993 PHC *Discussion paper on tobacco policy* and the 1995 PHC *Report on tobacco taxation*) (Thomson and Wilson 2001).

A key aspect of successful policy development during the 1980s was the associated research and evaluation activities conducted and commissioned by the Department of Health. In particular, it appears that the use of survey data to determine public attitudes and possible reactions to proposed interventions was critical.

The regular supply of new and topical survey data also allowed Department of Health staff and NGO workers to generate substantial ("free") media publicity that supported policy development. This history is well covered in a recent review by Laugesen and Swinburn (2000).

⁸ *New Zealand Smokefree eNews* – contact laugesen@mail.iconz.co.nz

Development Issues in New Zealand Tobacco Control Research

Research Gaps

In general, relatively little work has been conducted on smoking cessation, in particular for low income New Zealanders and for Māori and Pacific peoples. Some research has been commissioned on the constituents of cigarettes (Blakely NZPHR); more is required. Studies of the tobacco industry and its influence on decision-making in New Zealand are light on the ground, compared with work elsewhere that has drawn on the tobacco documents surrendered by the industry.

Very little social science research has been done relating to tobacco control. For instance, there is no research funded in almost all the areas of economics, sociology, anthropology, politics, history and policy studies that relate to tobacco control.

Research information is also lacking to support the development of current government tobacco control policies. Examples include:

- *the actions of employers*: The proportion of workplaces identifying second-hand smoke as an occupational hazard under the Health and Safety in Employment Act;
- *smokefree policy prevalence*: The present extent of smokefree schools and restaurants (while ASH is compiling a database, this will not cover all regions);
- *smokefree policy experience*: The experience of New Zealand smokefree restaurants – how easy is it to deal with customers, what issues arise, staff reaction;
- *the baseline population for smokefree bars*: The proportion of New Zealanders who go to bars/restaurants and the proportion of them who are non-smokers, and
- *prospective patronage*: The proportion of present bar patrons who would stay in bars the same amount of time or longer if bars were smokefree, and the proportion of the rest of the population would go to a bar if it all bars were smokefree.

Long-term Issues

These include:

1. New Zealand has failed to match the scale of tobacco control research (modest and ad hoc) to the magnitude of the health problems caused by tobacco (which is substantial, e.g. smoking is responsible for approximately 20 percent of premature deaths). The evidence for this includes:
 - the scale of HRC funding. In 2000 and 1998, the two years for which the HRC website can be searched, a total of \$252,600 was awarded for projects or programmes relating to tobacco or smoking. This is an amount equivalent to 0.58 percent of the \$43.4m annual government expenditure on health research;
 - the scope of the HRC funding. The projects funded by the HRC during 1986-2001 have only touched on the edges of the research needs for New Zealand tobacco control;
 - the lack of any New Zealand tobacco research programmes (as opposed to projects), and
 - the lack of a New Zealand focus for tobacco control research, a substantial body of experienced researchers in the area or any official plan for tobacco control research.

2. The lack of government accepted research on the economic effects of tobacco use, in contrast to Australia, Canada and other places. At present the New Zealand government does not have any accepted idea of the costs to the economy of tobacco use, even though the tangible effects alone may be almost 2 percent of GDP (Easton 1996).
3. The lack of research on the social effects of nicotine addiction. This is likely to include the exacerbation of poverty, child poverty, and crime by spending on nicotine addiction, and the effects on education by youth smoking.
4. The lack of data on the level of knowledge (as opposed to attitudes) by the general New Zealand public about the health or other risks of tobacco use.
5. The lack of a research purchasing approach that sees tobacco control as an interdisciplinary area. Such an approach would ensure that researchers were encouraged to acquire a range of skills, and funding would encourage the long-term collaboration of people from different disciplines.

Development Options

The Smokefree Coalition has argued that there is a need to develop a National Strategy on Tobacco Control Research for the following reasons:

1. The Government's National Drug Policy calls for further research "in many areas associated with tobacco and alcohol use". The policy encourages research funding organisations like the HRC, the Foundation for Research, Science and Technology (FRST), and other research funding bodies, to include research on key information gaps and evaluations in the tobacco area as priorities for funding.
2. However, at present there is a chronic lack of tobacco control research, few dedicated researchers and virtually no coordination.
3. The current Government has prioritised the reduction of smoking in its new national health strategy. Work to reduce the harm caused by tobacco cannot take place in an information vacuum.
4. There is currently no access to a speedy response to funding applications. Tobacco control works right up to the political interface and policy-writing bodies often demand a response within two months. The current funding bodies have an 18-month turn-around time.
5. Tobacco control research covers many disciplines such as economics, advocacy, toxicology, survey research, epidemiology, behavioural science, biochemistry and econometrics. However, funding bodies tend to give causation of disease the highest priority.
6. There are many government agencies and NGOs who have information needs on tobacco use in New Zealand. The information needs of all of these agencies and organisations are vast and often include controversial topics. Tobacco control research requires coordination to reduce duplication and ensure information gaps are filled.
7. The lack of research on Māori and Pacific peoples' smoking and exposure to smoke is a reflection of low sample sizes for quantitative work and the lack of access to funding for applied and qualitative research methodologies. Tobacco control research must extend past numbers to the investigation of behavioural responses to strategies such as price increases and to long-term studies of smoking behaviour.

The Smokefree Coalition argues that these gaps in our knowledge of smoking in New Zealand could be closed with the following steps:

- *Management of research needs* – An agency which surveys the field for research needs, and then matches research to funding sources, would give much needed coordination. Such an agency would inevitably provide a leadership focus for tobacco control research.
- *A substantial core of researchers* familiar with the aspects of the field (especially the cross-disciplinary nature of the field). Tobacco control researchers are thin on the ground and currently dotted around several institutions.
- *A dedicated research unit* that can focus on tobacco control research as there is for alcohol and injury prevention. Also there is no agency that ensures the cross-fertilisation of ideas within the tobacco control research field for New Zealand.
- *Funding sources* to respond to research needs, including applied and qualitative studies and proposal writing. These responses need to have the flexibility to provide resources speedily.
- *An overall monitoring agency*. While the Ministry of Health purchases some very basic prevalence survey data, and is developing a tobacco use surveillance strategy, no one agency sees a responsibility to establish what the overall research needs are, and to see that those needs are met.
- A location that has and keeps current information on published and unpublished information – a bibliography and a list of relevant databases (for instance the new Statistics New Zealand *Time Use Survey* database, which relates smoking time to other actions and demographic variables).
- *Publication* – A location that maintains a focus for the publication of relevant material. Currently there is a weekly email newsletter, but no central source of documents (e.g. a website) or series of hardcopy publications. A clear distribution process of research findings would also assist in the dissemination of information at both a national and global level.
- *Māori perspective* – A Māori focus for tobacco control research, and substantial bi-cultural tobacco control research capacity.

More detailed discussion of these and other tobacco control research development options can be found in the recent consultation document *A Tobacco Control Research Strategy for New Zealand*⁹ that seeks stakeholder input into the development of an agreed national tobacco control research strategy.

Alcohol

Approximately 90 percent of adult New Zealanders drink alcohol and about 1 in 5 are likely to experience an alcohol use disorder at some time in their life. Alcohol is also an acknowledged risk factor for some types of cancer, stroke and heart disease, and its use contributes significantly to death and injury on the roads, suicide and family violence (Ministry of Health 2001).

⁹ See footnote 4.

Existing Research Arrangements

New Zealand has two comparatively large and well-established research groups focusing on the problems of alcohol, the Alcohol and Public Health Research Unit (APHRU) and the National Centre for Treatment Development (Alcohol, Drugs and Addiction) (NCTD).¹⁰

The main focus of APHRU's work is alcohol harm prevention through national policy and community action research. In addition, the unit provides short courses and workshops on basic health promotion evaluation training for managers, health promotion advisors and community workers in the alcohol, public health and allied fields. It also runs specialised courses for Māori.

NCTD was established in 1997 under the directorship of Associate Professor Doug Sellman. Alcohol-related research conducted by the centre is treatment oriented and includes clinical research, development projects and Masters thesis/PhD dissertation work.

In addition to these two research centres, individuals with research expertise in aspects of the problems connected to alcohol use can be found in the medical schools and other university departments. Examples include staff within the Injury Prevention Research Centre (University of Auckland), the Injury Prevention Research Unit (University of Otago), the Goodfellow Unit (University of Auckland), and the teams conducting the Dunedin and Christchurch longitudinal health and development cohort studies (University of Otago). Several university departments also contain Masters and PhD students undertaking research projects with a focus on alcohol-related harm.

Some researchers with experience in the alcohol area are also based in government departments and ministries (e.g. Land Transport Safety Authority), Crown Research Institutes (e.g. ESR), iwi and advocacy groups, and private consulting firms (e.g. BRC Marketing and Social Research). There are also a few independent researchers working in the community (e.g. Dr John Bailey for alcohol-related traffic crashes).

Research in Clinical Settings

There is a history of housing specialist research positions within alcohol and drug clinical services. These positions are often temporary 'project' positions, but there have been attempts to create and maintain permanent positions within some service settings, such as the Clinical Information and Research Unit (CIRU) housed within the Auckland Regional Alcohol and Drug Services. These positions are ideally situated to conduct timely, relevant research specifically intended to inform clinical practice. This relevancy, combined with the presence of researchers in the service, enables a more efficient transfer of knowledge from the research stage to the treatment stage than is typically experienced when the two areas are separated. Furthermore, an on-going research presence within a service helps promote a supportive research ethos, reinforcing the value of research to clinical practice and encouraging clinician and consumer buy-in.

Despite the benefits that these positions convey, they are not a common feature of the alcohol and other drug treatment service landscape. Very few alcohol and other drug services are large enough to establish permanent research roles. In those that are, history has shown that

¹⁰ In July 2002, APHRU staff formed a new organisation, the Centre for Social and Health Outcomes Research and Evaluation (The SHORE Centre), situated at Massey University's Auckland campus. NCTD has also been renamed the National Addiction Centre (NAC).

funding uncertainties make them difficult to sustain. This uncertainty in funding has the potential to undermine the appeal of such positions when they do arise.

Funders and Funding Systems

The main funders of alcohol harm-reduction research in recent years have been the HRC, ALAC and the Ministry of Health.

The HRC has funded investigator-initiated alcohol-related research through project and programme grants, and supported research workforce development through research projects, scholarships and fellowships. The HRC evaluates research proposals on the basis of their potential to produce outcomes that contribute to the health of New Zealanders.

ALAC has used a number of research funding models. In addition to supporting investigator-initiated research and career development awards, ALAC has sought competitive tenders from academic and market research groups in response to an ALAC generated research brief, commissioned research using a preferred provider model, and called for tenders on specific alcohol-related topics.

While ALAC has invested in alcohol-related research at a consistent level over a number of years, the level of alcohol funding from the HRC fluctuates from year to year depending on the evaluation of research proposals received through its annual funding round.

Funding from the Ministry of Health is usually by way of commissioned studies. From time to time the Ministry has also jointly funded projects in conjunction with the HRC and/or ALAC.

Communication and Dissemination

The main forms of dissemination for alcohol-related research are through refereed journals, technical reports, newsletters, briefings, conference presentations, hui and videos.

New Zealand researchers in the alcohol field meet together infrequently for specific purposes. Generally researchers collaborate on particular areas of interest or meet and discuss common issues at conferences such as the Public Health Association annual conferences, the Cutting Edge annual conference (which focuses primarily on treatment issues), injury prevention conferences and international (usually Australian) conferences.

Regular newsletters include ALAC's *Alcohol.org.nz* (previously *Say When*), and *Treatment Research News* – the newsletter of the Treatment Research Interest Group (TRIG).

ALAC offers a visiting fellowship in alcohol-related research and these and other overseas researchers visiting New Zealand provide opportunities for networking among local researchers. APHRU and NCTD, in their roles as major alcohol-related research centres have hosted a number of overseas research visitors.

Some agencies offer internet resources. APHRU, for example, makes research findings available via its website. ALAC manages an alcohol and drug email network that includes contributions from researchers. It also supports a website (www.alcohol.org.nz) which includes an extensive database of New Zealand alcohol-related research publications and projects. Staff members from ALAC are also actively involved in developing the worldwide Virtual Clearinghouse on Alcohol, Tobacco and Other Drugs. This website (www.atod.org)

aims to provide free access to an extensive collection of fully-downloadable tobacco, alcohol and other drug publications (including research reports) from many different countries, including New Zealand. The Virtual Clearinghouse also contains an international email directory of organisations and individuals working in the field of alcohol, tobacco and other drugs.

Examples of Past Studies

Alcohol and Public Health Research Unit

APHRU is the national lead provider of alcohol survey data, surveying annually in the Auckland region from 1990 to 2000, and collecting national survey samples in 1995 and 2000. Staff in Whariki, APHRU's Māori research partner, have published data on drinking by Māori and conducted a national sample survey among Māori in 2000. As well, APHRU staff have participated in a number of evaluated community action projects. Many of the policies and strategies developed during these projects have been acted on by end-users, in particular by Māori organisations and communities, who have been assisted to document and validate their approaches to reducing alcohol-related harm (Casswell 2000).

APHRU has also been a key provider of alcohol policy research covering issues such as alcohol advertising (e.g. qualitative and quantitative studies of young people's responses to televised alcohol and moderation advertising), taxation (e.g. effect of excise tax on the price of alcohol and therefore consumption), sale of liquor legislation (e.g. studies of the implementation of the Sale of Liquor Act 1989 and subsequent 1995 amendments); last drink surveys (a community action tool), and influences on policy development.

Findings from the alcohol policy, survey work and community action research undertaken by APHRU/Whariki have contributed over the years to the implementation of various national policy reviews and changes.

National Centre for Treatment Development

NCTD's *Brief Treatment Programme for Alcohol Dependence study* (BTP, 1996-2000) showed a significant additional benefit attributable to motivational enhancement therapy. The *Collaborative Māori Project* (1995) investigated optimum treatment for Māori with alcohol and drug problems, while the *National Telephone Survey* (1998) of alcohol and drug treatment workers investigated the practice, knowledge and attitudes of clinicians working with alcohol and drug patients. *The Naturalistic Treatment Outcome Project* (NTOP, 2000-2002) investigated multi-dimensional treatment outcomes in people receiving outpatient alcohol and drug treatment services.

Results from the *Assessment and Management of Co-Existing Substance Use and Mental Health Disorders project* were used to develop a guidelines document for both mental health and alcohol and drug services personnel working with co-morbidity patients (Todd et al. 1999). *Guidelines for Clinical Process Self-Evaluation in Alcohol and Drug Treatment Agencies* (Deering et al. 1998) were developed in 1997-1998 through a process of literature review and consultation with providers, consumers and funders.

Other Research Agencies

Examples of sizeable studies completed by researchers in other agencies include the World Health Organisation collaborative project on brief intervention by General Practitioners for problem use of alcohol. This was undertaken by the Drug and Alcohol Research Unit (DART) and Goodfellow Unit at the Auckland School of Medicine (McCormick et al. 1999).

Findings from the study formed the basis for the development of a training programme for General Practitioners. The Ministry of Health's 1996/97 *New Zealand Health Survey* examined levels of alcohol use in the adult New Zealand general population (aged 15 years+) and used the AUDIT questionnaire to identify "potentially hazardous drinkers" (people at risk of developing alcohol problems). The longitudinal *Christchurch Health and Development Study* (University of Otago) has looked in detail at factors associated with alcohol use in a cohort of 1,265 children born in the Christchurch region during mid-1977.

Development Issues

Research Gaps

ALAC is in the midst of developing a *National Strategy for Alcohol Research*, focusing on the identification of future alcohol-related research needs. Indications are that the strategy is likely to give priority to research on effectiveness and evaluation issues, population-based indicators and workforce development issues. Foundational research will also be a priority in cases where it has direct links to efficacy, effectiveness and demonstration studies. More specific research priorities spanning these categories are currently being developed, based on a retrospective analysis or "stock-take" of previous research, systematic reviews, economic analysis of costs, analysis of etiologic fractions and end-user analysis.

Research workforce

At present the alcohol-related research workforce is subject to the same problems that occur throughout the research field in New Zealand. Recruitment and retention of both young as well as experienced researchers, including Māori researchers, is difficult due to 'soft' funding issues, with most research funded on short-term contracts. Many potential or highly skilled researchers are lost, particularly to central or local government jobs with more security and pay, and also to the private sector where a great deal more money is offered in many areas such as market research. The alcohol-related research field has lost both valuable senior researchers and promising new researchers in recent years due to the lack of sufficient positive incentives to work in what often appear to be increasingly uncertain conditions.

ALAC provides some grant aid for summer studentships/graduate work on a one-off basis that has been useful to aid the development of emerging researchers, but if there are no further job opportunities or contracts available then these people are also often lost to other fields or positions.

A return to core funding of alcohol-related research would be helpful for maintaining and building a skilled research workforce.

Communication and Dissemination

Time for Writing-up

The nature of contract research, which is generally utility-driven, means there is often not adequate time built in to write up research findings for academic publication before commencing the next project. This has prevented the results of research reaching a wider readership.

Uptake of Research

Results from alcohol policy research are not always accepted, addressed or acted on by the politicians and policy-makers in control of the policy agenda. For example, research into the

effectiveness of alcohol education in schools does not appear to have affected the types of programmes funded. Research results may not be congruent with their particular political agenda such as de-regulation and pursuing free market policies or may seem too contentious with their corporate constituents. Hard-edged policy research is frequently contested by the liquor industry. It is often in their interests to seek to undermine the credibility of researchers because it delves into areas that they consider may threaten their commercial viability such as marketing to young people.

Similarly the transfer of findings from clinical research to clinical practice is impeded in the absence of concerted and substantial efforts.

Improving Communication and Dissemination

All contract research could have a specified budget component built in for the dissemination of findings to end-users and the writing up of academic papers (in addition to the technical reports normally provided).

Roundtable meetings with funders and identified end-users could be organised to discuss the use of specific research findings (although, again, funding to enable researchers to participate in these would need to be included in research budgets).

Forums on particular alcohol-related research areas with contributing researchers, end-users and invited interested parties would also be useful and could be organised by the Inter-agency Committee on Drugs or ALAC.

Other Drugs (Illicit and Prescription)

In the New Zealand context, the main drugs to be considered in addition to alcohol and tobacco are cannabis, opioids, benzodiazepines and stimulants (Adamson et al. 2000).

The high rate of cannabis use problems at the clinical level is reflected by patterns of use among the general population. Cannabis is the most popular illicit drug, with 50 percent of a national sample, aged 15 to 45 and interviewed by telephone, reporting having tried cannabis, while 19.5 percent had used cannabis in the past 12 months, and 1 percent were daily users (Field and Casswell 1999).

The same survey found that slightly under 4 percent had tried opioids, with 1 percent having used in the past year and 0.6 percent classed as current users. While this latter figure is small relative to other drugs, the consequences for the individual and society of heavy opioid use are severe, not least due to the high costs and criminality frequently associated with regular use (Adamson and Sellman 1998).

Hepatitis C and HIV/AIDS can be transmitted via unsafe injecting practices. New Zealand rates of HIV/AIDS transmission via injecting are low because this blood borne virus is not strongly established in the injecting population. This is not the case for Hepatitis C for which transmission via injecting is happening at a dangerous rate. This infectious disease was categorised as “highest priority” in the newly released report *Integrated Approach to Infectious Disease: Priorities for Action 2002-2006* (Ministry of Health 2001a).

“Tranquillisers” of which the main group are the benzodiazepines, were used by 2.3 percent of respondents in the Field and Casswell (1999) sample, with use in the past year and current use both at 0.6 percent.

Stimulants include cocaine, amphetamine and methylphenidate (Ritalin) amongst other substances. Around 9 percent of the sample reported having tried these, with 3 percent using in the past year and 2 percent currently. Law enforcement agencies have noted an increase in the use of methamphetamines (such as “P” and “ecstasy”) and hallucinogens (such as “LSD”) among certain population groups.

The New Zealand drug scene differs from that in other countries in several important ways. Because of these differences, inferences from overseas research must be made with caution and the value of locally conducted research must be acknowledged.

Cannabis is used at a lower rate in many other Western countries (e.g. Australia, USA, UK) than is the case in New Zealand, resulting in a relative paucity of overseas research on factors influencing cannabis use or treatment modalities.

There is also a different pattern of opioid use. Heroin is the main opioid used internationally but is scarce in New Zealand, at least at present. In New Zealand the main sources of opioids are morphine sulphate tablets, opium poppies and diverted methadone. Consequently, the pattern of supply is likely to be different due to the nature of the sourcing of these substances. In addition, there are major positive health consequences, including the relatively low accidental opioid overdose rate in this country, due in part to the predictability of dose administered for morphine sulphate compared to the potentially lethal fluctuations in concentration (and presence of adulterants) for heroin. On top of this, the means of preparation, usually involving a stove, reduces the chances of street administration and street discarding of used injecting equipment.

Another key point of difference for the New Zealand other drugs scene is the presence of a significant Māori population for whom mainstream international data on treatment effectiveness may be less applicable.

Existing Research Arrangements

Research in the area of non-alcohol and non-nicotine drugs currently occurs in a range of settings. Key bodies in this respect are the NCTD, the APHRU¹¹ and Christchurch School of Medicine which since 1990 has conducted public health research in the area of cannabis and other illicit drugs (see previous Alcohol section for more details).

In addition, a number of other research groups have conducted related research as part of a larger research programme. The ESR has undertaken studies of the active ingredients and purity of illicit drugs and a number of papers from the *Christchurch Health and Development Study* (University of Otago) have examined cannabis use by young people. There is also drug-related research being conducted at Masters and PhD level by postgraduate students across all universities.

Funders and Funding Systems

Currently drug research is primarily funded by the HRC, ALAC (mainly for studies of people who use other drugs in conjunction with alcohol), university core grants, miscellaneous grants (e.g. Canterbury Medical Research Foundation) and commissioned projects (e.g. Ministry of Health).

¹¹ See footnote 10.

Communication and Dissemination

The chief forms of dissemination for other drug research are peer reviewed journal articles, reports, conference presentations, ALAC managers meetings, articles in national newsletters (e.g. *Treatment Research News*, a quarterly newsletter published by the TRIG), and websites (e.g. those of NCTD, APHRU and ALAC). Dissemination also occurs more directly to the treatment field through workshops, tertiary education and in-service training.

Communication within the research community and between researchers and other interested parties such as policy developers and providers occurs at a number of levels. This includes conferences (such as the annual “Cutting Edge” conference), *Treatment Research News*, Internet discussion groups (most notably the “A & D” netlink coordinated by ALAC) and researcher involvement in working groups and committees.

Examples of Past and Ongoing Studies

The amount of research undertaken in New Zealand on illicit drugs, whether from a clinical or a public health perspective, or from the perspective of justice and law enforcement, is small. This is at least in part because the health and social problems caused by illicit drugs are generally not on the same scale as those of the legal drugs like alcohol and tobacco.

One of the earliest studies to shed light on drug use in New Zealand was the *Christchurch Psychiatric Epidemiology Study*, conducted in the mid-1980s, which established the prevalence of six-month and lifetime diagnoses of drug abuse and dependence in a general population sample (Oakley-Browne 1989). Another substantial study in the area was the evaluation research supporting the design and monitoring of needle exchange schemes aimed at reducing the risks of transmission of HIV and other infections by intravenous drug users (Lungley 1988; Lungley and Baker 1990). Both the Christchurch and Dunedin longitudinal health and development studies have examined risk factors for the use of drugs, including cannabis, in early adulthood, with findings from these studies being used as the basis for designing and piloting new family-focused intervention strategies such as the *Early Start Project* (Fergusson et al. 1997; Fergusson et al. n.d; Fergusson and Horwood 1997; Fergusson and Horwood 2000; Fergusson and Horwood 2000a; Fergusson and Horwood 2001; Fergusson et al. 1996; Fergusson et al. 2000; Lynskey et al. 1998; Poulten et al. 1997; Stanton 1996).

APHRU researchers have undertaken national and regional population surveys on the prevalence of illicit drug use as well as price, availability and market structures (Black and Casswell 1992; Black and Casswell 1993; Black and Casswell 1993a; Dacey et al. 2000; Field and Casswell 1999; Field and Casswell 1999a). They have also completed several papers and reports on cannabis policy (Field and Casswell 2000; Field and Casswell 2000a; Abel and Casswell 1998; Abel and Casswell 1998b; Casswell 1997; Abel 1997; Abel and Casswell 1993a; Casswell 1980), including cannabis policy in schools (Abel and Casswell 1998a; Abel and Casswell 1997; Abel and Casswell 1993) as well as drug problem prevention issues (Casswell 1992; Abel et al. 1992).

Ongoing NCTD studies with relevance to the area include the *Degree of Drug Use Index Validity Study* (DDIVS), which aims to further develop a brief outcome measure for people being treated for opioid dependence. *Te Aka Roa o Te Oranga (The far reaching vines of wellness)* is a treatment development and evaluation study that aims to extend and evaluate Māori -focused substance use treatment. *The Programme of Youth Cannabis, Alcohol and*

Nicotine Studies (PYCANS) is examining the effects of cannabis use by adolescents on memory, attention and concentration.

Other relevant ongoing studies include the *New Zealand Mental Health Survey*. This is being funded by the Ministry of Health, the HRC and ALAC, and is currently under development. The study will measure the prevalence of mental health disorders (including alcohol and drug use disorders) in the general adult New Zealand population (16 years+). The New Zealand Drug Foundation is currently undertaking a study for the Ministry of Health estimating the cost of the Hepatitis C disease burden in New Zealand.

Development Issues

Research Gaps

Given the unique and distinctive features of New Zealand's other drugs scene, a number of research gaps become apparent. These include:

- very little in the way of research into effective treatment models for Māori, and
- a lack of clinical trials examining the effectiveness of different treatment options for cannabis dependence.

There is also a need to:

- determine effective ways to identify, engage and intervene with youth experiencing problematic cannabis use;
- identify public health interventions effective in delaying the early onset of cannabis use;
- develop knowledge of effective methods for reducing Hepatitis C infection rates among intravenous drug uses;
- investigate dose relationships to cannabis harm, and
- undertake more work to estimate the total costs of illicit drug use in New Zealand.

Possible relevant future research topics include:

- patterns of illicit drug use and availability (including good data on Pacific peoples);
- impact of supply control strategies, and
- price dynamics of the illicit drug market.

Workforce and Funding

Major issues confronting the drug research community include attracting and retaining young researchers and retaining experienced researchers. Underlying these clearly is the issue of funding. New Zealand lacks a funding stream explicitly dedicated to supporting research on non-tobacco, non-alcohol drugs. At present most of the funding available for drug-related research is contestable and open to applications from a much wider domain than illicit substances only. For example, while substance-related issues are included in the listed priority areas for HRC grants, there is no guarantee of money for drug-related research. Because the number of experienced researchers in the drug area is small, this reduces the ability of the field to compete for these funds. This is perhaps somewhat self-perpetuating, as the lack of successful funding applications contributes to the relative low desirability of moving into the drug research field for researchers deciding where to specialise, which in turn further undermines the prospects of attracting increased funds.

Recent decisions by the HRC not to provide core funding to key research agencies in the field means that in future the transaction costs for developing research proposals on issues related to illicit or prescription drugs may be more difficult for these research agencies to absorb. Researchers may be forced to focus on larger projects, meaning that it becomes less feasible to develop smaller research projects on illicit or prescription drugs.

In the area of clinical research, the relationship between those who work in the treatment alcohol and other drug dependency, and those working mental health sub-sectors is also pertinent. The relationship between service providers in the alcohol and other drugs sub-sector and the mental health sub-sector varies by region and in some areas a close association does not exist. This has the effect of downgrading the value of working in the alcohol and other drugs field. Since most clinical researchers in the drug area have joint academic-clinical appointments, this has the effect of reducing the pool of potential researchers to be found amongst the small group of well-qualified clinicians. Additionally, for those working clinically in the alcohol and other drugs area, the devaluing of the area relative to the rest of mental health may have the effect of promoting migration to clinical areas other than the alcohol and other drugs area.

Communication and Dissemination

At present, coordination and communication regarding research on other drugs seems to be largely by word of mouth. There is no agency adequately resourced to support gatherings of researchers and actively facilitate collaboration on research in this area.

Advocates in the drug field, such as the New Zealand Drug Foundation, need to know what research is underway and when it will be released. There may be a wealth of information residing in research papers by postgraduate students. The *A & D* list server funded by ALAC does place some information on illicit drug research. ALAC's online alcohol-related research database includes some information on cannabis research but there are no research listings under the following titles – ecstasy, methamphetamine, injecting drug use or opioids.

A barrier to the wider dissemination and uptake of research in the area appears to be an inclination towards distrust of research and reluctance to incorporate research-based evidence into practice. This may be particularly an issue for communication with treatment/health promotion providers. The problem may be compounded when researchers become relatively disconnected from the sectors they wish to influence.

Even when good research is conducted and some dissemination is undertaken, change does not always occur in the absence of strong advocacy. An example would be the ongoing situation in New Zealand with respect to our methadone waiting lists, with clients waiting a year or more in many regions to access treatment. This is despite clear evidence of the costs of waiting (Adamson and Sellman 1998), the benefits of going on to methadone (Dore et al. 1999) and a model for expanding the provision of methadone by increased utilisation of General Practitioners (Sellman et al. 1996). This inability of research to contribute to change in some instances may in part be due to the stigmatisation of drug addiction, but may also be due to a lack of emphasis on maximising dissemination. Thus there is a strong argument for active dissemination and advocacy as a vital part of the wider research process.

Possible Solutions

Funding

More reliable funding is needed to support research in the other drugs area, and in particular core funding to encourage recruitment and retention of researchers. Core funding is also needed to provide the secretarial and library support services necessary to academic work.

Allocating a small stream of funding specifically for illicit drug research would be justified as long as it does not take funding away from research on alcohol and tobacco.

Public health policies in the drug area, particularly those that relate to legal frameworks, tend to have strong political dimensions. It is important to ensure that research activity in the drug area can develop a focus on important issues regardless of political imperatives. This suggests a need for centres of excellence that have some core funding (although some funding should also be contestable to avoid complacency and provide a creative tension).¹²

Communication and Coordination

Because there is so little funding available for research in this area, it is essential that the research that does get done is strategic and on the cutting edge. To help ensure this happens, it is important to develop better links between all participants in the research/policy cycle including researchers, funders, implementers of policy and policy analysts.

Gambling

Gambling has expanded rapidly in New Zealand during the last decade. Gross annual turnover has increased from \$1.5 billion in 1989 to over \$8 billion in 2001. The proliferation of gambling is associated with the loosening of Government policy on the provision of gambling. In 1996 the government endorsed deregulation of several sectors of the gambling industry and subsequently, the largest jumps in gambling consumption followed. In that year, "Sports Betting" and "TeleBingo" were introduced, the first \$5 million jackpot "Lotto" occurred, the Auckland Casino opened, poker machine licences increased from 11 to 18 per site, and their jackpots were raised to a ceiling of \$1,000. In response, gross turnover rose from \$4 billion in 1996 to approaching \$6 billion in 1997.

The current paucity of government gambling policy and legislation is contributing to the rapid increase in the consumption of gambling and has led predictably to greater numbers of people seeking help for their gambling. However, to date, little in the way of research has been conducted on the effects of the proliferation of gambling in New Zealand.

The small amount of research being undertaken locally means that at present New Zealand is forced to rely largely on overseas findings to develop policy and legislation.

The Australian Productivity Commission (1999) recently conducted an independent national inquiry into:

- the economic and social impacts of gambling, and
- the effects of different regulatory structures on gambling.

¹² In this regard, the Tertiary Education Advisory Commission (2001) has recently recommended the progressive expansion in New Zealand of centres/networks of research excellence.

This inquiry was undertaken in order to enhance public understanding of the issues and assist government decision-making and policy development.

The Commission concluded that the recent rapid expansion of gambling has been the result of liberalisation of gambling legalisation and technological developments that have facilitated:

- a proliferation of gambling forms, most pronounced in the establishment of casinos and spread of electronic poker machines;
- increasing accessibility and ‘convenience’ of gambling so that it has become part of the suburban ‘entertainment’ scene;
- increased speed and ‘tempo’ of new gambling forms, with the opportunity to re-invest and gamble continuously, as exemplified in electronic poker machines;
- privatisation of new forms of gambling with a commercial profit motive in contrast to traditional government run lotteries and racing industries with their ‘public good’ motive, and
- pervasive advertising and promotion of gambling.

Currently New Zealand lacks meaningful research into the cultural, economic, or social impact of gambling, nationally or upon specific cultural and socio-economic groups. We need such systematic research to guide the direction of policy and the development of ameliorative measures for problem gamblers.

There have been suggestions, for example, that the expansion of gambling can have positive economic effects for regions and the country as a whole, through encouraging tourism and increasing jobs.

The Commission’s findings raise serious doubts about such promised economic benefits, indicating that production-side gains associated with expansion of the gambling industry are generally at the expense of other industry sectors that make more efficient use of economic resources, such as retailing and entertainment.

The negative impact arises from the ‘problem gamblers’ and others such as families and spouses seeking help. The Commission estimates that about 1 per cent of Australia’s adult population (130,000 people) have severe problems with their gambling, with another 1.1 percent (163,000) experiencing moderate problems.

Among the range of public health concerns, this prevalence rate is lower than the rates for excessive smoking or alcohol consumption, but greater than the use of illicit injection drugs.

The Commission also estimates that the 2.1 percent of adults experiencing gambling problems each affect a further 5 to 10 people in various ways, either as family members, workmates or victims of crime committed by problem gamblers. Hence between 10 percent and 20 percent of the Australian population are negatively impacted, in some way, by problem gambling. We have no evidence to indicate that this effect is any less widespread in New Zealand. These Australian Productivity Commission estimates, and our current dependence upon them, reinforces the need for structured, systematic research into New Zealand gambling and problem gambling, with particular emphasis upon the economic and social impacts experienced nationally and within cultural and socio-economic sub groups.

Existing Research Arrangements

The research workforce committed specifically to gambling research is very small. While a handful of academics have undertaken research projects, those specifically committed to gambling research are few. Demand will increase in the future for research to monitor the impacts of gambling and to devise effective interventions for problem gambling.

The Gambling Studies Institute

The formation of the Gambling Studies Institute was announced at a national conference organised by the Problem Gambling Foundation (PGF – previously the Compulsive Gambling Society) in July 1999. The Institute has received funding for a variety of consultations and small research projects and policy papers, e.g. *Gambling, Harm and Health: Two perspectives on ways to minimise harm and maximise health with regard to gambling in New Zealand* (Brown and Raeburn 2001).

The University of Auckland Centre for Gambling Studies

The formation of this Centre was announced in July 2001. The Centre brings together the expertise of health science researchers with backgrounds in economics, public health, sociology, psychology, psychiatry, primary health care, and Māori, Pacific and Asian health development. The Centre will provide public-good research with a particular emphasis on the impacts of gambling expansion on the social and economic functioning of New Zealand communities. It also seeks to improve understanding of factors that will enhance the effectiveness of public health and treatment interventions. Staff members associated with the Centre are currently involved in research on youth gambling, gambling by Pacific peoples, gambling and crime, clinical outcome studies and policy development.

Other work in the area has been undertaken by research staff in the Department of Internal Affairs (e.g. literature reviews, opinion surveys), by research students in university departments, by people contracted privately for research outputs (such as Professor Max Abbott and Dr Grant Paton-Simpson), and by research centres in Australia, most notably the Australian Institute for Gambling Research, which has provided commissioned research for the New Zealand Casino Control Authority and participated in New Zealand Casino application processes.

Funders and Funding Systems

Research interest in gambling is on the whole a recent phenomenon. Consequently research funding structures are in a relatively early stage of development.

Problem Gambling Committee (PGC)

The PGC administers funds received from a voluntary levy of the gambling industries and is made up of representatives from the gambling industries and problem gambling service providers. It mainly funds small research projects with a service and treatment orientation and its specific contribution to research varies from \$150,000 to \$260,000 per year. The government is undertaking a major policy and legislative review of gambling and the future role of the Committee is uncertain.

Government Departments and Ministries

The gambling environment in New Zealand is formally administered by the Department of Internal Affairs. The Department has commissioned several research projects, the largest being the two large prevalence studies conducted by Abbott and Volberg.

Since 2001, the Ministry of Health has been responsible for managing the development of health promotion, health protection and treatment services for gambling. It seems likely that these services will be designed to align with the *National Drug Policy* by endeavouring to minimise harm through supply control, demand reduction and problem intervention strategies. Implementing these developments will require improvements in the range and quality of health research on gambling.

Te Puni Kokiri, the Ministries of Justice and Social Policy, Treasury and the Departments of Courts and Corrections all share an increasing interest in the manner in which gambling is impacting on aspects of New Zealand society and the economy. They can be expected to be requiring both research input and expert advice on how to respond to these impacts.

Health Research Council

The HRC has recently funded its first postgraduate scholarship and strategic development contract on the health implications of gambling for Māori women and their whanau. With the Ministry of Health now involved and the health impacts of gambling becoming more apparent, there is likely to be an increased interest in funding this area of research in future.

Alcohol Advisory Council

Since the main form of gambling, the electronic gambling machine, is nearly always co-provided with alcohol, studies of gambling behaviour will continue to remain interlinked with drinking. ALAC has on occasions provided funding for PGF (and previously Compulsive Gambling Society) staff to attend conferences and looked seriously at funding research projects regarding the co-provision of alcohol and gambling.

Gambling Industry Providers

The current Gaming Review is likely to insist that gambling industry providers maintain adequate standards of host responsibility. To do this will require improved information and models on effective ways to promote responsible gambling.

Communication and Dissemination

The Problem Gambling Foundation in collaboration with the Gambling Studies Institute, and more recently the Centre for Gambling Studies, has organised several major forums for presentation of research and policy on gambling. These include three national workshop symposia and three major conferences involving international experts in the field. A major international conference was held in July 2001 and attracted 540 registrations, over 90 presentations and 40 overseas speakers. The international conferences occurring every second year provide the major forum for presentation and discussion of research findings.

The expansion of gambling has been a global phenomenon. Accordingly, the Problem Gambling Foundation and the Centre for Gambling Studies have actively pursued international linkages with other gambling research centres at various universities including the Universities of Harvard, Toronto, McGill and Hamburg.

Research findings have mainly been distributed in the form of technical reports. The Department of Internal Affairs and the Gambling Studies Institute have produced detailed reports on research activities. The main international publication, *The Journal of Gambling Studies*, is available in few libraries, although the internet journal, *The E-journal of Gambling*, is more easily accessed. The Centre for Gambling Studies is building a small library of relevant materials.

Examples of Past and On-going Studies

Research in New Zealand is minimal and has consisted mainly of one-off projects. The only major projects to date have been the two national epidemiological studies undertaken in 1991/92 and 1999/2000. Professor Max Abbott and Dr Rachel Volberg undertook a two-phase study (1991/92) reputedly costing in the region of \$1 million. This was followed by another major study in 1999/2000 costing \$1.2 million (Abbott 2001).

Other smaller scale research projects have been generated by staff of the Problem Gambling Foundation of New Zealand (previously the Compulsive Gambling Society) or individual university researchers and their students.

Examples of research completed by the Gambling Studies Institute include corrections prevalence studies (Brown et al. 1999) and health promotion and harm-reduction concept papers (Brown and Raeburn 2001). Institute staff have also contributed to a number of international conferences.

Development Options

A Comprehensive Research Strategy

The rapid expansion of gambling has led to radical changes in the gambling environment in New Zealand. The impacts of these changes urgently require monitoring. It is unclear what the long-term consequences will be on social and economic structures, or how communities will respond to increased rates of problem gambling. The sector is in urgent need of a comprehensive strategy to define the major goals and priorities for available research funding.

Research Priorities

In a recent workshop held at the Faculty of Medical and Health Sciences at the University of Auckland, the following key categories of research were identified:

1. *Information gathering:* Epidemiological, survey, qualitative and other such research is clearly needed to give accurate information about what is really happening in communities and society regarding gambling. Constant monitoring of international research is also needed.
2. *Social and economic impact studies:* Continuing assessment of the effect of the expansion of gambling and problem gambling on national and regional economies and social fabric is essential.
3. *Policy research:* Any action requires the appropriate legislative and policy environment.
4. *Cultural impact studies:* Population studies already indicate high prevalence of problem gambling in Māori, Pacific and Asian populations.

5. *Special population studies:* Research into the contribution that gambling makes to harm in high-risk populations, including youth, heavy alcohol users and criminal populations is required.
6. *Intervention research:* the major concerns are the design and implementation of intervention strategies in terms of public education, community development projects, health promotion, primary health and service treatment interventions.

Low priorities for research include:

- arbitrary studies reflecting the idiosyncratic interests of a researcher;
- biomedical or similar studies on the processes of gambling, and
- studies that emphasise the individual out of his or her wider context.

Adequate Independent Funding

Despite obtaining sizeable revenues from gambling, successive governments have chosen not to invest in research evaluating the economic, social and cultural impacts of the expansion of gambling. The recent transition of service management into the Public Health Directorate of the Ministry of Health signals the need for research to assess the needs of communities, devise appropriate interventions and monitor their impacts.

Researcher Recruitment and Training

The increasing demand for public-good research on gambling will require a multi-skilled, multi-disciplinary research workforce. These researchers will need to be engaged through a pyramid of training opportunities that build progressively the required number of suitably qualified researchers. Due to the various cultural impacts of gambling, particular emphasis needs to be given to the training of Māori, Pacific and Asian researchers. The sequence of workforce training opportunities would include:

- gambling content in undergraduate programmes (e.g. undergraduate medical and nursing programmes);
- post-graduate courses in gambling;
- training fellowships for Māori, Pacific and Asian Masters students;
- PhD scholarships, and
- post-doctoral fellowships.

Formation of a National Research Centre

The recent formation of the Centre for Gambling Studies at the University of Auckland is a first attempt to gather a critical mass of research skills for ongoing and independent public-good research into gambling in New Zealand. Its resources are at present limited and for the Centre to survive it will require ongoing financial and academic support. The Centre will also provide a location for teaching, research student supervision, international linkages, storage and dissemination of research publications, organisation of conferences and symposia and consultation to service and policy organisations.

Key Research Development Issues

New Zealand has significant health and social problems arising out of, and linked to, the widespread availability and use of tobacco, alcohol, other drugs and gambling. Achieving a better understanding of the complex origins of these problems, and identifying and evaluating interventions to counter them that are appropriate to New Zealand conditions, requires a robust infrastructure for designing, undertaking and disseminating relevant, good quality research in these areas.

This section builds on the information and impressions presented earlier in the document. In particular, it highlights some key development issues facing New Zealand's existing arrangements for harm-reduction research on tobacco, alcohol, other drugs and gambling. It then goes on to briefly propose two initial actions that could be taken in an effort to address these issues.

Research Users

To reiterate, there are several good reasons for considering the arrangements for harm-reduction research on tobacco, alcohol, other drugs and gambling altogether in this document. These include the fact that health, law enforcement, education and social services frequently treat, counsel or in other ways deal with people with problems linked to the use of multiple substances, and increasingly to gambling as well. In addition, the problematic use of these substances and activities, whether at the level of the individual or the population, is often shaped by similar social processes, such as the impact of youth cultures, alienation or commercial interests.

In New Zealand, many different audiences require research-based information on the harms associated with tobacco, alcohol, other drugs and gambling. They include policy makers in government and non-government organisations, clinicians and other service providers, health promotion workers, staff in the print and broadcast media, teachers and students, and members of community and advocacy groups. Some of these people are interested in research information simply out of curiosity or to advance their general understanding of the origins and consequences of the harms associated with tobacco, alcohol, other drugs and gambling. Others need research to help underpin the development of government policies, identify and evaluate best practice in the delivery of health services, improve the uptake of effective interventions, or monitor progress in the reduction of problems.

Funders and Funding Systems

New Zealand studies on aspects of the harms associated with tobacco, alcohol, other drugs and gambling have been supported in recent years by a range of different organisations. Prominent amongst these has been public sector agencies such as the Ministry of Health (primarily for policy-related research) and the HRC, while ALAC has played a significant role in the ongoing support of research on alcohol and, to a lesser degree, other drugs (especially treatment research).

Several other organisations have also provided support for studies from time to time in particular areas. These include the Cancer Society, the Heart Foundation and the Health Sponsorship Council for tobacco control research; the Land Transport Safety Authority (LTSA), ACC and Ministry of Education for research on alcohol- and other drug-related harms; regional alcohol and drug services for research on service users and treatment

outcomes; and the Department of Internal Affairs and the Problem Gambling Committee for research on problem-gambling prevalence and treatment issues.

Projects funded over the years have included a mix of investigator-initiated studies and commissioned studies. In investigator-initiated studies, the researchers determine the research topic to be explored and the research methods to be used. They then submit a funding application to a potential sponsor or funding organisation. In commissioned studies, the funding organisation normally identifies the issue to be investigated, and in some cases the kinds of research methods to be employed, and then seeks researchers willing to undertake this work.

In general, most of the external research funded by government departments, ministries and other Crown agencies such as the ACC, as well as non-government agencies such as the Heart Foundation or Cancer Society, are commissioned studies.¹³ These studies tend to be relatively small and of short duration and aimed at generating evidence to inform decisions on specific policy or service delivery issues. Many are commissioned and executed within quite tight timeframes.

Research Workforce

In New Zealand, researchers with some record of publication on topics related to the harms of either tobacco, alcohol, other drugs or gambling are mainly based in the universities, with probably the greatest numbers found in the various departments and units of the Otago and Auckland medical schools situated in Dunedin, Christchurch, Wellington and Auckland. This reflects the historically close connection between the health sciences and efforts to combat the problems of tobacco, alcohol, and other related substances.

Researchers with some experience in these harm-reduction areas are also found in other departments in the universities, including psychology, geography, anthropology, sociology, economics and law. As well, some are based outside the universities in Crown Research Institutes (especially ESR), government departments and ministries (e.g. Ministry of Health, Ministry of Justice, Police, LTSA), and treatment agencies. A few are also affiliated to non-government organisations, iwi and advocacy groups. Others work in the private sector, either as freelance contractors or in research consulting firms.

While outwardly these features suggest the growth of a robust, diverse and lively research workforce, in fact closer inspection lends support to the view that New Zealand's workforce for undertaking harm-reduction research on tobacco, alcohol, other drugs and gambling remains underdeveloped and fragile. In particular, there appear to be few individuals with an established track-record of publication in one or more of these four key areas, and very few who have managed to work successfully for a number of years exclusively, or almost exclusively, on harm-reduction issues.

This apparent lack of a sizeable body of researchers dedicated specifically to investigating the harms associated with tobacco, alcohol, other drugs and gambling appears at least in part to be a product of the comparatively modest levels of funding earmarked specifically for work in these areas, and its unpredictability. Much of the funding for harm-reduction research on tobacco, alcohol, other drugs and gambling has to be either secured in direct competition with

¹³ This would include studies commissioned by intersectoral or interdepartmental groups or committees like the Interagency Committee on Drugs, the Ministerial Committee on Drug Policy, and the Expert Advisory Committee on Drugs.

other research areas (such as through the HRC's annual funding round), or is subject to the limitations of the commissioned research system, which on the whole offers only one-off short- or medium-term project contracts, with little guarantee of continuity. Hardly any substantial funding is provided for extended programmes of research specifically within the alcohol or other drug areas (with the exception of that invested either now or in the recent past by ALAC and the HRC for APHRU and NCTD), and none, or virtually none, for tobacco or gambling.¹⁴

As a result, it seems that in recent years many researchers with an interest and training in tobacco, alcohol, other drugs or gambling issues have had to diversify and undertake research in other areas, or even leave research altogether. These outcomes may also be shaped, in part, by the extent to which harm-reduction research in the other drugs or gambling areas is undervalued and marginalised in the health sciences as a whole.

These issues and the barriers they impose on the development of specialist research careers, impact in turn on new graduates and other researchers entering these areas of research for the first-time, limiting the scope for on-the-job training and mentoring by more experienced researchers.

This is particularly significant for the development of Māori and Pacific researchers. Research aimed at minimising the harms associated with tobacco, alcohol, other drugs and gambling needs to effectively address and respond to the perspectives of Māori and Pacific peoples, using methods and approaches that are culturally appropriate and safe. The development of a dedicated Māori and Pacific research capacity is vital to this.

Also linked to this is the need to consider ways to effectively support the development of Masters and PhD students with the enthusiasm and ability to pursue a research career in tobacco, alcohol, other drugs or gambling. ALAC currently shows the way here with its scholarships specifically for post-graduate students studying alcohol-related issues. It also operates a separate Māori research budget that, among other things, has been used to fund summer scholarships for Māori health researchers wishing to develop their research skills.

The HRC and the universities offer a range of training and career development awards, including awards specifically for Māori and Pacific graduates, some of which have been awarded in recent years to students pursuing harm-reduction studies in tobacco, alcohol, other drugs or gambling.

Communication and Dissemination

There are currently several mechanisms, resources or services facilitating the exchange of information and skills between New Zealand researchers interested in harm-reduction issues related to tobacco, alcohol, other drugs and gambling, as well as the effective dissemination of research findings to end-users, both here and overseas. These include peer-reviewed journals (such as the *New Zealand Medical Journal*), newsletters (both paper and electronic) such as *New Zealand Smokefree eNews*, www.alcohol.org.nz, and *Treatment Research News*, and specialist information services such as that provided for alcohol and other drugs research by the ALAC library.

¹⁴ One possible exception to this is the funding provided by the Ministry of Health to the Institute of Environmental Science and Research for tobacco-related research.

Websites, databases and email networks developed by ALAC, APHRU, and NCTD also supply an array of information on past and ongoing research projects and publications.

Dissemination and communication is also promoted through holding regular conferences and workshops such as the National Smokefree conference, the Public Health Association conference, meetings of the New Zealand branch of the Australasian Epidemiology Association, and the Cutting Edge conference. For the first time, research papers presented at the annual Cutting Edge: conference have been published as a treatment research monograph (Sellman 2001).

Another recent development has been the decision by the HRC to create a National Health Research Database. This online database, once completed, will hold information on all health research in New Zealand, including tobacco, alcohol, other drugs and gambling research. This should be useful for promoting networking between researchers and publicising research expertise.

Despite these important initiatives, points raised earlier in this document highlight the need to develop other resources and mechanisms to support the sharing and dissemination of research expertise and data related to tobacco, alcohol, other drugs and gambling issues.

For instance, in the tobacco area, presently no agency maintains a comprehensive on-line bibliography of unpublished and published New Zealand tobacco research and a list of relevant databases. As well, there is no centralised resource where hard copies of this tobacco research can be obtained, including the often hard to find “grey” or “fugitive” literature, e.g. DHB reports, Masters and PhD theses.

Another issue is the need to explore ways in which data from previous studies on tobacco, alcohol, other drugs and gambling, including perhaps raw data not yet fully analysed, can be made available for further study.

There may also be a need to examine new ways to support researchers so they can write-up their research findings for academic journals. Funders of commissioned studies generally do not regard it as their responsibility to support this kind of work, even though publication in peer-reviewed journals is often vital to the survival and career advancement of university-based researchers.

As well, there may be merit in developing new approaches, such as regular forums or roundtable meetings, to promote more face-to-face discussion and networking between researchers, funding organisations and end-user groups with an interest in minimising the harms associated with tobacco, alcohol, other drugs and/ or gambling.

Agreeing on Research Priorities

Earlier sections have listed a number of examples of completed or ongoing studies focusing on the harms of tobacco, alcohol, other drugs and/or gambling. Several suggestions are also made about the kinds of general categories of research, or research topics that should have priority in future.

There is scope to build on this material and work towards achieving wide agreement on the types of tobacco, alcohol, other drugs and gambling research themes and topics that should have precedence in New Zealand. This should help to better align and focus the efforts of

research providers and research purchasing agencies, in the interests of making the best use of the limited resources available.

In the alcohol area, ALAC has already initiated a process, the *National Strategy for Alcohol Research*, aimed at identifying major research goals and priorities. In the tobacco area, staff at the Wellington School of Medicine, University of Otago, recently have prepared a consultation document, *A Tobacco Control Research Strategy for New Zealand*, which identifies a number of proposed priority areas for research based on a key informant survey.

There would be value in also seeking to develop statements outlining agreed research goals and priorities specifically for other drugs and gambling. Preparation of these statements should be based on consultation with a broad range of relevant research funding agencies, researchers and end-user groups.¹⁵

During any process of defining research priorities, there is likely to be a level of debate and disagreement. Researchers, for example, will be inclined to argue that their particular area of interest or expertise is the most important, while end-users in government or non-government agencies will tend to be most enthusiastic about studies that will generate information useful for their own work, such as policy development or evaluation. For this reason, the processes used to develop statements on future research goals and priorities for tobacco, alcohol, other drugs and gambling must be designed with care. Otherwise, there is potential for the exercise to founder.

Examples of potentially suitable processes for research priority setting include the approach taken by the HRC for the development of its research portfolio strategies, where meetings are held throughout the country to enable a wide range of interested parties to submit their ideas.¹⁶ Another is the approach taken in a recent Canadian consultation on health services and policy issues, which used postal surveys, interviews and regional workshops with decision-makers and researchers from a wide range of agencies (Gagnon and Menard 2001).

A Suggested Initial Way Forward

This section outlines two possible actions that could be taken as a start towards strengthening New Zealand's capacity to undertake good quality research on the harms associated with tobacco, alcohol, other drugs and gambling. Like all suggestions in this document, they are preliminary and tentative, offered here for further consideration and comment by interested parties.

¹⁵ This approach is consistent with the Government's *Blueprint for Change* document (Minister of Research, Science and Technology 1999), which emphasises the need for purchasers of research to work collaboratively to ensure coherence in areas of overlapping interest, and for portfolios of research to be designed and contracted through a three-way negotiation between providers, users and purchasers.

¹⁶ The HRC's Research Portfolio Strategy already makes some contribution to identifying priorities in the tobacco, alcohol, other drugs and gambling areas. However, these four areas are treated within the portfolios as only aspects of much larger health-related topic areas and consequently only a small number of specific priorities are listed.

Coordination

A high-level advisory committee could be established that has a clear mandate to regularly review and make recommendations on ways to further develop New Zealand's workforce and infrastructure for tobacco, alcohol, other drugs and gambling research.

While ALAC has a history of leadership in the alcohol area, at present there is no single group or agency clearly identified as having responsibility for reviewing and coordinating the development of New Zealand's harm-reduction research capacity across all the four closely linked areas of tobacco, alcohol, other drugs and gambling. Among other things, this may increase the likelihood of gaps, unnecessary duplication and other deficiencies arising in New Zealand's overall research effort within and across these areas.

Responsibilities of the new advisory committee could include:

- identifying emerging researchers and research groupings with promise and recommending ways that their work could be supported;
- identifying opportunities to support and facilitate interdisciplinary studies and perspectives, and greater collaboration and the sharing of expertise both within and across the boundaries of the biological and health sciences, the social sciences, and the fields of education, social welfare and law enforcement (subject to the outcome of the *Tobacco Control Research Strategy* exercise);
- identifying opportunities to improve the dissemination and availability of research findings and enhance communication between researchers and end-users of research;
- identifying key topic areas and priorities for future research, and recommending ways to foster relevant research projects and/or programmes in these areas, and
- identifying how research could be better framed to meet the needs of end-users, including the needs of policy organisations funding research.

There are at least two options for the membership of the advisory committee.

One would be for the committee to be made up of representatives of the different government and non-government agencies that have a history of investment in, or reliance on, New Zealand research on the various harms associated with tobacco, alcohol, other drugs and gambling. Examples include the Ministry of Health, HRC, ALAC, Ministry of Justice, Ministry of Youth Affairs, Ministry of Education, LTSA, Police, Te Puni Kōkiri, Department of Corrections, the New Zealand Drug Foundation, the National Treatment Forum, and the Heart Foundation.

A second approach would be for the committee to include not just representatives from key government and non-government agencies, but also representatives from a range of New Zealand research providers. This would include groups such as the NCTD, APHRU, the Centre for Gambling Studies, and the New Zealand Drug Foundation. Māori representation could be included through research providers such as Te Pūmanawa Hauora, the James Henare Māori Research Centre, Te Rōpū Rangahau Hauora a Eru Pomare and the International Research Institute for Māori and Indigenous Education (IRI).

The second option is perhaps the more desirable, as it would foster a greater diversity of perspectives. Ultimately this should enhance the quality of the group's deliberations and recommendations.

Agencies that potentially might be suitable to host the new advisory committee include the HRC¹⁷, the Ministry of Health (possibly under the auspices of the Inter-Agency Committee on Drugs)¹⁸ or one or more of the universities.

A Dedicated Research Development Fund

A pool of money could be earmarked specifically for investment in research projects and other targeted initiatives aimed at strengthening New Zealand's infrastructure and capacity for undertaking harm-reduction research in the tobacco, alcohol, other drugs and gambling areas. Contributions to the fund could come from government and non-government agencies with a significant stake in the development of good quality New Zealand research on the harms associated with these substances and activities.

The fund could be managed by an appropriate agency such as the HRC, along similar lines to the approach used for the Mental Health Research and Development Strategy,¹⁹ or the Ministry of Health, perhaps under the auspices of the Inter-Agency Committee on Drugs.

Investment decisions would be guided very much by the recommendations of the new advisory committee. The fund could be used to support an array of initiatives including the commissioning of research projects with broad inter-sectoral relevance. As well, it could be used to invest in strategies aimed at strengthening the capacity and quality of the research workforce and the communication and dissemination of research. Examples include:

- assisting new and emerging researchers to prepare high quality research funding applications;
- establishing and/or maintaining key databases or other centralised information sources;
- establishing scholarships and other targeted career development opportunities, and
- supporting conferences, workshops and other forms of face-to-face dialogue on key research issues or topics.

If the funding pool was sufficiently large, it might also be possible to use it to wholly or partially support a small number of relatively long-term research projects in certain key areas.

¹⁷ The HRC's Investment Strategy for 2001/02 indicates that the Council intends to build research capacity in areas of need and ensure New Zealand has the infrastructure to support health research of the highest quality.

¹⁸ The IACD is an officials group chaired by the Ministry of Health. In conjunction with the Ministerial Committee on Drug Policy (MCDP), it is responsible for implementing the National Drug Policy and ensuring that drug-related policies and programmes throughout Government have consistent goals. The IACD is currently in the early stages of developing a working group with a specialised focus on research issues.

¹⁹ The Mental Health Research and Development Strategy is a partnership between the Ministry of Health, HRC and Mental Health Commission. The aim of the strategy is to use research and development to identify ways to improve the planning, purchasing and delivery of New Zealand mental health services. The Strategy is funded by the Ministry of Health and has a budget of \$3 million for contestable Research Tenders over the next three years. Research tenders are issued for specific projects identified by a Steering Committee.

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Appendix B: Summary of February-October 2002 Consultation Process

Introduction

This section summarises the comments made by contributors to the consultation process that followed the distribution of the January 2002 Discussion Document. The consultation process had two phases:

- receipt of written submissions on the Discussion Document (February-May 2002), and
- key informant interviews (June-October 2002).

Receipt of Written Submissions

This phase aimed to canvass widely for responses on the content of the Discussion Document. Approximately 350 copies of the Discussion Document were distributed to organisations or individuals perceived to have an interest or involvement in research in the tobacco, alcohol, other drugs and gambling areas. This included relevant government ministries and departments, research funders, research providers, relevant service providers, individual researchers and consumer groups. The Discussion Document included question boxes to prompt feedback and people were encouraged to write in with their ideas and concerns.

Key Informant Interviews

The aim of this phase was to seek a broader and more detailed range of views from key organisations and stakeholders in the sector, as it was expected the number of written submissions would probably be low and not necessarily cover people from key organisations. Catherine Kissell, an independent interviewer, was commissioned to provide a set of key informant interviews. Catherine is a clinical psychologist with considerable practice experience in the alcohol and drug field. She specialises within the field in the area of educational development. She had no previous involvement with the project. The project team worked with her to identify the key question zones and to formulate prompt questions (see Appendix C). Key informants were identified across a grid according to sub-sector (tobacco, alcohol, other drugs and gambling) and role (researcher, administrator, service provider, funder, policy maker). A list of those interviewed is provided in Appendix D.

Analysis

Catherine analysed the content of both the written submissions and the key informant interviews. This involved reading and re-reading the texts, identifying themes, and then clustering individual themes into recurrent categories. The categories were then grouped under five main categories: overall coordination, quality enhancement, funding mechanisms, research workforce development, and communication and dissemination.

Main Comments and Suggestions Raised

The following is a summary of the main ideas and issues raised in the key informant interviews and the written submissions.

Overall Coordination

Issues:

- There was wide general agreement on the need to coordinate the approach to funding and improve access to general funding pools.
- Monitoring population change and the impacts of government policy on drug-related harm is important for all sub-sectors.
- The four sub-sectors are developmentally different in terms of research infrastructure and approach, with each therefore requiring a different set of strategies and priorities.
- Representatives of the gambling and tobacco sectors were unconvinced the inclusion of their sub-sectors in a coordinating structure or process would be wholly advantageous.

Suggestions:

- The development of a permanent national committee was proposed in order to provide coordination between sub-sectors and to increase the sub-sector profiles.
- The functions of this committee were primarily identified as coordinating and supporting research, along with the development of an overall strategic direction for the sector and the identification of research priorities within sub-sectors.
- A high level position was also supported if the National Coordinating Committee was to provide an advisory function.
- Clear research priorities and strategies require development that is overtly and ably communicated to researchers.
- A range of participants would ensure that the National Coordinating Committee does not represent a narrow viewpoint and therefore promote a singular vision.
- As far as the desire for inclusive representation is concerned, it was cautioned that the National Coordinating Committee should not be so large and unwieldy that its functioning would be impaired.

Quality Enhancement

Issues:

- Research undertaken within the sectors is viewed generally as piecemeal and of varying quality and utility.
- There was consensus among those interviewed on the importance of promoting quality research, no matter what the focus.
- Complex social issues benefit from a multidisciplinary approach with expertise gained from across sub-sectors.

Suggestions:

- Significant potential advantages were identified in forming a coordinating body that could respond to the wide range of viewpoints across the sector and that enabled discussion and exchange of expert knowledge, thereby strengthening input into research strategies and individual proposals.

- Clear parallels between the sub-sectors in social research could be additionally utilised if there was a requirement for agreed definitions between sectors e.g. on “addiction”, “harm reduction”, “cessation of use” and “prevention” that would make research more accessible between sub-sectors.
- There should be representation from the wider social, economic and law enforcement agencies, which often work from a different paradigm, so inclusiveness increases the pool of expert knowledge.
- The gap between research consumers and researchers should be reduced so that there is cooperative agreement on the strategic development of research.

Funding Mechanisms

Issues:

- The current funding environment is described as limited and fragmented. Research funding is difficult to access, especially within a competitive environment.
- There is a critical need for an improvement in the overall level of research funding. This could be achieved through a collective effort to promote the needs of the sub-sectors and the value of tobacco, alcohol, other drugs and gambling harm-reduction research.
- A mainly commissioned research environment creates major entry barriers for researchers, as contestable research is both costly to tender for and an unreliable source for sustaining commitment.
- Funders do not want to dilute their control over funding. They express concern at the possibility of external groups advising on the strategic direction of research and research development.
- Government agencies require expert knowledge or training to manage the process of commissioning research. Several researchers described inefficiencies and loss of research data through lack of a quality system.
- Ring-fenced funding for research is not favoured in the current funding environment.

Suggestions:

- Any future coordinating process aimed at improving the tobacco, alcohol, other drugs and gambling research infrastructure should have representation and be positioned independent from funding bodies. Its processes should be visible and democratic.
- A process to facilitate communication between funding agencies, researchers and other stakeholders was seen as desirable.
- The setting of funding priorities could be assisted by a coordinated process where the various funders identify their research requirements and involve consultation with public health providers, treatment providers and researchers.
- Improved communication within the sector would also be beneficial in clarifying the role of HRC and FRST in their prioritisation of research projects.

Research Workforce Development

Issues:

- There was clear accord with the discussion document on the lack of a robust research capacity in New Zealand.
- Many good researchers were identified, but the paucity in research expertise does not provide the critical mass required to develop or maintain expert knowledge.
- Some sub-sectors (e.g. gambling and other drugs) have yet to develop an extensive expert knowledge base from which recruitment can be made.
- The lack of workforce development is particularly evident in the low recruitment and retention of Māori and Pacific researchers.

Suggestions:

- The provision of support for workforce development through coordination and promotion of research, and promotion of a transparent process for the prioritisation of research were identified clearly as a possible function of the coordinating committee.
- The development of a critical mass of researchers/advisors, across sub-sectors, that provides a strategic framework for further development and the provision of economies of scale.
- Increasing the stability of employment within universities for researchers through the development of courses that reflect the sub-sectors, thereby increasing the number of academics with long-term interests in the field.
- The promotion of training (e.g. within universities), promoting applied research at an undergraduate level to stimulate an interest within the student population that may translate into recruitment into the workforce.
- The provision of research scholarships within the universities, along with PhD scholarships and post-doctoral fellowships, will also develop training opportunities.
- The further development of a more cooperative research environment so that access to funding is more efficiently managed, lessening gaps in employment for experienced researchers.

Communication and Dissemination

Issues:

- A key concern of researchers, policy advisors and funding organisations is that accessing existing research is difficult, therefore expensive and not always comprehensively achieved.
- Research, including secondary analysis, should be more accessible to a greater range of end-users including treatment providers / District Health Boards, researchers, advocates, policy makers and communities / whanau.
- Dissemination should include web-based communication, community appropriate communication methods which may be diverse or culturally linked e.g. through media, Māori hui, high profile government funded public meetings for Asian communities.

Suggestions:

- An electronically based central registrar was frequently identified as an efficient use of funding and a priority that could be easily achieved.
- A comprehensive stock-take of current research was identified by a majority of the participants as the first priority.
- Targeting culturally specific ways of disseminating information and the physical location of information was considered important.

Main Conclusions

- Sub-sectors would benefit from working separately to provide analysis of research needs and priorities. All sub-sectors are currently engaged in this and it would seem impossible to develop a consensus for prioritisation.
- Funding agencies and government departments are not the most appropriate people to coordinate strategy. The focus of these agencies is short-term and policy driven, compounded by few individuals with expert knowledge.
- A coordinating function will provide benefits to all sub-sectors particularly by addressing workforce development needs, enhancing quality and synergy in the research process and enhancing the process of dissemination.
- A more inclusive and transparent process is required during the appraisal and commissioning of research.
- A long-term plan is required in establishing the relationship between the tobacco, alcohol, other drugs and gambling sub-sectors and in the development of an inclusive research strategy.

Appendix C: Question Guide for Key Informant Interviews

- 1. Have you been involved in the discussion document? What are your perceptions at this time?**
- 2. What is your position on the need for a high-level advisory group to coordinate research development?**

Agree

Do you support the need for coordination? Why?
Where would it be positioned? (part of Ministry of Health, in HRC, university)
Who would form the membership? (government, non-government agencies, researchers)
What would be the key responsibilities? (supporting emerging research, support, collaboration and interdisciplinary studies, enhance dissemination of information and promote communication with key stakeholders, identifying research priorities and needs of end-users to coincide where possible)

Disagree

Why is the current structure adequate?
What sort of improvement is required?
What is required to support growth and improvement?
How this could be achieved?

- 3. Do you support a dedicated research development fund for harm-reduction research? (Y/N)**
How would the fund be managed?
- 4. What would be the advantages / disadvantages of a coordination committee?**
- 5. What are your specific recommendations as to the needs / requirement for developing research in your area?**
- 6. Are there advantages of developing the whole sector inclusively?**
What are the convergent issues / divergent issues?
What would be the benefits of harm-reduction research to the whole sector?
- 7. What are your comments on providing links between stakeholders, (policy makers, providers, researchers, community members and funders)?**
Is this a priority?
What are the advantages?
How could it be achieved?
- 8. How can dissemination be improved? (national data base, conferences, forums, email networks, centralised resource base)**
Is this a priority?
How can this be used to enhance / support research?
- 9. What are the primary considerations for determining research priorities? How can a collaborative process be achieved?**
Who will decide on priorities?

How will this be decided?
How will the decisions be implemented?

10. Does the level of funding need to be improved or the money that we have made to work more effectively

What proportion of research should be commissioned vs investigator-initiated, what are the advantages in this?

What improvements could be made to the present situation?

- Funding extended research programmes
- Less fragmentation in funding
- Increasing research in some areas
- Promotion of need for research in these areas as a whole
- *(A coordinating body to oversee research funding)*

11. Do you have thoughts on Centres?

How does the creation of Centres impact on research?

What are alternatives for the composition of provider organisations? Multiple nodes, private vs university organisations. What issues arise from alternatives?

12. Is there an adequate workforce/ workforce development

Is there a need for more specialist researchers, if so how can they be recruited / maintained in the workforce? (scholarships, career structure, organisational structures, repatriation)

13. What is the best balance between generic and specialist researchers in your area? What are the benefits/disadvantages of both?

14. What are the indicators of academic vitality? (publications, controversy, debate, contested viewpoints, PhD's)

Are we developing adequate academic vitality?

Appendix D: Participants in Key Informant Interviews

1. Dr Mike McAvoy, (Alcohol Advisory Council)
2. Cynthia Maling, (Public Health Directorate, Ministry of Health)
3. Kim Conway, (SHORE Research, Massey University)
4. Dr Michelle Sullivan, (Health Research Council)
5. Dr David Chaplow, (Director of Mental Health, Ministry of Health)
6. Andrew Zielinski, (Ministry of Health / IACD)
7. *Simon Adamson, (National Centre for Treatment Development, Christchurch School of Medicine)
8. *Dr Sampson Tse, (Centre for Gambling Studies, University of Auckland)
9. Anne Dowden, (BRC Marketing and Social Research)
10. Caroline Maskill, (HealthSearch)
11. *John Markland, (Department of Internal Affairs)
12. Paul Marriot-Lloyd, (Police / IACD)
13. Dale Walker, (Te Puni Kokiri / IACD)
14. *Dr Barry Boorman, (Public Health Intelligence Unit, Ministry of Health)
15. George Thompson, (Wellington School of Medicine)

* indicates the person also made a written submission.

Appendix E: Individuals who made written submissions

1. Patsy Watson, (Massey University)
2. Dr John Hay, (ESR)
3. Dr Elisabeth Wells, (Christchurch School of Medicine)
4. Sally Jackman, (New Zealand Drug Foundation)
5. Dr Grant Paton-Simpson, (Waitemata DHB Mental Health Services)
6. Caroline Lockhart, (Massey University)
7. Tony Bliss, (Land Transport Safety Authority of New Zealand)