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The Role of Research Evidence in Drug Policy Development in Australia

ALISON RITTER[*]

Summary

The mantra of "evidence-based policy" is continuing to gain ground, with calls for public policy to be informed by scientific evidence. However, in many areas of public policy the role of evidence and science is highly contested. This is amply demonstrated in the area of illegal drugs policy. Illegal drugs policy, concerned with governments' approaches to controlling the sale and use of drugs such as heroin, cocaine, and cannabis, is a highly contested area, and hence a fruitful case example of the complexity of policy. The features of illicit drug policy explored in this paper are: government actors, which span multiple departments; political ambivalence and multiple stakeholders outside government; community attitudes and a high media profile. These features need to be taken into account in understanding the relationship between policy and research evidence. In this context, the role of research evidence can be fraught. Examination of a number of current 'hot topics' in drug policy demonstrates the variety of ways in which evidence is used in drug policy processes.

Keywords: evidence-based policy, illicit drugs

Introduction

Evidence-based or evidence-informed policy is a common mantra. Good public policy includes consideration of research evidence, but the uptake of evidence in policy-making processes is fraught with barriers (Anderson *et al*., 2005; Brownson, Royer, Ewing & McBride, 2006; Edwards, 2005; Gregrich, 2003; Hanney, Gonzalez-Block, Buxton & Kogan, 2003; Lomas, 1997; Secker, 1993; Stone, Maxwell & Keating, 2001). Barriers from the research perspective include the long timeframe

[*] *Alison Ritter*, Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of New South Wales, Sydney, Australia.

for research; often contradictory or equivocal findings; research questions that are not relevant; the absence of any research evidence; and the research environment – which does not reward policy relevant activities. From the policy point of view, barriers include the policy environment itself, the short timeframe for decisions, rapid change, lack of skills to interpret and use research effectively and poor access to research. In my experience, researchers feel frustrated and policy makers feel misunderstood. “The policy world is as alien to most researchers as a distant foreign land and most do not even realise it” (Agar, 2002).

Drug policy is a perfect example of a complex social problem, without obvious solutions, driven by highly emotional arguments and strong interest groups. It is ideal for the study of the role of evidence, inasmuch as evidence is but one input into policy.

There are many current debates in drug policy internationally. These include, amongst others, law reform: legalisation of use/possession, especially of cannabis; injecting rooms; prescribed heroin; goals for drug treatment (abstinence or reduced use); and workplace drug testing. Not every country or state is considering these policies actively, but many people in society have a view about drugs policy, and these topics are frequently raised. How can evidence contribute to these? What kinds of evidence contribute? Or are these policy debates less about evidence and more about ideology? I will return to this theme at the end.

Illicit Drug Policy: Government Actors

Drug problems are complex and involve physical, social, psychological and community aspects. For some people, drug problems are seen solely as a criminal justice problem – drug users should be arrested, and drug traders punished. For others, it is firmly a health problem. In the USA, promulgation of “addiction as a disease” has seen the growth in treatment interventions and a strong push for the health portfolios of government to lead the way in drug policy. For example, DuPont *et al.* (in press) state that “the root of the drug problem is found in the human brain, specifically the brain’s reward centers that control behaviour”. At the same time, the “addiction as a disease” concept has attracted criticism from social scientists, who note that drug use is a social phenomenon, and occurs as a consequence of environment, social circumstances and so on. In addition, the “addiction as a disease” leaves little room for recreational drug use. Recreational drug use is the most common form of drug use (only a minority go on to develop a dependence or addiction per se) (Wagner & Anthony, 2002). Yet recreational use can be harmful – and should be the subject of drug policy as much as “addiction”.

Taking the broader perspective on drug policy, which is inclusive of health but also of social and community aspects, leads to the appreciation that drug policy

spans multiple areas of government, notably law enforcement and policing, health, community services and education. Table 1 displays the large variety of 'drug policies' within the four pillars of drug policy: Prevention; Treatment; Law enforcement; and Harm reduction (Ritter & McDonald, 2008).

Table 1. Drug Policy Options, Divided by the Four Pillars of Prevention, Treatment, Law Enforcement and Harm Reduction

Prevention policy options	**Treatment policy options**	**Law enforcement policy options**	**Harm reduction policy options**
• Mass media campaigns • Targeted media campaigns to at-risk groups • Media advocacy • Employment • Reducing poverty • Improving overall public health • School-based drug education (SBDE) programs – education and information • Affective education programs in schools • Resistance skills training programs in schools • Generic skills training/competency enhancement programs in schools • Social influence programs in schools • Community/ system-wide school programs • Community--building / neighbourhood enhancement programs	• Drug monitoring programs • Drug detection devices • Brief interventions • Telephone information and counselling services • Withdrawal treatment • In-custody withdrawal services • Methadone maintenance • Buprenorphine maintenance • Heroin maintenance • Naltrexone maintenance • LAAM maintenance • Morphine maintenance • Therapeutic community • Contingency management • Supported accommodation programs • Relapse prevention programs • CBT (individual and group)	• Drug-free zones • International treaties and conventions • Bilateral and multilateral international agreements and operations • Prohibition • Decriminalisation • Prescribed availability of drugs • Licensed availability of drugs • Legalisation of drugs • Crop eradication programs • Crop substitution programs • Customs and border control • Multi jurisdictions taskforces against trafficking • Crackdowns • Raids • Undercover operations • Intensive policing • Zero tolerance policing	• Peer-led advocacy and support programs • Needle Syringe Programs • Outreach programs • Peer education for users • Regulations (and/ or legislation) in relation to drug paraphernalia • Overdose prevention programs • Peer administered naloxone • HIV prevention and education programs • HIV/hepatitis voluntary counselling & testing programs • Supervised Injecting facilities • Tolerance zones • Harm reduction programs in prisons • Non Injecting Routes of Administration (NIROA)

Prevention policy options	**Treatment policy options**	**Law enforcement policy options**
• Community programs for young people • Crime prevention through environmental design (CPTED) • Infancy and early childhood programs for at-risk groups • At-risk family interventions • At-risk youth programs • Post-natal support for drug dependent mothers • Parenting skills for drug dependent women • Proactive classroom management & school policy • Mentoring and peer support programs • Renewal programs • Drug Action Teams • Screening in health settings • Drug testing in schools	• Family therapy • Psychodynamic psychotherapy • Work/industry programs • Dual diagnosis programs • Services for pregnant women – pre-natal • Narcotics Anonymous • NARAnon • Drug education in prison • Treatment programs in prison • Parole programs • Post-release programs	• Police management reform • Asset forfeiture • Financial controls and monitoring re: money laundering detection and prevention • Controls on precursor chemicals • Crime mapping technology • Multi agency taskforces/ partnerships • Community policing • Civil remedies, third party policing, drug nuisance abatement • Police discretion • Police cautioning programs • Court programs • Restorative justice programs • Detention of intoxicated drug user • Neighbourhood Watch groups • Drug driving programs • Monitoring of drug use by inmates

Source: Ritter & McDonald, 2008

More than 100 different drug policy options can be readily identified, each of which has a variable evidence base (some strong, some weak). There are a number of reflections that can be made when drug policy is examined from this perspective of multiple policy options.

Firstly, it demonstrates the requirement for a comprehensive, whole of government approach to drug policy. This in itself creates many challenges: government departments often operate in silos and certainly in competition with each other for limited resources. Thus, if the health system argues that greater investment in health responses will lead to reductions in spending within the criminal justice areas, this is of little comfort to the health bureaucrats because the savings do not accrue to their portfolio. In addition, portfolios can have conflicting goals. For example, attendance by police when an ambulance is called for a drug overdose. The goal of the police is to arrest the user; the ambulance officer's goal is to save the person's life. (In Australia there is now agreement that police do not attend overdose events.)

The second observation is that usually one area of government is required to provide overall leadership for drug policy. In many countries, including Australia, this occurs within "Health". In most EU countries, this occurs at the President, Prime Minister or cross-Ministerial levels (e.g. USA Drug Tsar, Office of National Drug Control Program). In Croatia, the 'Commission for Combating Drugs' is composed of members of all relevant ministries and is chaired by the Deputy Prime Minister in charge of social issues and human rights. And in other countries, this occurs within the crime and policing portfolios. Notably in South East Asian countries, responsibility for drugs occurs more often through criminal justice or social departments, such as "The Department for Social Evils Prevention" (within the Ministry of Labour Invalids and Social Affairs) in Vietnam. Interestingly, there has been no documented analysis or research on the impact of where the policy control body sits within government.

Thirdly, returning to the list of possible options, it should be apparent that one must rely on a portfolio of strategies, across all the areas, rather than single interventions. This is consistent with the notion that effective drugs policy must contain both a supply reduction element (law enforcement) and a demand reduction element (treatment and prevention). Reducing supply without reducing demand for drugs will have little influence; likewise reducing demand for drugs without attending to supply will also be limited. This begs the question regarding an appropriate "balance" between drug policy elements. Many nations formally state that drug policy should entail balanced efforts across multiple domains. For example in Australia, one of the aims of the National Drug Strategy is 'to achieve a balance between harm-reduction, demand-reduction and supply-reduction measures to reduce the harmful effects of drugs in Australia' (Ritter, 2010). Similarly, the recent American National Drug Control Strategy emphasises a balanced policy of prevention, treatment, law enforcement and international cooperation (Office of National Drug Control Policy, 2010). In Switzerland's four pillar model, balance is seen as 'a pragmatic middle way', with the Swiss strategy aiming to increase the interchange between prevention, treatment, harm reduction and law enforcement (Swiss Confederation, 2006). Despite this rhetoric, however, there is little policy analysis of how balance can be achieved, or what that 'balance' should look like – which is a fruitful area for research (Ritter, 2010).

Fourthly, and finally, such a list of possible interventions across four pillars tempts the notion of evidence-based policy. Surely the key task for governments is to choose from amongst these options those which show the greatest effect for the least cost, operate synergistically and minimise unintended consequences. In a world where evidence reigns supreme, drug policy would be a rational construction from the menu of options, and one which achieves society's desired goals in the most cost-effective manner.

This technocratic view of drug policy ignores the reality of a policy area where there are strong emotions, morality politics are at play and there are not necessarily shared goals. The technocratic view of policy processes is infrequently supported in other areas of social policy: the role of politics, public opinion, interest groups and coincidental 'opportunities' have been well documented in the policy literature (Kingdon, 2003; Lindblom, 1959, 1979; Ritter & Bammer, 2010; Sabatier, 1988, 2007; Stone, 2002; Weiss, 1983). Illicit drugs are no exception, and carry symbolic significance (Bertram, Blachman, Sharpe & Andreas, 1996; Keane, 2002). We turn to these factors next.

Politics of Drug Policy

Characterised on a simple spectrum, the politics of drug policy can be either 'zero tolerance' or 'harm reduction'. For the former, drug policy signifies a moral statement by government against drug use and an endeavour to eliminate such "social evil" from society, through a zero tolerance or abstentionist position. Drug use must be eliminated, those responsible must be punished, and society must be protected from those (marginalised and stigmatised) individuals. For harm reduction, government's role is to protect society from the consequences of drug use, but not to eliminate drug use itself (which is seen as unrealistic). The harm reduction position accepts that the majority of people in society use drugs (either once or often, across many substances), and that the harmful consequences of such use are the target of government policy. In its extreme, legalisation of all drugs would reduce the harmfulness of drug use given that arguably many of the harms arising from drug use occur as a consequence of its illegality (criminal sanctions, imprisonment, impure substances, black market activity, and so on).

Internationally, it is difficult to ascertain where on this simplified spectrum drug policy is heading. Three international bodies are responsible for the implementation of international drug policy: the Commission on Narcotic Drugs (CND), the United Nations Office on Drugs and Crime (UNODC), and the International Narcotics Control Board (INCB) (Babor *et al.*, 2010). The international bodies are clearly abstentionist and the international treaties explicitly note the requirement for nations to criminalise drug use and drug trade. These include the United Nations *Single Convention on Narcotic Drugs*, the *Convention on Psychotropic Substances*, and the *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (United Nations Office on Drugs and Crime, 2010).

The US has been highly influential in international drug policy and their restrictive policy 'holds sway'. At the same time, there is a groundswell towards decriminalisation and in some cases legalisation of cannabis. Portugal's now famous decriminalisation policy (Hughes & Stevens, 2007) has been discussed across the

globe as an example. The same goes for the recent Californian referendum (November 2010) on the legalisation of cannabis, which was narrowly defeated (53.5% voting against it). The latter has been subject to policy analysis (Kilmer, Caulkins, Pacula, MacCoun & Reuter, 2010), but there are few other examples of such policy analysis at the macro level.

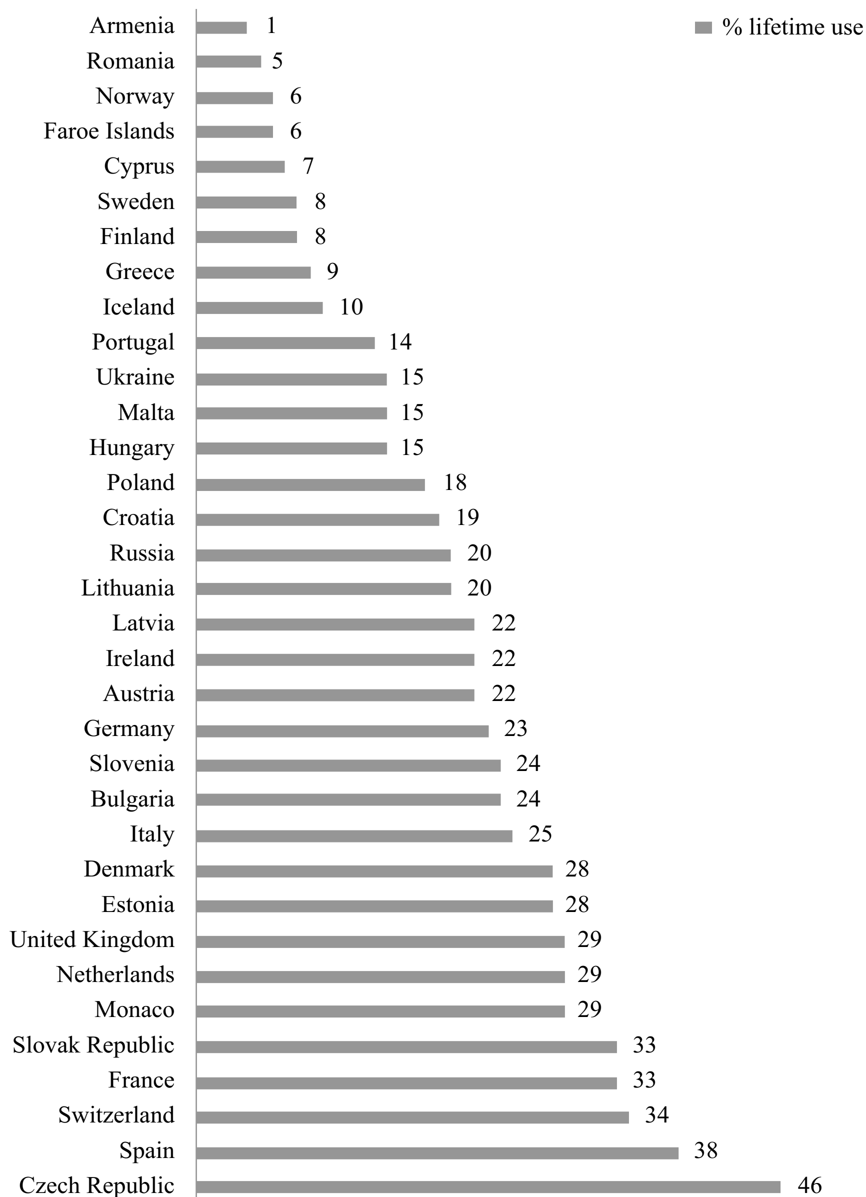
This is despite there being notable differences between countries in rates of drug use – indeed, there is an 'objective' policy measure in this instance (although some would argue that rates of use per se are not sensitive to more important variables, such as extent of harm). By way of example, Figure 1 on the next page provides lifetime drug use rates in students across 34 countries. As can be seen, drug use rates vary greatly across European countries.

There has been little policy analysis that compares policy stance and drug use rates. It has been suggested that the states with stronger welfare policies have lower rates of use, but this is not substantiated. (The reverse has also been argued by DuPont [in press].) Policy stance likewise does not obviously distinguish countries. And one notes that drug policy has actually been largely stable. For example, in the USA, their restrictive drug policy has remained stable since the 1970s despite changes in political parties (Democrat vs Republican). This is also true in Australia in that both our Liberal and Labour governments have maintained the same drug policy since 1985. There does not appear to be a simplistic left-right, conservative-progressive divide.

One possibility to account for the 'stability' is that drug policy does not have any attractive or beneficial aspects for a politician. Putting drug policy on the agenda merely identifies a problem – the solutions are not obvious, and any substantial shift in direction (from repressive to progressive or vice versa) would entail substantial effort. Given the global stability in drug use rates (United Nations Office on Drugs and Crime, 2009), there appears little in it for a politician. In Australia, this appears to be the case. In the last two federal elections (November 2007 and August 2010), illicit drugs were not a significant part of the campaigns, and since the change in government in 2007 little has been said that could be interpreted as a comprehensive policy statement. Rather, the focus has been on alcohol and tobacco, which, although timely and to be encouraged, could indicate that the issue of illicit drugs has slipped off the agenda (Ritter, Lancaster, Grech & Reuter, 2011).

The paradox, however, appears to be the central interest by the general public in drug policy. Drug policy attracts media, and most of the general public hold views about drugs. In the 2008 'Public Opinion Towards Governance: Results from the Inaugural ANU Poll' (http://www.anu.edu.au), 2% of Australians thought that illicit drugs were the most important issue facing Australia, behind the environment (19%), the economy (17%) and jobs (6%). We will now examine public opinion more closely.

Figure 1. Lifetime Use of Any Illicit Drug. Secondary School Students. 2007



Source: The 2007 ESPAD Report, p. 85, Figure 14b

Public Opinion

The interrelationship between policy and public opinion has been well documented (Burstein, 2003; Gonzenbach, 1992; Page & Shapiro, 1983; Stimson, 2004). Public opinion on illicit drugs has been the subject of frequent polls – in Australia, the general public are surveyed every three years regarding their opinions on a number of drug policy questions (Matthew-Simmons, Love & Ritter, 2008). Research has shown changing opinions on issues such as cannabis legalisation. For example, in 1993 support for cannabis legalisation was 26%, climbing to a high of 34% in 1998, with subsequent declines to 19% by the year 2007 (Matthew-Simmons *et al*., 2008). There has also been a rise in the overall numbers responding that they do not know what their opinion is on drug policy issues (Matthew-Simmons *et al*., 2008). In Australia, we can conclude that if policy follows public opinion, then it is highly unlikely that governments will move to change the legal status of cannabis; the window of opportunity for that policy shift appears to have been in the late 1990s and is now closing.

More generally, the Australian public opinion research suggests a generally conservative shift in attitudes towards a range of drug policy issues (Matthew-Simmons *et al*., 2008). But the picture is not straightforward. Although support for reforms such as cannabis legalisation decreased and support for law enforcement increased, there was also evidence of increased support for harm reduction measures such as needle syringe programs and safe injecting centres (Matthew-Simmons *et al*., 2008). This suggests that polarised political debate is unlikely to resonate with the community at large. McKnight (2005) argues that the left-right ideological divide is increasingly irrelevant for many issues in Australian politics, and that Australian society will increasingly prefer for policy to be judged on its own merits. The trend in public opinion in relation to drug issues would suggest that this might be the case for this policy arena, as much as any other.

Media Influence

The role of the media in shaping public opinion and political debate is also significant (see for example Fan, 1996). The media can define public interest by setting the agenda and frame issues through selection and salience (Lancaster, Hughes, Spicer, Matthew-Simmons & Dillon, 2010). The media can build consensus about which issues are most important and the associated solutions (McCombs, 1997; McCombs & Shaw, 1972). This can then feed into political debate and decision making. This has implications for many aspects of illicit drug policy.

There have been a small number of studies in Australia examining the influence of the media in relation to illicit drug policy. In a study of press coverage of a proposed heroin trial, it was found that dominant media portrayals of heroin

users as 'deviants' presented by opponents of the trial played a significant role in the political demise of the heroin trial (Elliott & Chapman, 2000). Likewise, Lawrence *et al*. (2000) suggested that it was the substantial negative coverage by selected media outlets which ultimately influenced the final policy decision not to proceed with the trial. There are also positive examples of the role of the media in shaping public attitudes to drug issues. For example, McArthur (1999) noted the shift in media coverage regarding the efficacy of methadone treatment in the 1980s which contributed to greater community understanding of the benefits from treatment in reducing crime.

Media portrayals of drug issues over a 6 year period (2003 to 2008) in Australia revealed that the dominant media portrayals concerned law enforcement or criminal justice action (Hughes *et al*., 2010). This is despite the strong government focus on health responses and an overarching framework of harm minimisation.

Interestingly, the media analysis research also found that most articles were reported in a neutral manner, in the absence of crisis framings (Hughes *et al*., 2010). The 'neutrality' of the media drug portrayals (at least in Australia) is consistent with illicit drugs not being on the political agenda, and the overall stability of illicit drugs policy. This suggestion is complemented by the public opinion data (in Australia) demonstrating increasing rates of 'don't know' responses, coupled with the lack of a consistent 'ideology' amongst respondents. This seems to suggest an environment where evidence-based policy may have some traction, given that issues which have very high emotional content tend to attract greater contest regarding the evidence. Where does evidence-based drug policy sit given this context?

Evidence-based Drug Policy?

Alas, despite this somewhat promising analysis, the role of evidence in drug policy remains limited. On a broad level, we can certainly say that evidence competes with other information, and then competes with interest groups and ideology (Weiss, 1983). Likewise, 'advocacy coalitions' may use research evidence, notably in professional forums (Sabatier, 1988). In Kingdon's multiple streams model of policy processes, research plays a central role in the policy stream, where new solutions are explored (Kingdon, 2003). Perhaps most frequently, however, policy change occurs in a series of small incremental shifts (Lindblom, 1959, 1979) where decision makers are choosing between marginal improvements. These can frequently be informed by research evidence. In each of these theoretical frameworks for policy, case studies of research evidence being used to inform illicit drug policy have been identified (Ritter & Bammer, 2010).

As a first step, however, decision makers need to access research. Even if we think that policy processes are complicated and that research only plays a minor

role, we still need to know how to get research onto the desks of decision makers, so that it can at least be considered within the mix. Ritter (2009) surveyed Australian government drug policy makers (across health and police government portfolios) and asked them to nominate the sources of research evidence that informed their most recent policy decision.

In every case, the policy maker contacted someone who they regarded as 'expert' and asked for advice. Interestingly, the expert was not necessarily an expert on the topic at hand, but someone trusted and available. In addition, all the respondents said that they looked for some reference, in their office, that they could use (Ritter, 2009). This speaks to the value of having readily available technical reports that the policy maker can take down and rapidly consult as required. The third most common source was 'google' – not 'google scholar' or particular academic sites, but simply 'google'. It should be remembered that many policy makers do not have access to academic libraries, journals and so on, so they rely on whatever they can find rapidly and without cost/subscription. Reassuringly, in Australia at least, more than half the policy makers referred to statistical data in making their most recent decision. Finally, less than half consulted academic literature (35%; Ritter, 2009). There were a number of comments made about the use of academic literature: it is difficult to source, it is highly specific to a particular topic, and one can frequently find an alternate paper that will contradict the one one wishes to cite. This last point is important: policy makers need research to stand by the decision, but they also need it not to be refutable. Academic publishing is concerned with publishing refutable pieces, or refuting pieces of work. This is an inherent problem for policy makers.

The ways in which research can be taken up and used has been most extensively examined by Carol Weiss and colleagues (Weiss, 1979, 1977; Weiss, Murphy-Graham & Birkeland, 2005). In her typology, there are three primary ways in which research is used: instrumentally, politically/symbolically, and conceptually. The instrumental view is akin to an engineering model, where research gives direction to policy, and research findings lead to action. This is the usual interpretation, but is arguably the most uncommon use of research. In political/symbolic utilisation, research is used to support or justify pre-existing preferences or actions or to justify delay. It has primarily a legitimating function and offers proof of responsiveness. The conceptual use of research is also termed 'enlightenment'. In this delayed and indirect research usage, research contributes to percolation of new ideas and concepts which over time become 'common knowledge' and contribute to the overall knowledge endeavour rather than any one specific policy decision. (Weiss also notes two further uses: imposed/mandated use; and ignored entirely.) A systematic approach to understanding the extent of research utilisation by policy makers would be to examine Weiss' research utilisation typology as it applied to specific pieces of research.

Conclusions

I have argued that a whole of government approach is required across multiple government actors; that politics influences drug policy, but there has been a level of stability in drug policy that belies its emotive content; that public opinion on drug policy is less driven by coherent ideology, and more by pragmatic responses; and that decision makers rarely access academic literature and use research in instrumental and symbolic ways.

To return to the current debates listed at the start of this paper: how can evidence contribute to these? And what kinds of evidence contribute? It is striking that in the case of some of the topics, research evidence is either completely absent or marginal to the question. This applies to legalisation of drugs. As noted earlier, there is a slowly growing group of studies on cannabis legalisation, but these are most commonly conducted by advocates who have already established a position (with RAND's work being a notable exception). In the case of prescribed heroin, however, we have a very strong evidence-base demonstrating efficacy (Oviedo-Joekes, Brissette, Marsh *et al*., 2009) without subsequent policy uptake, at least in Australia. It may be the case that the results of the heroin trials conducted elsewhere have not been accessible to decision makers given their reliance on non-academic research sources. Perhaps more importantly, however, this is an example of where politics and interest groups play a more substantial role than the evidence base per se. This is certainly the case in the Australian injecting room debate (Van Beek, 2004). This suggests that evidence is a necessary but insufficient requirement for policy, and in some instances what is required is strong community support, positive public opinion, and media uptake.

On topics such as suitable goals for drug treatment (abstinence versus reduced use), research evidence can contribute data on outcomes (e.g. DuPont & Humphries, 2011), but it cannot resolve what is essentially a moral or ideological question. This requires engaged public debate. Similarly, workplace drug testing has both proponents and opponents. Research may contribute with better technology, but ultimately it is a question of values. These two examples (along with human rights drug policy and harm reduction) highlight the importance of policy processes over and above research evidence.

Finally, one obvious gap in our research evidence has to do with policy research. Throughout this paper, I identify numerous issues that would benefit from close examination. They include: the extent to which restrictive or progressive regimes have different rates of drug use; analysis of the impact of where the policy control body sits within government; exploring notions of 'balanced' drug policy; comparisons of how other policy makers access research evidence when making decisions; and, of course, more research on the topics of interest in drug policy, such as legalisation.

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Mailing Address: **Alison Ritter**, University of New South Wales, Sydney, Australia.
E-mail: a.ritter@unsw.edu.au