Bringing evidence and analysis
together to inform UK drug policy

UKDPC

UK DRUG POLICY COMMISSION

How to make drug policy better:

key findings from UKDPC research into drug policy governance

December 2012

About UKDPC

The UK Drug Policy Commission (UKDPC) is an independent body providing objective analysis of evidence related to UK drug policy. It aims to improve political, media and public understanding of drug policy issues and the options for achieving an effective, evidence-led response to the problems caused by illegal drugs.

UKDPC brings together senior figures from policing, public policy and the media along with leading experts from the drug treatment and medical research fields:

UKDPC is a company limited by guarantee registered in England and Wales No. 5823583 and is a charity registered in England No. 1118203. UKDPC is grateful to the Esmée Fairbairn Foundation for its support.

The UK Drug Policy Commission (UKDPC)
Kings Place
90 York Way
London N1 9AG
Tel: +44 (0)20 7812 3790
Email: info@ukdpc.org.uk
Web: www.ukdpc.org.uk
This publication is available online at http://www.ukdpc.org.uk/governance-project/
ISBN: 978-1-906246-45-7

Contents

Abbreviations

ACMD – Advisory Council on the Misuse of Drugs

CCSA – Canadian Centre on Substance Abuse

CSJ – Centre for Social Justice

DSDC – Drug Strategy Delivery Commission

MRC – Medical Research Council

NICE – National Institute for Health and Clinical Excellence

RCT – randomised controlled trial

Summary

Drug use and dependence is a very complex area, which impacts in different ways on many people and has ramifications throughout society. It is also a particularly controversial area. There is a range of new challenges facing drug policy, including the rapid development of new drugs and new routes of supply, which require responses. However, it is difficult to discuss even the possibility of new approaches and it increasingly appears from the range of people who call for reform on leaving office that those involved in drug policy making are not satisfied with, or helped by, the architecture within which they work.

This study of drug policy governance, or how drug policy is made, involved a wide range of people including current and former ministers, parliamentarians, senior civil servants, practitioners, think-tanks, advocacy bodies and academics. It has identified the important issues for good governance, where the system seems to be going wrong, and options for improving the way policy is made. Everyone has an interest in improving the way we make policy so that its impact can be maximized.

A number of cross-cutting themes emerged from the review, including ones that facilitate effective policymaking as well as deficits in: leadership, organisational structures and processes; knowledge development and application; accountability; and stakeholder engagement. Key issues identified and our recommendations for addressing these are:

- The polarised and contested debate around drug policy is preventing an open discussion about the goals of drug policy and the options for achieving these.

  Recommendation 1: Create a cross-party political forum to progress discussion about future policy, including engagement with the public.

- Within drug policy there is an overemphasis on enforcement and a view of drugs as a criminal justice issue which is skewing public policy responses.

  Recommendation 2: Move the political lead for national drug policy from the Home Office to the Department of Health.

- The public debate about drug policy has become dominated by disagreement over the assessment of harms of different drugs much of which occurs in the media using partial and unevaluated evidence. This hampers sensible discussion about drug policy.

  Recommendation 3: The government should initiate a formal review of the powers and remit of the Advisory Council on the Misuse of Drugs (ACMD) and explore different options for the assessment of harms and the classification process.

How to make drug policy better

- Drug policy making is insufficiently evidence-imbued. There is a lack of coordination, drive and adequate resourcing, which has resulted in large gaps in our knowledge in a range of areas, and strategies and policies are rarely evaluated.

  Recommendation 4: Evaluation needs to be embedded into the policy process. Drug strategies should include a commitment to their evaluation from the start.

  Recommendation 5: A new independent body should be established to co-ordinate the drug research effort and to provide policy analysis and dissemination. A proportion of the money raised by the forfeiture of assets from drug-related crime might be used to fund this body and drugs research more widely.

- Localism and devolution are an opportunity for natural experiments but there is also a threat of pockets of poor practice.

  Recommendation 6: Put in place structures and processes to scrutinise and evaluate emerging local approaches in order to highlight and spread good practice and identify problems early.

- There are a wide range of stakeholders in drug policy, which, taken together with the complexity of the issues, means that an on-going dialogue about the evidence and the implications for policy is necessary.

  Recommendation 7: There is a need to develop and test the use of deliberative methods for engaging with the public around the complexities of the evidence base and the goals and options for drug policy.

In a rapidly changing world it is essential that policy is able to change in response to new challenges and learn from evidence of what is and is not working, which may also change over time. We should also be able to learn and be inspired by developments in other countries. It is very clear from this review that there is no single correct way of making policy and also that no structures and processes can guarantee that a policy will be successful. However, it is possible to identify some characteristics that appear to make good outcomes more likely. We have identified some areas where we believe adopting new processes or structures could help to increase the effectiveness of drug policy and reduce the harms experienced as a result of drug use and dependence. It would help stabilise the policymaking process and make it more consistent, reliable and cost-effective.

1. Introduction

This policy report, about what we call the 'governance' of drug policy, draws on and synthesises the findings from a unique and extensive programme of research, which involved a large number and a wide range of people including: former Home Secretaries and Drugs Ministers, former permanent secretaries and other senior civil servants, parliamentarians, current government officials, treatment, enforcement and prevention providers and practitioners, think-tanks and advocacy bodies, academics and media correspondents. This provided a wealth of information and insight, which are described in detail in separate background reports. Here we present an overview of the important issues for governance at each stage of the policy process, where they seem to be going wrong and possible options for addressing the deficits identified. We then consider the best ways to improve drug policy governance in order to maximise the impact of drug policy in the future.

A brief overview of how we conducted the review is given in Appendix A. More detailed findings and research reports from the different elements of the project can be found on our website at www.ukdpc.org.uk/governance-project.

1.1 Why governance matters

Drug use and dependence is a very complex area, which impacts in different ways on many people and has ramifications throughout society. It is also a particularly controversial area. Successive commentaries have noted that drug policy is often driven by a mix of reactivity, polarised, position-driven analysis and campaigning interests, emotive media reporting, adversarial relationships between scientists, experts and policymakers along with a contested and limited evidence base. It has been described quite aptly as a "battle ground".[1] A good example of this is the political 'yo-yo' over the reclassification of cannabis after 2000 which saw a continuing clash between experts, politicians and some quarters of the press.[2] [3]

There are a range of new challenges facing drug policy, including the rapid development of new drugs and new routes of supply, which require responses. However, as is illustrated by the immediate response from the Government to the recent Home Affairs Committee report,[4] rejecting calls for a Royal Commission to review policy on the grounds that current policy is working, it is difficult to discuss even the possibility of new approaches. It also appears from the increasing range of people who call for reform on leaving office that those involved in drug policymaking are not satisfied with, or helped by, the architecture within

[1] The Guardian. Professor Nutt's Sacking Shows How Toxic the Drugs Debate Has Become. London, 31 October 2009. http://www.guardian.co.uk/politics/2009/oct/30/professor-david-nutt-drugs-sacking

[2] The Guardian. Government Drug Adviser David Nutt Sacked, 30 October 2009. http://www.guardian.co.uk/politics/2009/oct/30/drugs-adviser-david-nutt-sacked

[3] The Independent. Academics Attack Professor Nutt over 'Incorrect Statements' on Drugs, 8 November 2009. http://www.independent.co.uk/life-style/health-and-families/health-news/academics-attack-professor-nutt-over-incorrect-statements-on-drugs-1817012.html

[4] House of Commons Home Affairs Committee, *Drugs: Breaking the Cycle*, Ninth Report of Session 2012-13, HC 184-1, December 2012.

which they work.

No systematic account of this system, its advantages and disadvantages and how it compares to other systems elsewhere, had been conducted and we concluded that there was a need to look at ***how*** drug policy is made in the UK, and to identify suggestions for positive changes that might lead to more effective policymaking processes that can respond to the changing nature and context of drug problems in the 21st century.[5]

1.2 What we mean by governance – scope and coverage of the project

When people talk about 'policy' and 'governance' they may mean different things. We use the following definition:

> Drug policy governance is *'the processes and mechanisms by which policy is directed, controlled and held to account'*. [6]

We take this to include national leadership configurations, the organisations, people and legislation and the dynamic processes which link structures to each other, including consultation, research support and commissioning, the contribution of scientific and other expertise, inspection and democratic accountability mechanisms.

We define drug policy as *'the pattern of legislation and government action that aims to affect the use of drugs and the related problems'*.[7] As such, policy could be seen as the outputs or actions that result from policy governance. However, we must acknowledge that governance processes are never completely separated from policies.

1.3 The broader context within which drug policy is made

All policymaking takes place within a wider context, both domestic and international, which has an impact on both the policy and how it is made. The illicit drug market is global so drug policy needs to address international issues such as trans-national crime. The UK is also signatory to a number of international conventions which have an impact on the way we address drug problems; the most important of these are shown in Box A. These place some obligations and restrictions on the policy options available, although there is considerable 'room to manoeuvre' within these[8] and national discretion as to the domestic policymaking structures and processes. We will consider some of this international variation later in the

---

[5] Previous research by UKDPC looking at the impact of localism and austerity on the delivery of drug services at the local level addressed some governance issues, such as leadership, accountability and stakeholder engagement, but with a focus on policy delivery. The report of that study entitled *Charting New Waters* is available at: http://www.ukdpc.org.uk/publication/charting-new-waters.

[6] Hughes, C., Lodge, M., & Ritter, A. (2010). Monograph No. 18: *The coordination of Australian illicit drug policy: A governance perspective.* DPMP Monograph Series. Sydney: National Drug and Alcohol Research Centre.

[7] Reuter, P and Stevens, A, (2007) *An Analysis of UK Drug Policy.* London: UKDPC

[8] Dorn, N. & Jameison, A., 2000. *Room for Manoeuvre. Overview Report.* London: DrugScope. Available at: http://www.ahrn.net/library_upload/uploadfile/manoeuvre.pdf [accessed 24/07/2012].

report but for practical reasons the main focus of our review has been on domestic policymaking processes.

BOX A: KEY INTERNATIONAL DRUG CONVENTIONS

United Nations Drug Conventions:

The 1961 **Single Convention on Narcotic Drugs** was set up as a universal system (replacing the various treaties signed until then) to control the cultivation, production, manufacture, export, import, distribution of, trade in, use and possession of narcotic substances, paying special attention to those that are plant-based. Over 100 substances are listed in four schedules, placing them under varying degrees of control.

The 1971 **Convention on Psychotropic Substances**, in response to the diversification of drugs of abuse, introduced controls over the licit use of more than 100 largely synthetic psychotropic drugs, like amphetamines, LSD, ecstasy, valium, etc again divided over four schedules. An important purpose of the first two treaties is to codify control measures in order to ensure the availability of narcotic drugs and psychotropic substances for medical and scientific purposes, while preventing their diversion into illicit channels.

The 1988 **Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances** was agreed in response to the increasing problem of drug abuse and trafficking during the 1970s and 1980s and provides for comprehensive measures against drug trafficking. These include provisions against money laundering and the diversion of precursor chemicals, and agreements on mutual legal assistance.

European Union decisions:

The 2004 **Framework Decision on penalties for trafficking** lays down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking and has led to more harmonisation on penalties across the EU.

The 2005 **Council Decision on new psychoactive substances**, which is being reviewed in 2012, provides for the information exchange, risk-assessment and control of new psychoactive substances and has led to the setting up of an EU wide 'early warning system'.

Domestically, drug policy making is subject to a range of government policymaking guidance[9] and it is also being shaped by the broader policy context of greater localism and financial austerity. Devolution has added to this complex picture, with the extent to which different policy elements are devolved varying between countries. There are now separate drug or substance misuse strategies in Scotland, Wales and Northern Ireland as well as an overall UK Government drug strategy, elements of which cover the UK, while some are specific to England. There are therefore also separate governance structures and processes in each country and Table 1 summarises the key components of these.

[9] For example, *Professional Policymaking for the Twenty-First Century Report* by Strategic Policymaking Team, Cabinet Office, 1999; HM Treasury *The Green Book: Appraisal and Evaluation in Central Government*. 2003 edition updated 2011; *A Practical Guide to Policymaking in Northern Ireland*. Office of the First Minister and Deputy First Minister, updated 2011; Commission of the European Commission (2001) *European Governance A White Paper*.

Drug policy also sits within a framework of wider national policies. Efforts to get people into work, change the welfare benefits system, improve education performance, re-configure the delivery of health and social care, punish those who commit crime, or to re-model how public services get delivered such as through 'payment-by-results' systems, will all affect drug policy. As does foreign policy, whether driven by security needs or through international development assistance. Ensuring coherence and complementarity between all these is no easy task and one that is by no means unique to drug policy.

But for drug policy, perhaps more than many other areas, the problems of unintended consequences and the prevailing orthodoxy of being seen to be tough on criminality continually generate clashing policy objectives and contradictions between aims and outcomes.

TABLE 1: OVERVIEW OF THE 'FORMAL' STRUCTURES FOR DRUG POLICY GOVERNANCE IN THE UK

Functions	Westminster/UK-wide	Scotland	Wales	Northern Ireland
Leadership (organisational and individual)	Cabinet Home Affairs Committee Home Secretary (plus British Irish Council Drug Misuse Group)	Scottish Cabinet Minister for Community Safety and Legal Affairs	Welsh Local Government and Public Services Cabinet Committee Minister for Local Government and Communities	Minster for Health, Social Services & Public Safety
Coordination	Inter-Ministerial Group on Drugs (chaired by Minister for Crime Prevention); Drug Strategy Group (officials)	Alcohol and Drug National Delivery Group (officials)	Substance Misuse Strategy Board (officials and stakeholders)	Ministerial Group Public Heath; NSD Steering group for Drugs and Alcohol (NDSSG)(officials and stakeholders)
Independent expert/scientific advice	Advisory Council on the Misuse of Drugs	Drug Strategy Delivery Commission (DSDC)	Advisory Panel on Substance Misuse (APoSM)	
Main national & local implementation mechanisms	National Crime Agency (2013); NHS Commissioning Board; NTA/Public Health England (2013); Police & Crime Commissioners; National Offender Management Service; Health & Wellbeing Boards. Local partnerships??	Single Scottish Police Service (2013); NHS Scotland; Scottish Prison Service; Alcohol & Drug Partnerships	Community Safety Partnerships and Area Planning Boards	Drugs & Alcohol Co-ordinations Teams (DACTs); Probation Board for Northern Ireland; Police Service of Northern Ireland; Northern Ireland Prison Service; Public Health Agency
Evaluation		DSDC	APoSM	NDSSG
Scrutiny/accountability	Parliamentary Select Committees (eg Home Affairs; Science & Technology; Public Accounts)	Scottish Parliament Committees (eg Justice)	Plenary debates in National Assembly for Wales	

2. Issues and concerns at different stages of the policy cycle

2.1 Identifying and understanding the problems to be tackled and the scope of drug policy

The first step in policy development is to define the problem to be tackled. This involves understanding the problem, setting the overarching goal of policy and identifying the intervention options.

SETTING GOALS

A central element of governance is knowledge of what you are attempting to govern: as senior civil servants highlighted, *"you've got to know what it is you're trying to do before you can govern it"* [CS-2]. It is important as it *"… sets the goals and the vision …* [and is] *there for people to unite around"* [CS-1]. The goals that are set also provide the criteria for determining whether a policy has been a success or not.

The unusual complexity of drug policy is a challenge for goal setting. Most of our interviewees agreed on the importance of **clear overarching goals**, but many felt that the current UK strategy does not have them because the aims of the strategy do not match the actions proposed. Other interviewees warned that a broad overarching goal could be open to different interpretations, potentially leading to a 'phoney consensus' in which differences in approach have not been confronted and which, in the words of a current civil servant: *"… cost so much argument and it took so much nervous energy from everyone concerned to try and keep the co-ordination arrangements together."* [CS-2].

The lack of clear aims can also inhibit evaluation and accountability because ambiguity means no-one is quite sure what effectiveness would look like. There is a difference between the overarching goals and the more detailed objectives that stem from these and some interviewees felt that there were benefits in having an overall policy consensus combined with 'functional vagueness'. They suggested, for example, that in Scotland the consensus around the drug strategy has been maintained by the lack of specificity about exactly how it was to be achieved. It was also suggested that it could allow flexibility for local variation in implementation in response to different contexts, as well as responsiveness to changes in the drug problem.

Other positive aspects of **consensus and cross-party support** for the overall goal and vision highlighted by interviewees included the way this protects the strategy from regular shifts associated with changes in government, allowing the necessary time for policies to take effect. For example one current MP remarked:

> *"…we're dealing with an issue that isn't going to be solved in a programme of government, and by its very nature has deep roots and takes time to see huge changes. So you've got to build a consensus beyond your normal party walls..." [Pol-4].*

It was also suggested that such consensus could make policies more resilient to pressures for knee-jerk responses to perceived threats, such as the intensive coverage of apparent mephedrone deaths that were later found to be due to other substances.

However, achieving such agreement requires active leadership, as occurred in Scotland for the development of the *Road to Recovery* strategy, and the difficulties of getting and maintaining cross-party support or depoliticising the issues should not be underestimated. As a former Home Secretary highlighted:

> *"… getting political partisanship out of this is* [very] *difficult … because politics is such a vicious activity that people really, really, really do want to make whatever advantage they can out of areas of government. And getting to a state of affairs where you don't have that adversarial approach is very difficult. It is an argument against our system in my view. But you can only do it by the party leaders saying these areas we are putting to one side." [Pol-3]*

In Scotland, the consensus has been challenged recently with a newspaper-led campaign about the prescribing of methadone. This in turn has led to a political challenge to current policy, which has put the consensus on drug policy under strain. What many experts in Scotland and elsewhere worry about is that drug policy becomes a political football and a hard-won consensus breaks down. However, the governance structures established in their strategy are being used to address and defuse the issue, with the Chief Medical Officer alongside the independent Drug Strategy Delivery Commission (DSDC) investigating the matter.

In some circumstances, though, consensus may act as a brake on change in a way that perpetuates ineffective policies. It was suggested that this is the case in the UK, where many participants in our research felt that a consensus exists around a view that it is politically essential to 'be tough' no matter the effect.

This highlights the way in which the chosen goals may constrain the policy options that are given consideration for addressing the problem. As one former permanent secretary remarked in relation to the consensus on the need to 'be tough':

> *"… there wasn't much room for discussions about alternative approaches to tackling the problem. The solution was almost always to crack down. The headlines were we're going to toughen up the policy. … It was the prevailing paradigm and the accepted view and it was what prime ministers expected of home secretaries and, in the political debate therefore within government, there wasn't much room for a debate about alternatives." [CS-3].*

It also raises the issue of the role of different drivers, including politics, moral viewpoints and evidence, in setting the goals. While most interviewees were clear that it was inevitable, and indeed essential, that values and politics would be important in the goal-setting process, since it is *"the process upon which we decide what kind of society we want to live in",* they were also clear that there was an important role for evidence in the consideration of *"what is it that might be appropriate goals"* [CS-4], that is what might be realistic goals.

One of the factors which has undermined confidence in much of drug policy has been the widely expressed aim to 'eradicate' illegal drugs, most notably captured in the United Nation's 1998 goal of 'achieving a drug free world by 2008'. To avoid this sort of situation arising, it was felt that goal-setting needs to include in-depth consideration of whether or not a policy goal is achievable and with specific objectives that are specific, measurable, achievable, realistic and targeted. Our expert process suggested that goals needed to be **realistic but aspirational**. Thus there is a need for evidence in relation to understanding the problems, their causes, and potential responses, but there remains a role for values in setting the aspirational element of the goals.

It was noted by many participants that the drugs field is **a particularly polarised and contested area**. For example, one former Home Secretary remarked that: *"It carries slightly more baggage than most of the big issues you can do."* [Pol-1]. It was suggested that this deters real discussion of objectives and alternative policy approaches, which is having a negative impact on policy development. As one parliamentarian described: "*… my view is drug policy is in a debate-free zone in which there's almost a fear, and it's come back with a vengeance, to debate views that are in any way at loggerheads with the prevailing view led by the press, fuelled by ministerial dictat. I mean this is a non- party political point, you know, either way." [Pol-8]* A senior civil servant remarked: *"…I've never, in my policymaking years in Whitehall, had what I would call a proper policy discussion in this area." [CS-12].*

Suggesting an alternative approach might be tried tends to trigger defensive reactions and leads to people being labelled as extremists and to policy being largely 'stuck'. The Government's immediate rejection of the recent Home Affairs Committee report on drug policy[10] and the suggestion that there should be examination of the likely impact of removing criminal penalties for some personal possession offences illustrates how difficult it is to have a proper discussion about drug policy.

It was also suggested that this **lack of debate** extends to a failure to consider where goals of drug policy may be affected by or contradict goals of other policy areas or overarching objectives of a government, eg greater localism or reduced public spending. There was therefore a need for more consideration and articulation of trade-offs.

POLICY DESIGN

Once the goals of policy are agreed the next stage is to consider what should be done to address them. Research indicates the importance of policies having **clear logic models** underpinning them that are **based on evidence**. This will involve reviewing what is known about the causes of the problem, what interventions have been shown to work to deal with these, both in this country and others, but also what we know about such things as behaviour change in other areas, to allow innovation even where there is limited evidence.[11] As one former Permanent Secretary said

[10] House of Commons Home Affairs Committee, 'Drugs: Breaking the Cycle', Ninth Report of Session 2012-13, HC 184-1, December 2012.

[11] As suggested in the 2010 discussion paper from the Behavioural Insights Team at the Cabinet Office *Applying behavioural insight to health*.

to us, *"… if you haven't got a sort of … framework for thinking what's going to influence behaviour, you're in trouble" [CS-6].*

To maximise effectiveness and value for money, it is also important that there is **consideration of a wide range of options** and that account is taken of potential unintended consequences. This is made more challenging in the drug policy field because there is very limited evidence about the effectiveness of many interventions in some areas, such as enforcement and prevention.[12]

The government's official advisory body, the Advisory Council on the Misuse of Drugs (ACMD), has undertaken much valued work since it was set up in 1971. The ACMD brings together both scientists and experts by profession and experience to carry out two core functions: one is advising Ministers about the harms of particular substances and hence whether and how they should be controlled. Crucially, from the ACMD's outset, this advice was used to inform those handing down sentences about the level of punishment to be applied to those who broke the law. The other core function of the ACMD, also enshrined in legislation, is that of providing advice about how the social harms of drugs can be addressed. This has led the ACMD over the years to provide policy advice about educational, preventive, treatment and criminal justice measures aimed at reducing those harms. Many of their proposals have found their way into drug policy and practice.[13] However, the ACMD operates within a very limited budget; as one ACMD member said: *"… we are working at a disadvantage … a rather modest project … could help us categorise, classify some of these new drugs … But we have no budget at all. … But in general we don't have the ability to commission research and I think that's a weakness." [Res-1].* This, alongside the need to respond to government requests for harm assessments for the increasing number of new psychoactive substances, appears to be increasingly constraining its contribution to wider policy issues.

Many of the participants in our research raised concerns about the evidence and policy options analysis stage in the drug policymaking process more generally. While not all assessments were as bleak as that of one interviewee who remarked: *"Policy design that balances evidence? No. Generates clear logic models? No. Incorporates clear mechanisms for evaluation and feedback? No"* [CS-9], a very wide range of concerns about policy design processes were raised.

Firstly, some options appear to be 'off-limits' regardless of the strength of the evidence that they work, for example drug consumption rooms. Secondly, it was suggested that, particularly at the UK level, there was an increasing tendency for only one option to be considered and that this was perceived to be the one that the minister wanted: *"…people weren't putting forward the full range of options because for one reason or another they thought that some of them were not acceptable to ministers."* [CS-5]. The reasons suggested for this were that in the current climate civil servants are worried about their job security:

---

[12] National Audit Office (2010) *Tackling Problem Drug Use.* London: The Stationery Office

[13] UKDPC (2009) *Submission to Sir David Omand's Review of the Advisory Council on the Misuse of Drugs (ACMD).* London: UK Drug Policy Commission.

> *"… the new government coming in and saying, actually, we're starting from the premise that you've got to prove yourselves, you know. Civil servants aren't always the font of all knowledge. We'll go elsewhere. You're just one option. So civil servants felt very threatened…" [CS-5].*

In drug policy as in other policy areas, the rapid turnover of civil servants, the loss of 'institutional memory',[14] the focus on developing generalists alongside the greater movement between the private and public sector may also contribute to this state of affairs, since as a result policy-makers tend to have less topic knowledge and a greater investment in pleasing ministers than the long-term policy outcome, which they are less likely to be in post to see. This has been described as a sort of 'group-think' whereby civil servants anticipate ministers' preferences, who in turn anticipate No 10 preferences, which in turn anticipate likely press responses.

In addition it was suggested that having leadership of drug policy within the Home Office may skew the types of options considered. The end result has been a narrowing of policy options combined with an acceptance that 'this is the way it is'. One former senior civil servant describing the process said:

> *"We get ill thought through policies because ministers like things that will present well. The ministerial judgment, the political adviser judgment will be, what will the media think about this? It will also be, what do they think voters think about this, because bearing in mind, politicians are … constantly surveying and hearing what people think, and we've got politics where all parties seek to please their voters and they pay much more attention to their voters than was possible in the 1950s or '60s when those techniques didn't exist. So Harold Macmillan probably did what he thought was right, … and he may have got lots of things wrong, but he didn't rely heavily on polling evidence, whereas now we've governments much more tied into a PR system. David Cameron does know exactly what floating voters are thinking at the moment, and he's trying to tailor policies to affect their view of it. … They then moan like mad when it doesn't deliver the results." [CS-8].*

It was also suggested that there is very rarely any in-depth consideration of the mechanisms or processes through which it is hypothesised that the policy will work, nor of any potential unintended consequences or trade-offs that may be required. For example, one permanent secretary remarked: "*… in my experience people in Whitehall jump too readily from situational awareness to prediction, and they don't spend enough time really testing the hypothesis or set of hypotheses and assumptions on which their modelling is based.*" [CS-10]

There are governance processes, such as impact assessments, that are supposed to ensure this happens, but drug policy impact assessments were viewed very negatively by respondents in this research, being described by one as "*…pathetic, our impact assessment system is broken and needs to be completely reformed."[CS-13]*. UK drug policy is very high level and provides no logic framework to support the options chosen and very little discussion of the evidence to support them. The Scottish, Welsh and Northern Ireland strategies are better in this respect as discussed

[14] Scottish Drugs Strategy Delivery Commission, (2011) *First Year Report & Recommendations to the Minister*.

in more detail below, and the Scottish Government also commissioned a review of the evidence to underpin the *Road to Recovery.*[15] Another area of concern in the drug policy field is where new policy is developed rapidly in reaction to a particular event, in which case the proper policy processes are often not followed.

Linked to this is the role of 'interest groups' and lobbying in influencing policy decisions. A number of interviewees questioned how these influenced decision-making in the drugs field. There are formal processes of consultation that should allow all interested parties to comment on policy proposals but, as Roberts in his essay for this review points out,[16] it is not at all clear how the different opinions are assessed and weighed up and what impact these have. Since drug policy is an area in which evidence is highly contested and opinion polarised this is an important issue. The new consultation processes currently being proposed do nothing to address this issue and by allowing more flexibility in when and how consultations are conducted may only worsen the situation.[17]

In her analysis for this review, Rutter highlights the opportunity that opposition can bring for taking a fresh approach to policy issues,[18] and the shaping of drug policy prior to elections has been a particular feature in the UK over the past 15 years. In the 1997 General Election, the Labour Party committed itself to creating the post of national 'Drug Czar' and to prioritising the reduction of crime by getting offenders who committed drug-related crime into treatment. In 2005, in the final Parliamentary 'wash-up' arrangements before that year's general election, the Drugs Act was hurried through. In 2007, the Centre for Social Justice (CSJ), a think-tank with direct connections to the Conservative leadership, published *'Breakthrough Britain'*, which put forward strong criticism of the then Government's drug policies. After the change of government, implementation of the CSJ proposals was assured with the location and transfer of key people involved in the original work into senior and advisory positions within government.

2.2 Policy implementation

However good the strategy or policy is, its effectiveness is dependent on the way in which it is implemented, and governance processes and structures play an important role in this.

Our research highlighted the potential for a damaging mismatch between what is done day to day and the goals of the strategy. It was noted that even if there is a change in strategic direction, if the same people are delivering it, then there may not be any real change on the ground. As one parliamentarian suggested:

---

[15] Best, D. et al (2010) *Research for Recovery: A review of the Drugs Evidence Base*. Edinburgh: Scottish Government

[16] Roberts M. (2012) "Consultation processes and good governance: from 'unproductive process' to 'real engagement'" in *Essays on the governance of drug policy.* pp60-83. London: UK Drug Policy Commission.

[17] Cabinet Office (2012) *Consultation Principles*. Available at: http://www.cabinetoffice.gov.uk/resource-library/consultation-principles-guidance [accessed 19/12/12]

[18] Rutter, J. (2012) *Lessons on policy governance: what drug policy can learn from other policy areas*. London: UKDPC

> *"You could get a minister that thinks well that's that box ticked now let me get on with other more pressing things. Meantime you might find that further down the chain, out in the country where different organisations are supposed to be delivering the strategy that there are some fairly entrenched views and just decide they will go on doing what they do anyway." [Pol-2]*

A number of our interviewees suggested **a continuous leadership drive is needed to push the strategy through** but that there is also a need to allow time for changes to get bedded in. That is a tendency in drug policy for what one interviewee described as *"initiative-itis"*, so that programmes never get properly established. The challenge, then, is to strike a balance and provide stability and continuity without this turning into inertia.

Drug strategies vary in the level of detail they provide on how the strategy is to be implemented. The shift away from a very strongly driven top-down approach within the new 2010 UK Strategy was generally welcomed. It was seen as **an opportunity for policy to be adapted to meet differing local needs and also for innovation** and 'natural experiments' that could enhance understanding of what can work to tackle drug problems.

However, some people saw a 'dangerous vagueness' with respect to implementation within the new UK strategy and were concerned about the potential for the development of a postcode lottery and a shift away from evidence-based practice that could be harmful. It was also suggested that it can be difficult on the ground to balance the harms to the individual drug user against the harms to the wider community in choosing between policy interventions and that this dilemma is never explicitly addressed. This is a particularly stark issue given the stigma associated with drug users.

To address some of these potential downsides without resorting to directive target setting it was suggested that there might be **a need for the specification of minimum standards** to provide a backstop to local flexibility. Alternatively it was suggested that a model such as that in Wales, where Public Health Wales has a pro-active strategy to ensure evidence is translated into practice, might be adopted. It was noted that the smaller size of Wales, Scotland and Northern Ireland makes such oversight easier. In England, the recent spate of public service reorganisations and reconfigurations have yet to be worked through, and it is not yet clear how the differing responsibilities of the National Institute for Health and Clinical Excellence (NICE), Public Health England, the Care Quality Commission and, at the local level, Healthwatch, Health and Wellbeing Boards and Police and Crime Commissioners will address use of evidence and standard-setting.

The shift to **localism requires a different role for central government**, which was seen to involve oversight, leadership of change, and keeping enough 'discomfort' in the system to encourage progress. It was pointed out that this requires an adaptive leadership approach. Also, the wide-ranging and cross-cutting nature of drug policy makes it essential that leadership is proactive and collaborative in nature. The importance of committed leadership at a high level in order to deliver resources was a recurring theme; contributors cited the way in which Tony Blair's interest in drugs as a cause of crime unlocked additional resources as an example. With greater localism more decisions will be made at the local level and it is not clear yet what the impact for

leadership of drug policy will be in the long term. The importance of some continued national oversight, however, was highlighted:

> *"… there's a risk if you give it away that people don't deliver. And so I think central Government has to … have some levers on something like drug policy because if this goes wrong the outcomes for all of us are catastrophic. People will die, crime might increase. If they get this wrong these are lives that are at stake here. So, you can't just wash your hands of it. And I think there's a risk of localism that it's just, right, that's your problem, job done. And you lose the leadership and the outcomes and the vision. So, there is a tension there." [CS-4]*

The importance of resources for effective policy implementation came up throughout our review. It was pointed out that it is of course easier to do something radical and bring people along and ensure action if there is additional money provided, as was the case when the 2002 updated drug strategy was implemented. However, it was also pointed out that if you throw too much money at a problem it is not possible to spend it all efficiently and it gets wasted. Money tightening was felt by some to be an incentive for efficiency and, as one civil servant put it, an *"…opportunity to do things in a different way."* [CS-11], but it also makes it harder to move money around. Decisions about what to invest in should utilise evidence concerning the value for money of different interventions. Benchmarking may provide a useful approach.

Drug policy interventions involve health, enforcement, justice, education, welfare and communities so there is a need for co-ordination between many different departments and bodies at the national, regional and local levels and partnerships are important. With increasing devolution there is an increasing requirement for vertical as well as horizontal co-ordination. Several barriers and facilitators to effective collaboration for policy implementation were highlighted in our research.

There is much literature and research about the challenges of collaborative and partnership working in public services. In our research, at both the national and local level, different **departmental cultures** were seen as often creating barriers to collaboration and leading to tensions. The police are an experience-based profession who are seen as very action-oriented and 'can do', while health professionals tend towards a more scientific and evidence-focused approach - a difference exacerbated by the varying quality of the evidence underpinning interventions in their different areas. As one senior civil servant indicated with respect to the current drug strategy:

> *"… at the moment it's still largely each department… Health seeing themselves as we're recovery, Education seeing themselves as well we're prevention and [Home Office are] the nasty boys who do the supply stuff, rather than necessarily a completely shared sense of mission which is something we want to try and get onto." [CS-7]*

Differing priorities and vested interests or territorial concerns may also hamper co-operation and integration at all levels. This may be a particular issue in the current climate of uncertainty created by the structural reorganisations coupled with austerity. On the other hand, financial

austerity may also instigate more joint-working, to increase efficiency.[19]

Throughout the UK, at the local level, formal partnerships have been established to help co-ordinate action to address drug and alcohol issues and promote joint-working. At the national level there are also **formal structures to facilitate co-operation** among different departments (Table 1 above provides an overview of these). In the UK there has been a long standing tradition of having ministerial committees and sub-committees to coordinate and oversee the implementation of drug strategies, sometimes with a direct line into Cabinet committees, most usually Home Affairs. The current government has an Inter-Ministerial Group, which some interviewees suggested had improved buy-in to the strategy from some departments, although there is concern that some departments continue to give lower priority to the issue. Education was mentioned by some as an example of this.[20]

Another range of issues relate to the people involved in developing and implementing policy. The **importance of individuals and their personal qualities**, for example *"… upbringing, personal experiences, where politicians come from, what they've done in life…" [CS-5]*, both as facilitators and barriers to co-ordination and policy innovation, were mentioned by many participants. Linked to this is the fact that it takes time to build up relationships, so the current frequency of change in personnel in government departments and among ministers at the UK level, and the amount of change at the local level in England, was felt to be having a detrimental impact. Four junior Home Office drugs ministers in three years since 2010, coupled with four changes in the civil servant in charge of drug strategy at the Home Office in as many years, is perhaps not the most effective way to inspire leadership and commitment. **'Institutional memory'** and learning is undermined and policy caution becomes apparent. Those working in Scotland, Wales and Northern Ireland all mentioned that because of their comparatively small size they tended to *"know everyone"* working in the area, which made it easier to work together. This might seem an uncomfortable informal proposal for making policy better, but it appears to be quite central to a multi-agency issue.

Another aspect of effective collaborative working that came up in our research was the **sharing of good practice and broader knowledge transfer**. A number of participants expressed concern about this in the current shift to localism, since there did not seem to be any clear mechanism for taking advantage of the lessons that might be gathered from the natural experiments mentioned above.

---

[19] UKDPC (2012) *Charting New Waters: Delivering drug policy at a time of radical reform and financial austerity.* London: UK Drug Policy Commission.

[20] This is supported by responses to written parliamentary questions which reported that ministers from the Department for Education had attended only four out of at least 15 IMG meetings since May 2010. See: http://www.theyworkforyou.com/wrans/?id=2012-11-28a.128375.h&s=%28drug+OR+substance+OR+heroin+OR+cocaine+OR+%22legal+high%22%29#g128375.r0 and http://www.theyworkforyou.com/wrans/?id=2012-07-09b.114622.h [accessed: 14/12/12]

2.3 Policy review and evaluation

The final stage of the policy process should be review and evaluation, followed by feedback into policy development or amendment. This does not just improve policy outcomes and build the evidence base about what works, it also provides people with the evidence they need to hold to account those responsible for a policy. Its importance is acknowledged in a wide range of guidance for policy-makers, which also stress the importance of this being built in from the start if it is to be effective.[21] However, the Institute for Government report *Policy Making in the Real World*[22] found that it was the area in which ministers and civil servants felt policymaking was weakest. This was echoed by the participants in our research with respect to the UK drug policy field, in relation to the evaluation of individual interventions and programmes and of the drug strategy as a whole. For example:

> "*…* [the reluctance to evaluate and learn lessons] *is part and parcel of being in the 'too difficult box', isn't it? … you're not doing evidence-based policy-making and therefore you're not following up to see whether the evidence you were using has been good enough to inform the right policy decisions. Or it's not been implemented right or the policy wasn't thought through right, because the classic policy-making cycle is that you must be reviewing impact of policy."* *[CS-12]*

> *"One of the … challenges is that there have been many interventions at local level where there has been no formal assessment of effectiveness and assessing the effectiveness of interventions can be quite taxing, it is a big challenge." [Res-8]*

Our research highlighted some important distinctions within the broad heading of review and evaluation. It encompasses:

- on-going monitoring of processes, outputs and outcomes to provide information about what is happening on the ground to facilitate management of implementation;
- overall evaluation of the strategy, which might use similar information alongside additional data to draw conclusions about the overall effectiveness and value for money of the strategy as implemented; and
- evaluation of particular interventions or programmes within a strategy, which might be of different types, including feasibility studies, natural experiments to randomised controlled trials, depending on circumstances or the stage of development of the programme.

All these **types of evaluation and review** need to be incorporated within a drug strategy and it is also necessary to think about how decision-making will be affected by such reviews. Many research participants felt this was an area that was a weakness of governance, particularly when

---

[21] For example: HM Treasury (2011) *The Magenta Book: Guidance for Evaluation.* p25; Jowell, R. (2003) *Trying it out: the role of 'pilots' in policy-making.* London: Cabinet Office; Haynes, L., Service, O., Goldacre, B. and Torgerson, D. (2012) *Test, Learn, Adapt: Developing Public Policy with Randomised Controlled Trials.* London: Cabinet Office

[22] Hallsworth, M., Parker, S. & Rutter, J. (2011) *Policy Making in the Real World*. London: Institute for Government.

it comes to stopping things that have been shown to be ineffective. Negative findings tend to be viewed as an admission of failure, rather than important lessons. As one former senior civil servant commented:

> *"…the criminal justice system's getting itself involved in areas where it's just not very effective. It's too slow to be responsive. And it's going into volume processing of people. It's just bloody terrible at that. And it produces stupid outcomes as well where it's tying people into a system, we know labelling is a problem, it's not just some wishy washy liberal theory, there's good hard quantitative evidence to support the problem that labelling causes. And we've known that for 30 years so why we haven't done anything about it is beyond me …" [CS-9]*

Another common criticism of drug policy is that innovative interventions are prematurely rolled-out before their impact has been evaluated, as is currently occurring with the various Payment-by-Results schemes.

Several participants in our research expressed concern that there has not been any formal evaluation of the effectiveness of the UK drug strategy for the last 10 years. This view was echoed by the Public Accounts Committee following its review based on a National Audit Office investigation that sought to look at the value for money of the different elements of UK drug policy. The NAO review struggled with the absence of evidence of effectiveness of many areas of the strategy, in particular around the impact of enforcement and some prevention interventions.[23] The PAC concluded that:

> *"Given the public money spent on the strategy and the cost to society, we find it unacceptable that the Department has not carried out sufficient evaluation of the programme of measures in the strategy and does not know if the strategy is directly reducing the overall cost of drug-related crimes. Following a recommendation made by the National Audit Office, the Department has agreed to produce an overall framework to evaluate and report on the value for money achieved from the strategy, with initial results from late 2011."*[24]

The most recent strategy[25] included a commitment to *"continue to develop and publish the evidence base on what works"* and indicated it was *"developing an evaluation framework to assess the effectiveness and value for money of the Drug Strategy"*. However, two years into the strategy neither have materialised. The strategy also contained a pledge to review the strategy annually and a one-year review was published in May 2012[26] but it contained largely descriptive information on the types of action that had been undertaken or were planned. This is perhaps not surprising given the early stage of implementation, more concerning was the complete absence of any critical review of what had been achieved combined with a lack of any indication of what

---

[23] National Audit Office (2010) *Tackling Problem Drug Use.* London: The Stationery Office.

[24] House of Commons Committee of Public Accounts (2010) *Tackling problem drug use. Thirtieth report of session 2009-10.* p.3 London: The Stationery Office.

[25] HM Government (2010) Drug Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug free life. London: Home Office.

[26] HM Government (2012) *Drug Strategy 2010. Annual Review – May 2012*. London: Home Office

outcomes were expected and how these would be identified.

The devolved governments have given more consideration to evaluation and review in their strategies. For example, the New Strategic Direction on Alcohol and Drugs in Northern Ireland[27] includes a separate pillar of monitoring, evaluation and research. Also when the first phase (2006-2011) neared an end there was a review,[28] which used a logic model approach and considered process and outcome measures along with a wide-ranging consultation which informed the development of the second phase. In Wales, the Health Care Inspectorate is doing a series of thematic reviews, the Substance Misuse Review Programme, and an independent evaluation is underway. It was suggested that where departments of health have lead responsibility for a strategy it might be easier to embed evaluation as they are more geared to an evidence-based approach and have stronger cultural ties to science and research.

Several of those involved in our research stressed **the importance of independent review**: *"if you know there is a problem with achieving the objectives then I think it is important to understand why that is and that an independent evaluation might play a particularly important role in that case." [Res-8].* Some suggested that an independent expert body outside parliament to critically review the strategy and its impact, and free to speak out, is crucial. However, it was felt that this would need to be advisory, rather than decision-making, and an adjunct to parliamentary scrutiny, to avoid undermining democratic accountability. It is interesting that the ACMD has, to our knowledge, not been asked to perform this function. In contrast, Scotland has set up an independent Drug Strategy Delivery Commission to review and advise on the implementation of their strategy.[29] As shown in Table 1 above, other advisory committees or steering committees also play a role in reviewing policy.

Parliamentary committees are an important review mechanism for the UK drug strategy. As MacGregor[30] points out, the changes made to the Select Committee system in recent years has resulted in them becoming more influential. However, with respect to drug policy there are a number of issues that may hamper their operations and impact. Firstly, the cross-cutting nature of drug policy means the number of committees who might take an interest is large, including for example: Home Affairs, Science and Technology, Public Accounts, Social Services, Public Admininstration, International Development, Justice, Transport and Health, which may diffuse their impact. Secondly, having the drug strategy led by the Home Office means that the House of Commons Home Affairs Committee most often considers drug policy and its focus tends to be on legal issues and enforcement and less on health issues. It is also not clear that there are effective mechanisms for following up to see if their recommendations are acted upon, although this might be expected to be the role of the Chair but the extent to which it will happen will depend on the

[27] DHSSPSNI (2006) New Strategic Direction for Alcohol and Drugs (2006-2011).
DHSSPNI (2012) New Strategic Direction for Alcohol and Drugs Phase 2 (2012-2016).

[28] DHSSPSNI (2010) New Strategic Direction for Alcohol and Drugs (2006-2011) NSD Update. April 2010.

[29] Its first annual report was published in October 2011: *Scottish Drugs Strategy Delivery Commission - First Year Report & Recommendations to Minister*. Available at: http://www.scotland.gov.uk/Publications/2011/10/10142851/13 [accessed 14/12/12.

[30] MacGregor, S (2012) "Parliamentary Committees and Drug Policy Governance" in *Essays of the governance of drug policy.* pp5-32. London: UK Drug Policy Commission.

individual concerned and competing demands. Different ways of dealing with these issues were suggested in our research, including joint select committee enquiries or the Public Administration Select Committee having responsibility for looking at cross-government strategies.

In the current context of financial austerity **evaluation and review are important tools to reduce the risk that scarce resources are wasted** on activities that are ineffective or which do not offer taxpayers value for money. The shift to localism raises considerable new challenges for drug policy, with commissioning of different drug-related interventions devolved to a range of organisations at different levels. There will be a need to give flexibility to meet local needs while still holding areas to account for outcomes. The development of an early warning system to highlight emerging problems or unintended consequences at an early stage will be important, but challenging. It will require consistent data collection over time and between organisations, quickly enough to provide feedback for management and sufficiently related to outcome for performance monitoring and evaluation. But equally there is a need to avoid overburdening those delivering programmes with bureaucracy. It is also not yet clear how effective scrutiny will be at the local level as the mechanisms are still being set up. A mechanism is needed for review and for engaging the public, including those who use drugs, in a conversation about what is being done.

2.4 Cross-cutting concerns in relation to the use of evidence

Our research highlighted knowledge development, which covers the building and use of the evidence base in policy design, implementation and review, as a key problem area for drug policy. The UK Drug Policy Commission was itself established with charitable funding specifically to address a perceived deficiency in the use of evidence and analysis in the drug policy process, and the issues raised about knowledge development here echo our experiences in reviewing evidence across many aspects of drug policy.

When talking about evidence-based or evidence-informed policymaking there is a tendency for people to assume this means evidence of 'what works' and for some people an emphasis on randomised controlled trials (RCTs). However, in the ideal policymaking world uses of evidence will go far beyond this narrow perspective and should be an essential tool for:

- describing the problem or issue, eg who is affected and in what ways;
- understanding the problem, eg its causes and manifestations;
- identifying possible solutions: using information from this country and elsewhere, using evidence of interventions that have been tried before but also knowledge about things like behaviour change which might underpin new interventions;
- checking if a possible solution is effective, which can involve a range of issues, eg:
  - whether the objectives were achieved?
  - is it providing value for money?
  - does it work for everyone?
  - is it better than alternatives?
  - can it be done better?
  - is it having unanticipated or broader effects?

The multifaceted and multidisciplinary nature of the evidence for different aspects of drug policy means that the evidence base can be complex and hard to access. It is also often equivocal and takes time to obtain, given the often chronic and long-term nature of drug problems.

It is also important to acknowledge that evidence is not static or set in stone. As we learn more or develop more sophisticated methods, our understanding of the evidence may change. Having established the current state of knowledge in a particular area, regular reviews are essential.

The need to balance values and evidence in policy has led to a shift from talking about evidence-based policy to one of evidence-informed policy. However, both these terms imply reference to a fixed evidence-base early in the policy development process. However, our research indicates a need to recognise the importance of evidence as a valuable tool throughout the policy process and the benefits of adopting a scientific approach that incorporates review and learning into the process; which might be described as evidence-imbued policy.

Our research also highlighted a number of challenges to better use of evidence in drug policy, some of which have been touched on earlier:

1. There is polarisation and contested interpretations of the evidence regarding both the problems and the solutions:

   "… there's no shortage of alleged experts in this field and they all disagree with each other … and they all believe whatever they're doing is working. So that's one constraint that is the lack of a one true path." [Pol-7]

2. There is disagreement over what counts as evidence. There are many different types of evidence and uses of evidence. Personal experience and what politicians see in their constituencies has a powerful influence and quality research often struggles against the 'killer anecdote'.

   "… we often think about scientific evidence or research evidence but … in policy process, what we call research evidence is only one of the forms of the information or evidence the policymakers consider. [Res-9]

3. People's backgrounds and expertise influences their attitude to evidence. For example, it was suggested that ministers who have a background in the sciences may be more reluctant to overrule scientific advice than those who do not. The high turn-over of both civil servants and ministers, was also felt to have an impact, as it is difficult for them to master the range of evidence needed and appreciate the limitations of certain kinds of studies and information sources.

4. The difference in expectations between policymakers and the research community was highlighted by many interviewees. It was suggested that there was a disconnection and in some cases a lack of mutual understanding and even respect between policymakers, politicians, civil servants and researchers.

   "…when you talk to people in the academic world about this they are massively frustrated about the failure to influence the way government thinks about their area of

work. By the same token many, many politicians are very frustrated by the academic world. … what the politicians are looking for is some sense of ***certainty*** *and the academics, quite rightly of course, can't offer that …" [Pol-3]*

"It's information but it's pointless. It does not tell me anything I can do something with. It's very interesting but it isn't important. … Evidence has to be ***action orientated*** *or otherwise it's just interesting." [CS-4]]*

Differing **time frames** were also seen as an important problem for integrating research into policy. While to undertake good quality research into, for example, the early childhood determinants of drug problems or the outcomes of interventions, inevitably takes many years. However, a government may only be in office for one term so they want much quicker answers.

"The problem was that the research is all long term. … it's very difficult for policymakers. They have to be very lucky to find there is actually evidence that can … be applied to the construction of their policies. It's normally … give us money and in three or four years' time we'll have conducted this longitudinal study and we may … have some evidence to give you. [CS-10]

5. In the area of drug policy the evidence is uncoordinated, fragmented and patchy. Its cross-cutting nature involves many different disciplines, including epidemiology, medicine, neuroscience, criminology, and sociology. These use very different methodologies.

"The first is you're on the cusp of … health policy and crime policy (drugs) and … that's what makes it difficult, … because you're bringing two completely different sort of frameworks of what is evidence … to bear " [CS-6]

The development of evidence was also perceived as being uncoordinated and seriously limited, particularly in enforcement and parts of social policy. Even with recent investment by the Medical and Economic and Social Research Councils, it is still seen as an area which is seriously under-resourced. The same significant evidence gaps are repeatedly identified in reviews.

"It wasn't co-ordinated across Whitehall. As far as I could see it wasn't at all." [CS-2]

3. Options for improving the policymaking process

A number of cross-cutting themes emerged from the review of how the current drug policy process is working. On the positive side there are a number of factors that facilitate effective policymaking: there continues to be a national drug strategy; the function of the ACMD is enshrined in statute; resources for drug treatment have been protected to a degree; and there is coordination through a reasonably well functioning ministerial committee. But on the downside, deficits have been identified in: leadership, organisational structures and processes; knowledge development and application; accountability; and stakeholder engagement. This section considers the key issues within these themes and the improvements that might address them.

3.1 Leadership

KEY POINTS:

- There is a need for the development of a calm, 'neutral' space for open discussion of the objectives and options for drug policy. There are examples of one-off commissions or groups that have successfully moved policy on in other contested areas.
- In areas that have become politically charged and evidence is central to decisions it can be helpful to 'technocratise' or delegate certain aspects of decision-making to an independent body.
- Where political leadership lies can have an impact on the policy adopted and how it is implemented. To give new impetus to drug policy to help it address new challenges it may be timely to consider whether the current model is the most appropriate.

DEVELOPMENT OF A 'SAFE' SPACE

The need for pro-active political leadership to create cross-party support for the goals of drug policy has been identified, as have the difficulties of achieving this. It was generally felt by participants that the devolved governments were better positioned to do this because they were designed to deliver a more co-operative style of government. The adversarial style of the UK government, on the other hand, was felt to promote 'politicisation' of the issue, particularly a 'bidding up' of tough sounding rhetoric about drug use. Our research participants said that at present drug policy is viewed as a low priority and a 'toxic' issue which is best avoided.

While there is widespread recognition that drug policy needs a considered, less politicised approach, the political concern about potential voter and media backlash appears to be never far from the surface. When events create media storms, the temptation to engage in reactive policymaking can be hard to resist. But it is interesting to note that over the past two years, the number of ex-international leaders and public servants becoming more visible and vocal about the

shortcomings of current drug policy is growing, globally, in Europe and in the UK.

To overcome reactive policymaking and to neutralise the contested nature of the drug policy debate in the country as a whole it was suggested that the policy process should create a calm space in which a sensible debate could be held about the goals of drug policy and what policy options might be most effective. This might be through a time-limited initiative such as a commission or inquiry. Longer term stability and protection against reactive policymaking, might be achieved through an expert body with powers to decide on certain aspects of policy.

A number of options were suggested within our research that might meet this need. Drawing on lessons from other policy areas Rutter[31] cites the Turner Commission on Pensions as a good example of *"… an evidence-based policy process which helped reframe the debate and then develop a widely agreed way forward that political parties all supported."* (p10). Other possible models that she highlights are: the Stern review on climate change economics; the Australian Productivity Commission; the Royal Commission on Environmental Pollution and the Educational Endowment Foundation. Although making it clear that external processes are not a panacea, Rutter highlights a number of their advantages. These include having a dedicated and focused team without other policy distractions, the ability to bring a fresh perspective and multidisciplinary expertise, and insulation from the demands of politics, government and departmental interests. They can also bring continuity, which in light of the high turnover of both ministers and civil servants in the drugs area, could be important. However, for these to be realised, she points out, requires commitment of time and money, as well as independence from government.

DEPOLITICISATION AND DELEGATED DECISION MAKING

Several participants in our research, including both Conservative and Labour former ministers, favoured an approach of this sort for drug policy, usually suggesting a high-level cross-party forum to raise the issue *"above the party political fray"* [Pol-9]. It might possibly be set up to report after the next election but with all parties committed to the outcome, thus preventing it from becoming a politically-charged issue. The importance of the members of such a forum being credible and commanding respect was also stressed. It was suggested that this approach could provide politicians with a neutral space for the consideration of alternative approaches. This would also be in tune with the current coalition government's desire for open policymaking.[32] However, a few participants emphasised the need for good leadership rather than new structures. As one former minister remarked *"I don't think you need another inquiry I think you need political will."* [Pol-7] The challenge is, how can that political will, and interest, be stimulated?

If consideration of policy alternatives is required, as many but not all our contributors suggested, but political leaders are reluctant to make a policy area a priority, there are examples of leadership from outside government which might be of relevance to the drug policy field. In her report, Rutter gives the examples of: the smoking ban, in which leadership from Ireland and the devolved administrations, the Chief Medical Officer, the Health Select Committee, and ASH and

[31] Rutter, J (2012) *Lessons on policy governance: what drug policy can learn from other policy areas.* London: UKDPC

[32] HM Government (2012) *The Civil Service Reform Plan.* pp14-16

others managed to push the government further than they wanted to go; and the climate change bill, in which *"… a series of opportunistic events"*, including pressure from a campaign group and the leader of the opposition, created conditions where "unplanned" leadership emerged which changed the policy dynamic allowing a new approach to be adopted.[33]

The idea of delegating some areas of policy decision-making to an independent body, in a similar way to NICE assessments of medicines or interest rate setting by the Bank of England Monetary Policy Committee, elicited a mixed reaction from participants. There were concerns about how it would be held to account. It was also felt that while there might be some areas of drug policy where this might be appropriate these were quite limited. As one respondent opined:

> *"… wouldn't it be nice if we had something … that was set apart from… I don't think it should be the ACMD, but set apart from Government, a statutory body whose advice on harmfulness of drugs would be that's it. It's like the Monetary Committee in the Bank of England says the interest rates are going to be 1.5%, that's it. Nobody can argue with it. And it takes away from the politicians the backlash in the Daily Mail, etc…." [Res-1]*

However, on the whole people felt that it was right that advisers advise and governments decide, for example one advisory body member said: *"I think in the case of drugs policy, I think it is so politically charged that at the end of the day it is right that the government of the day has the final say."* [Res-6]. It was also pointed out that the focus of debate might end up switching to the membership of such an organisation. However, as a former permanent secretary remarked *"… who would have thought you could have handed the setting of the interest rates over. That seemed at the time a bold step. It had always been done by government, hadn't it, so it seemed like a bold step. It now seems like an obvious step and one that you would never reverse."* [CS-3].

In the case of drugs, giving the ACMD delegated authority to decide on the classification and scheduling of drugs, with appropriate accountability safeguards put in place, might be one option for limited 'technocratisation' that could help to diffuse some of the tensions around the evidence on and assessment of harms.

DEPARTMENTAL LEAD OF DRUG POLICY

Another cross-cutting issue raised was the impact of the Home Office leading drug policy. Participants suggested that this skewed the policy options considered and had an impact on the extent evidence was used within policymaking, given the more action-oriented, rather than science-driven, culture associated with policing. Perhaps the most frequently raised issue was that Home Office leadership tended to frame the drug problem as a criminal justice rather than a health issue. But set against this was the fact that this had made it a priority issue. It had delivered resources, particularly for treatment of those committing crimes to support drug habits, which might otherwise not have materialised. As one former Home Secretary said; *"… trying to get Health, even at the ministerial level, even the Secretaries of State, to take this as a priority was almost impossible." [Pol-3]*

[33] Rutter, J (2012) *op cit* p24-26

It is unsurprising that there was a split of opinion among participants in our research over where leadership for the coordination of drug policy is best placed. There are international examples of health departmental leads, justice or home affairs leads and central leadership, such as Drug Czars. In the UK, the Drug Czar experiment was not deemed a success by our respondents and was seen as lacking departmental support, although this may have been partly due to personality issues and limited resources. However, it was also suggested this model was *"…a system that cut across our form of government"* [CS-10]. The Home Affairs Committee has recommended that the Home Secretary and the Secretary of State for Health take joint overall responsibility for drug policy.[34] Another example is where the coalition government in 2010 appointed a Minister with joint responsibilities for policing and justice, thereby having a footprint for reform in both departments.

Rutter suggests that while in the UK the Cabinet is the formal mechanism for joining up policy and implementation and is crucial for getting interdepartmental agreement they do not, in practice *"…particularly help promote either joined up analysis or joined up implementation"*.[35] She goes on to describe three different models that have attempted to address these:

- the Stabilisation Unit, which oversees a pooled budget drawn from Department for International Development, Ministry of Defence and the Foreign and Commonwealth Office;
- the Troubled Families initiative led by Louise Casey and which has a central programme team but local implementation structure and a dedicated central budget with matched funding local authorities; and
- the CONTEST counter-terrorism strategy, which has leadership and a dedicated unit based in the Home Office but clear engagement of all relevant policymakers and implementers in strategy development and the production of a delivery plan.

These all have strong top-down commitment, resources, and clear goals and a joint plan with clearly specified roles that all relevant departments have agreed to.

Sometimes change itself can reinvigorate a policy area and a number of participants in our research felt that a shift of leadership for drug policy to the Department of Health would be symbolically important. Others were concerned that within the Department of Health it would never be given sufficient priority because of the enormity of other health challenges. However, the current devolution of responsibilities to local authorities and the establishment of Public Health England, provide a new landscape and focus in which a range of local leadership models may emerge.

[34] House of Commons Home Affairs Committee, 'Drugs: Breaking the Cycle', Ninth Report of Session 2012-13, HC 184-1, December 2012.

[35] Rutter (2012) op cit; p27.

3.2 Knowledge development and utilisation

KEY POINTS:

- There is a need for greater investment in research development and translation for drug policy, in particular in the areas of enforcement and prevention. There are a number of promising initiatives, not necessarily drug-specific, and research in the drug policy area needs to benefit from these.
- It is important to recognise the wide range of evidence that goes to make up the policy knowledge base. We need structures and processes that provide greater leadership and co-ordination of knowledge development and transfer to support evidence-imbued drug policy. This needs adequate resourcing and must have the stature to be able to reconcile different perspectives on evidence.

INVESTMENT IN AND CO-ORDINATION OF RESEARCH

As discussed in sections 2.3 and 2.4, there was a widespread view that use of evidence within drug policy is a particularly problematic area and that there is an inadequate culture of review and evaluation. While the devolved governments were generally perceived as better in this regard, they have, because of their size, limited resources to devote to their research. Quite a few participants highlighted the potential, which they felt was not being exploited, for learning between different countries and from the natural experiments offered by devolution and localism. Many of our research participants felt that overall the investment in research is insufficient and piecemeal and that this is hampering the development of effective drug policy.

Our research highlighted some international examples of models of evidence generation and use that might be worth considering.

Australia, despite its much smaller population and similar sized drug problem to the UK, undertakes a large amount of high-quality research. The interviewees from Australia attributed this is, at least in part, to investment in building research capacity. Drug research centres have been established in three universities, creating centres of expertise that are able to compete internationally for research funding in addition to government-funded research. The government also allocates a percentage of the money from seized assets to fund research into enforcement through the National Drug Law Enforcement Research Fund.

In Australia there is no national research strategy (although it was reported that this has recently been discussed as a possibility). However, the size of the research community is such that less formal mechanisms for co-ordination are effective. For example, there is an annual conference that most of the sector attend, which helps communication. On the other hand, engagement between the research community and policymakers is ad hoc and is dependent on individual's disposition to do it. The Drug Policy Modelling Programme is unusual in seeing policy-makers as their core customers does briefings on topical issues that arise.

There is also a general reluctance to engage with the media and few researchers would see the public as a key audience. There have been two concerted attempts, one by federal and one by state government to engage with the public about drugs – an evaluation was done but not published and the programme discontinued. There is a strong commitment to independent evaluation of the drug strategy, which are commissioned and published. Nevertheless, there is still often a reluctance to publish and act on what might be perceived as negative findings and some well-evidenced programmes do not get adopted.

The **Canadian Centre on Substance Abuse** (CCSA) is another interesting international model. The CCSA is a unique example of an independent authoritative body with a legislative mandate to "provide national leadership and evidence-informed analysis and advice to mobilize collaborative efforts to reduce alcohol- and other drug-related harms". It was established in 1988 through the Canadian Centre for Substance Abuse Act and the 'sponsoring' governmental department is the Ministry of Health, although its activities span the interests of other government departments.

CCSA is governed by a Board of Directors consisting of a Chairperson and 12 directors whose backgrounds or experience assist CCSA in the fulfilment of its purpose. The Chairperson and up to four other directors may be appointed by the Governor in Council on the recommendation of the Minister of Health. Up to eight directors, known as members-at-large, are recruited from a number of sectors, including the business community, labour groups, and professional and voluntary organizations. The Minister of Health and Minister for Public Safety are ex-officio members of the board. The organisation tables an annual report to Parliament and the provincial and territorial legislatures, through the Minister of Health, for information and not for approval.

The CCSA agrees core funding with Health Canada every five years. Currently Health Canada's annual core grant is nearly $4m with an additional $3m of other national contributions for specific research projects. CCSA has received significant support also from the federal enforcement communities. The nature of the Canadian governmental structure is such that the federal government 'owns' the Canada Health Act and also the Controlled Drug Substances Act, but it is largely the Provinces and Territories which are responsible for healthcare and enforcement services.

The **United States** has traditionally invested considerable sums on drug policy research and as a result much of the evidence used by countries around the world in reviews has its origins in the US. They have a range of government research funding and knowledge transfer initiatives that fund drug policy research and recently the Office for Management and Budget (OMB) has made a commitment to requiring RCT evidence of benefit for programmes that it supports. Also, the Substance Abuse and Mental Health Services Administration invests in regional Addiction Technology Transfer Centers, which support and facilitate knowledge transfer between researchers and practitioners.

Within the UK, there also have been some initiatives to promote the generation and use of evidence for policy, both drug policy specifically and other policy areas. The Medical Research Council (MRC) and Economic and Social Research council (ESRC) Addictions cluster funding initiative sought to foster inter-disciplinary collaboration and to increase the policy relevance of

the research. It has been successful to a degree, for example one cluster is involving biostatisticians and criminologists in analysis of the Drug Data Warehouse developed by government, and the Research Council 'badging' of the initiative was cited as adding credibility. However, the amount of funding was quite small and dominated by the MRC, which may have limited the spread of topics supported. The new National Institute for Health Research provides another potential source of funding for research alongside projects funded by individual government departments (although the latter is a shrinking resource).

The UK Focal Point on Drugs, which is based in the Department for Health and the North West Public Health Observatory, produces a valuable annual report on the drug situation in the UK drawing on a wide range of administrative data and research.[36] However, its remit is limited to meeting the requirements for government reporting to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and it does not provide any critical analysis of the current situation or of particular policies.

The drug treatment sector is unusual in that a large proportion of it is delivered by voluntary sector providers which may constrain their ability to undertake research, for example because of their size, their funding or their skill mix. The recently announced collaboration between one of the larger providers, CRI, and Manchester University may be a useful model for the future, while Blenheim CDP also recently published a report highlighting the benefits that voluntary sector providers can get from participating in research projects but also the resource implications of doing so.[37] Other valuable supportive systems have begun to be developed, such as the Recovery Academy, but these are developing in an ad-hoc way.

Whether the new College of Policing, the National Crime Agency and the single police service in Scotland will facilitate or trigger more investment in enforcement focused research remains to be seen. Evaluation of supply side and enforcement efforts more generally has been very thin on the ground and this leaves a huge challenge for the Treasury and others in demonstrating value for money. The Home Affairs Committee in their recent report recommend that the Government should set up allocated ring-fenced funding to drugs policy research and that this should sit with the Medical Health and Research Council, while recognising the need for cross-disciplinary research.[38] They also proposed that the ACMD should coordinate research and further evidence gathering.

KNOWLEDGE TRANSFER AND USE

In order to translate research findings into 'knowledge' which is useful to policy-makers, there is a need for a process of synthesis and analysis. International initiatives such as the Cochrane and Campbell Collaborations provide an on-going review of research in specific areas but there is also a need for analysis of the research that is geared to current domestic policy issues. All countries

[36] See: http://www.nwph.net/ukfocalpoint/page.aspx?categoryid=36&id=99

[37] Blenheim CDP (2012) *Making Research Work: How Blenheim hosted a successful Contingency Management Research Project.* London: Blenheim CDP.

[38] House of Commons Home Affairs Committee (2012) *op cit*

in the UK have an independent advisory body or steering group that may, as part of their remit, undertake some of these broader types of analysis, such as the review *Hidden Harm* produced by the ACMD. But they have limited resource and tend to be focused on government needs. Factors that participants in our research felt were important to their effective functioning were: effective leadership, having the right people on them, sufficient resourcing and independence and credibility. While there was widespread acceptance these bodies should be advisory it was felt that there should be a presumption that their advice in general would be accepted and that, if advice was rejected, the government should be required to explain why. These are similar to the factors that were highlighted by Rutter[39] as essential 'design features' for effective independent 'evidence institutions', which were: independence and credibility; institutional reputation; transparency; resourcing models that underline this independence; access to internal government information and the ability to draw on or create a robust evidence base; and being clearly linked into the policy process.

A number of participants in our research expressed the view that the standing of the ACMD has diminished in recent years following the cannabis reclassification saga and the sacking of Professor Nutt, its Chairman. Monaghan in his essay for this project *Cannabis Classification and Drug Policy Governance*[40] suggests that the period 2000 to 2010 can be viewed from the perspective of a policy cycle. He suggests that in the first part of the period, the then Home Secretary David Blunkett was swayed by the build-up of evidence that cannabis was misclassified and for the potential for police efficiency savings towards changing the classification from B to C. Similarly his successor, Charles Clarke, when pressed to reconsider the decision in the light of possible new evidence regarding the potency of new strains of cannabis, also respected the advice of the ACMD in making no change. However, he suggests that when Gordon Brown became Prime Minister in 2007 and with a change in Home Secretaries, the new leadership was keen to establish its authority and the move to reclassify cannabis was one aspect of this. In this case, when ACMD reviewed the evidence again and still found that cannabis should remain a class C drug, political considerations triumphed over evidence and it was reclassified to class B. Not long after this the ACMD published a review of ecstasy and recommended a downgrading to class B, which was again rejected. As one former civil servant interviewee remarked: *"… once that spell was broken, that allows them to do it again." [CS-14]* It is interesting that recently the ex-Home Secretary, Jacqui Smith revisited the decision she took to reclassify cannabis for a BBC radio documentary.[41] She told BBC Radio 5 live that her decision to change cannabis's legal status from class C to class B was based on public opinion and said the reclassification had not made any difference to people's drug habits.

A key issue throughout this series of events was that, even after the experts on the ACMD had reviewed all the evidence available, there were still people who disputed their assessments or claimed that the evidence used was not correct or insufficient. This issue was also picked up by

---

[39] Rutter, J. (2012) *Evidence and evaluation in policy making.* :London: Institute for Government. p.27-28

[40] Monaghan, M. (2012) "Cannabis Classification and Drug Policy Governance" in *Essays on the governance of drug policy*. pp44-59.

[41] http://www.bbc.co.uk/programmes/b01p0v7k

McKeganey in his essay for this project[42] which highlighted the power that some simple concepts like the 'methadone car park' can exercise within public and policy discourse and, while initially useful at highlighting a particular problem, can then become resistant to challenge by evidence. This suggests that some agreed mechanism is needed for agreeing what counts as evidence and what it means for policy. Of course this expert mediating role is what the ACMD was supposed to do but a number of our interviewees felt that it has lost credibility and needs re-configuring, despite one fall-out from the imbroglio being the development of a Working Protocol between the Home Secretary and the ACMD. The purpose of this protocol was to "provide a framework under which the Government and the ACMD will continue to engage through the provision and receipt of advice on matters relating to drug misuse as well as associated matters"[43].

Another development from this episode was the setting up of the Independent Scientific Committee on Drugs (ISCD) by Professor Nutt and a number of scientists, including former ACMD members who had resigned in protest. The membership includes scientists from across the spectrum of relevant disciplines and its focus is on ensuring that "the public can access clear, evidence based information on drugs without interference from political or commercial interest."[44] It does not commission research but seeks to review, promote and pull together on-going work and interpret it in an accessible way. There are also some bodies working at knowledge 'translation' primarily for practitioners (eg Skills Consortium, Drug & Alcohol Findings; trade press) that make a valuable contribution to the promotion of evidence-based policy and practice. However, this piecemeal approach was considered inadequate by many participants in our research given the scale of the challenge.

UKDPC has demonstrated the value of an independent 'mediating' body that has a broader remit to keep the evidence base under review, and engage with policymakers and the research community to help them incorporate evidence into all aspects of the policy process. An important aspect of this widely respected work was the breadth of the issues addressed, covering for example treatment and enforcement, as well as cross-cutting issues such as stigma towards those with drug problems and their families.

The preponderance of research is still on the health side and there is a need to address the imbalance in the evidence base with respect to enforcement and prevention. This is a problem that has existed for years, indicating that current structures are incapable of addressing the issue. This suggests that there is a need for greater co-ordination and drive to improve knowledge development.

---

[42] McKeganey (2012) "Eclipsing Science: The Magical Power of Language in Shaping Drug Policy" in *Essays on the governance of drug policy*. pp33-43. London: UK Drug Policy Commission.

[43] Home Office: http://www.homeoffice.gov.uk/publications/agencies-public-bodies/acmd1/workingprotocol?view=Binary

[44] See: http://www.drugscience.org.uk/about/us/

3.3 Accountability and scrutiny

KEY POINTS:

- Evaluation needs to be built into drug strategies from the start and properly resourced if they are to provide a proper basis for accountability.
- In the current drive to localism it is important that there is analysis of local variations in policy implementation and outcomes in order to highlight best practice and identify emerging problems before they become too severe.

EVALUATION AND REVIEW

Monitoring of progress alongside evaluation and review provides the foundation for accountability and scrutiny. It is important that those involved in both policymaking and implementation are held to account for what they do or do not achieve. However, if no evaluation is undertaken this is not possible and, as was pointed out earlier, this is an area that with respect to the UK strategy is perceived to be a key weakness. For it to be effective the evaluation must be built in from the start so that baseline data is available.

ANALYSIS OF LOCAL VARIATION

Currently there are a range of mechanisms for scrutiny and accountability within the UK. In Scotland there is the independent Drug Strategy Delivery Commission set up specifically to scrutinise progress and make recommendations on potential areas requiring further work. In Wales the Advisory Panel on Substance Misuse (APoSM) and in Northern Ireland the NSD Steering Group provides a similar role. At the UK level, the ACMD does look occasionally at specific policy areas but does not have a specific remit to evaluate the effectiveness of the drug strategy. Indeed under the Working Protocol *"the ACMD will be guided by the relative priority given by Ministers to each of the specific commissioned areas of work to inform a 3 year programme of work, taking into account work that it may wish to undertake of its own volition in this period"*. This, in effect, circumscribes the ACMD's ability to proffer advice about the evidence of the impact of the government's policies.

As described in section 2.3, there are numerous parliamentary select committees that occasionally consider drug policy issues but there is no apparent co-ordination between Committees and little follow-through on whether and how recommendations were acted upon. Joint select committee hearings might be one way of increasing the impact of parliamentary scrutiny.

Implementation at the local level has in the past been driven through the setting of targets. More recently the use of 'outcomes' and 'indicators' has replaced these, sometimes with financial strings attached. In England the money being allocated to local authorities for spending on public health will include incentives and penalties relating to performance against outcomes. However, it is crucial to have the right targets to prevent gaming – but it is also necessary to look at trends and other information to show if gaming is occurring.

In England the move to localism has opened up the possibility of a variety of approaches being adopted. This and devolution at the UK level provides opportunities for natural experiments but also for problems with local delivery. It will therefore be important that information is collected to facilitate comparisons between areas and benchmarking to guard against unacceptable increases in drug-related harms in some areas. This might be a role for the National Audit Office and the Public Accounts Committee.

As Puttick in the foreword to the NESTA report, *Evidence for Social Policy and Practice,* says: *"We recognise that with local autonomy comes an enormous opportunity for innovative approaches to thrive, but in order for this to happen practitioners, commissioners, users and other decision makers must know what works – and what doesn't. Sharing evidence will help improve outcomes whilst helping to prevent duplicated efforts and wasted resources."*

For any meaningful scrutiny at either national or local level it is essential that evidence for what is happening on the ground and whether progress is being made towards objectives or not, which requires both collection of the evidence and analysis of what this means in terms of performance.[45] A possible option Rutter highlighted for the first part of the process is an "observatory", such as the Migration Observatory or the National Obesity Observatory. For the analysis function in politically charged areas, the use of an independent body of some sort seemed a common model. Examples identified, although with quite different functions, were the Low Pay Commission, the Office for Budget Responsibility, and the Committee on Climate Change and the Institute for Fiscal Studies.

However, all of these function at the national level and there is a need for improved understanding of effective models of local scrutiny as well, as this area remains fluid and is developing rapidly.

3.4 Stakeholder engagement

KEY POINT:

- There are a wide range of stakeholders in drug policy and to engage them meaningfully should involve a range of different techniques and an on-going dialogue. However, this will be resource intensive on all sides so needs to be undertaken only if there is a genuine opportunity to influence policy.

Another important cross-cutting theme within policy development, implementation and review is the engagement of stakeholders. The wide-ranging impact of drugs and drug policy mean that the range of stakeholders is equally wide and the extent to which they can and should be involved varies depending on their role and the stage of the process. The appropriate mechanisms this are equally varied.

Rutter discussed some of the methods used to engage with different groups in some other policy

[45] Rutter, J (2012) *op cit*.

areas, using as examples the DH consultation exercise "Your Health, Your Care, Your Say", the "GM Nation" public debate, and department of Business, Innovation and Skills funded centre Sciencewise.[46] These included: deliberative events, which can explore issues in more depth but can include only fairly small numbers of people; broader on-line consultation exercises using questionnaires which may be very open or more structured; local listening exercises where, for example, people are invited to attend open meetings; magazine surveys and other forms of polling; and citizens summits. She concludes that public dialogue can be effective but only if the engagement is genuine with an opportunity to influence final decisions.

Civil society organisations make a critical contribution to the development and implementation of drug policies. They fulfil a number of valuable roles, including:

- Self-help and mutual aid support for those with dependency problems, including those that may be faith-based;
- The delivery of contracted dependency treatment, prevention and educational services for the health, education and criminal justice systems;
- Advocacy for particular marginalised groups;
- Research and information services;
- Representational activities on behalf of a membership or services sector;
- 'Campaigning' and lobbying efforts.

Policymakers will frequently seek advice and input from such bodies, either informally or as part of a structured consultation or engagement process. On their part, many civil society bodies will actively seek to inform or influence national and local politicians and policy influencers on a wide range of issues including resources, legislation, good practice and service user interests. The history of the evolution of drug policy over the past two decades has shown how civil society bodies have made a significant impact on drug policy and the implementation of successive drug strategies.

In his essay for this project, Roberts looks in more detail at UK government consultation procedures from the perspective of the voluntary sector with a particular focus on those relevant to drug policy, which because of the cross-cutting nature of drug policy, can emanate from a wide range of different departments.[47] He highlighted the considerable resource costs for both sides of any consultation process and the lack of clarity about how the contributions from different people and groups, who will have a range of knowledge and expertise on any subject, are evaluated and weighed up. As well as research into and the development of guidance on when and how different consultation methods should be used he suggests consideration of some mechanism for independent monitoring of how they are conducted. He reached four specific conclusions of relevance to drug policy consultation processes:

[46] Rutter (2012) *op cit.*

[47] Roberts (2012) "Consultation processes and good governance: from 'unproductive process' to 'real engagement'?" in *Essays in governance of drug policy*. pp60-83. London: UK Drug Policy Commision.

1. Given the wide range of departments whose consultations are of relevance to stakeholders in the drug policy area, there would be merit in a sector specific review of consultation practice, including innovative processes such as co-design.

2. There are concerns about the impact and effectiveness of recent consultations in the drugs field which raises issues about accountability.

3. The localism agenda is bringing unprecedented levels of change for people providing services and it is not clear how easy it will be for the 'voice' of the sector to be heard within new local structures. At present in many areas they are not involved in these important discussions.

4. People with drug problems are a highly stigmatised and marginalised group and they may be excluded or 'drowned out' within consultation processes if special effort is not taken to ensure their perspective is represented.

A point raised by Roberts that also came up in our interviews was the fact that politicians, influenced by opinion polls, the media, or the people who make a point of lobbying them, may have an inaccurate perception of what public opinion actually is. Opinion polls are inevitably superficial and do not give information on what underpins people's attitudes or how attitudes can change if more information is provided. This is a particular problem in an area as complex as drug policy that is beset by trade-offs and unintended consequences. Making greater use of deliberative processes may help address this issue.

4. Conclusions and recommendations

Our research has identified the following as key issues for drug policy at the UK level:

The polarised and contested debate around drug policy is preventing an open discussion about the goals of drug policy and the options for achieving these.

The toxic nature of the debate about drug policy inhibits consideration of the full range of options for policy and favours maintenance of status quo. There is a need to create a calm space for discussion of, and agreement on, the goals of drug policy and the best approach for addressing these. Establishing a cross-party consensus will be important to provide stability and time for impact of any new policy and to create the climate to allow implementation of any proposals there will be a need to include public and media engagement with the complexities of the evidence through deliberative approaches.

Recommendation 1: Create a cross-party political forum to progress discussion about future policy, including engagement with the public.

Within drug policy there is an overemphasis on enforcement and view of drugs as a criminal justice issue which is skewing the responses.

Although Home Office leadership and the recognition of the link between drugs and crime has delivered greater resources and given a higher priority to drugs than might otherwise have occurred, we feel that is now restricting the policy options being considered. While it may be largely symbolic, given the importance of continued inter-departmental working, we suggest a shift of leadership for drugs to the Department for Health would help to reframe the debate and open up alternative approaches to drug problems. It also fits with the shift in the localism agenda to a greater focus on public health within local authorities.

Recommendation 2: Move the political lead for national drug policy from the Home Office to the Department of Health.

The public debate about drug policy has become dominated by disagreement over the assessment of harms of different drugs much of which occurs in the media using partial and unevaluated evidence. This hampers sensible discussion about drug policy.

The polarised nature of the drug policy debate leads to continual disputes about the evidence and what it means, which makes it hard for policymakers and the public to make informed decisions. In this sort of environment decision-making is open to accusations of politicking which brings it

into disrepute. Both the ACMD and the New Zealand Law Commission have proposed that an independent body could be empowered to take delegated decisions about controlling new drugs, which could overcome this problem. There is some debate about the merits and downsides of this suggestion and of extending it to reviewing the current arrangements for controlling existing drugs. Some experts have argued that either the ACMD or a new statutory body, with democratic safeguards, might assume delegated responsibility for taking decisions about the classification and scheduling of all substances. There are precedents for this type of approach, National Institute for Health and Clinical Excellence (NICE) and the Medicines and Healthcare products Regulatory Agency (MHRA) operate in a similar manner and, although there are inevitable controversies, by and large the systems work well and are respected. With appropriate parliamentary oversight and accountability, we see no reason in principle why decision making over the process of classification might not be delegated in its entirety to a new statutory body. This might avoid some of the more inaccurate headlines which accompany the process of drug control.

Recommendation 3: The government should initiate a formal review of the powers and remit of the ACMD and explore different options for the assessment of harms and the classification process.

Drug policy making is insufficiently evidence-imbued. There is a lack of coordination, drive and adequate resourcing, which has resulted in large gaps in our knowledge in a range of areas, and strategies and policies are rarely evaluated.

A key feature of good governance is having evidence and knowledge development embedded into the policy process, but this was highlighted in our research as a key weakness in drug policy. Action to address this needs to include evaluation of the drug strategy, in addition to developing a more coordinated programme of research and knowledge dissemination to politicians, policy-makers, practitioners, the media and the wider public.

If drug policy is to be effective and provide value for money, it is important to build learning and evaluation into the process, which needs to include learning from when things fail: if something is not working it should be stopped or changed and then re-evaluated.

Recommendation 4: Evaluation needs to be embedded into the policy process. Drug strategies should include a commitment to their evaluation from the start.

As an interim step to improve co-ordination of research, consideration should be given to the establishment of an annual interdisciplinary drug policy research conference for the UK. Similarly, investigating the potential for more secondments of researchers into government departments, for example as part of the PhD process, could help improve the communication between the academic and policy communities.

However, we believe a more comprehensive solution is necessary. The work of UKDPC in

analysing and disseminating evidence has been valued highly by policy, practitioner and research communities, and there is a gap there that needs filling. But other needs, for research coordination and formal scrutiny of policy have also been identified. While the ACMD has also conducted some influential reviews and is respected internationally, its capacity is limited. Therefore we believe there is a need for a new independent body which could take on new functions of providing independent leadership and coordination of research and policy analysis. Working in collaboration with new bodies such as the College of Policing and National Institute for Health Research (NIHR) School for Public Health Research, as well as the established research councils and the devolved administrations, the role of this new body might include commissioning and managing research in areas not covered by existing mechanisms, alongside evaluating the impacts of drug and alcohol strategies and intervention programmes. Such a body could take a role across the UK, which would allow it to exploit the opportunities for natural experiments arising from diverging drug policies.

The argument for such a new body is strong, both to develop our knowledge and to respond to the pressures of the economic situation. The issue arises, of course, about how such a body might be funded. In addition to the funding made available by the various research councils there may be a strong case for some of the resources being raised through the forfeiture of assets from drug-related crime, as occurs in Australia. Perhaps some £10 million a year could be redirected for this purpose. We believe that the principle of re-channelling seized assets to help develop and improve our knowledge and understanding is a sound one, and a strong business case could easily be built to validate this. Such a body might be attractive also to some charitable trusts and foundations, given its independent status.

Recommendation 5: A new independent body should be established to co-ordinate the drug research effort and to provide policy analysis and dissemination. A proportion of the money raised by the forfeiture of assets from drug-related crime might be used to fund this body and/or research.

Localism and devolution are an opportunity for natural experiments but there is also a threat of pockets of poor practice.

Devolution and localism should be seen as unique opportunities for natural experiments in drug policy which can, and should, be properly evaluated. Unfortunately we can find little evidence that either national or local public service bodies are considering this opportunity, except where they are initiated by central government, such as the payment by results programme.

Across the fields of policing and healthcare, innovative approaches are both possible and desirable, for example whether and how the drug law is implemented, such as for possession of cannabis, or public health based efforts to provide help for those that continue to inject drugs. In the UK, we are poor at systematically developing independent knowledge about the impact of different approaches and transferring this knowledge into wider networks.

This might be a role for the new independent research co-ordination body described above should it be established. But as an alternative, or until it is established, there is also a need to ensure that knowledge is spread more widely. This might be a role for Public Health England, or a body analogous to the National Obesity Observatory or the US Addiction Technology Transfer Centres might be established.

Recommendation 6: Put in place structures and processes to scrutinise and evaluate emerging local approaches in order to highlight and spread good practice and identify problems early.

There are a wide range of stakeholders in drug policy, which, taken together with the complexity of the issues, means that an on-going dialogue about the evidence and the implications for policy is necessary.

As we highlighted in our recent report *A Fresh Approach to Drugs*, there is a need for a new public conversation about drug policy and the issue of substance use in 21st century UK. A number of participants in our research identified the importance of perceived public opinion in politicians' attitudes to drug policy but also the fact that it was not clear how correct these perceptions are since traditional consultation methods, opinion polls and focus groups are poor means for digging down into and understanding public attitudes. The policymaking cycle could adopt more sophisticated means of testing public attitudes using deliberative approaches and make more use of social media to engage young people.

Recommendation 7: There is a need to develop and test the use of deliberative methods for engaging with the public around the complexities of the evidence base and the goals and options for drug policy.

In conclusion, this programme on research has been unique and extremely wide-ranging and so this report has focused on the key issues emerging through our interviews with those most closely involved over the years with developing and implementing drug policy. We have been lucky to have the involvement of a very large number of people with enormous expertise in policymaking and we are very grateful for their contribution.

Our research has shown that while people recognise a number of areas in which drug policy has been successful, for example treatment and HIV control, there remains considerable disquiet about other areas and, in particular, about the relationship between drug policy and evidence. In a rapidly changing world it is essential that policy is able to change in response to new challenges and learn from evidence of what is and is not working, which may also change over time. We should also be able to learn and be inspired by developments in other countries.

What is very clear from all the work we have undertaken is that there is no single correct way of making policy and also that no structures and processes can guarantee that a policy will be

successful. However, it is possible to identify some characteristics that appear to make good outcomes more likely and we have identified some of these through our expert consultation process. Comparing drug policy against these characteristics has identified some areas where we believe adopting new processes or structures could help to increase the effectiveness of drug policy and reduce the harms experienced as a result of drug use and dependence, stabilising the policymaking process and make it more consistent, reliable and cost-effective.

Appendix A: The components of the research

BOX B: OVERALL STUDY METHODOLOGY

The study drew on a combination of methods:

- Expert consultation (modified Delphi process) to identify key characteristics of good policy governance;
- Consideration of how current drug policy governance structures & processes impact at different stages of the policy process and where there are issues through:
  - Interviews & round tables
  - Essays
- Identification of ways to address the issues identified through:
  - Examples from other countries/policy areas identified from fieldwork, literature and IfG briefing.
  - Consultation with stakeholders.

The project has used a number of different approaches and engaged with a wide range of different people involved in drug policy making in order to examine the governance of drug policy in the UK and how this might be improved. The different components of this study are described in Box B. The review commenced with a deliberative process involving national and international experts in drug policy and related fields which sort to identify what were generally considered to be the key characteristics of good policy governance. This deliberative process began with 26 experts participating in a two-day event at St George's House, Windsor including: four academics, politicians from different levels of government, civil servants, representatives from third sector organisations, such as research think tanks and advocacy organisations, and from international institutions and the media. This fed into a modified Delphi exercise in which 29 experts from a similar range of backgrounds and from seven countries including the UK participated. The details of the types of people involved in these and other elements of the research programme are shown in Table A.1.

The next stage used these key characteristics to explore, through interviews, round tables and desk research, the extent to which current drug policy governance in the UK adheres to good governance practice and what are the strengths and weaknesses of current practice. This involved interviews with 41 people with a wide range of experience and expertise, including current and former leading politicians (from both Houses of Parliament and the devolved governments), current and ex-civil servants, academics, and practitioners with a further 31 taking part in four round table events or seminars. In addition we commissioned the Institute for Government (IfG) to produce a briefing which considered the findings from their work under their Better Policy Making theme and the lessons for drug policy governance from other contentious policy areas. Finally we commissioned four experts in the drug policy field to write essays focusing in more detail on particular aspects of governance. The findings of all these different components are available at www.ukdpc.org.uk/governance-project.

Table A.1: Research participants by background and component in which they participated.

Background of participants*	Research component				Total participating **
	St George's event	Delphi expert consultation	Interviews	Roundtables & seminars	
Former Home Secretaries and Drugs Ministers [Pol]	0	0	5	0	**5**
Other parliamentarians [Pol]	3	3	4	5	**13**
Scientific and expert advisors to governments [Res]	1	3	7	3	**15**
Current and former Permanent Secretaries [CS]	0	0	3	2	**5**
Civil servants involved in drug policy [CS]	2	2	13	7	**19**
Officials from national and local enforcement, health and educational services [Oth]	4	2	1	1	**6**
International and UK think-tanks and expert policy researchers [Res]	11	15	7	6	**32**
Media specialists [Oth]	1	0	2	1	**3**
Civil society organisations [Oth]	4	4	0	6	**11**
Total participating	**26**	**29**	**41**	**31**	**109**

* Some people had experience in more than one area but have been categorised here by only one of these.

** Some people participated in more than one part of the research programme.