UKDPC

UK DRUG POLICY COMMISSION

A Response to Drugs: Our Community, Your Say Consultation Paper

Briefing

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UKDPC is a registered charity, established to provide independent and objective analysis of drug policy and find ways to help the public and policy makers better understand the implications and options for future policy.

UKDPC has been set up with support from the Esmee Fairbairn Foundation, initially for three years. Our objective is to analyse the evidence and explore options for drug policy which can improve the health, well being and safety of individuals, families and communities.

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The UK Drug Policy Commission
Response to the Drug Strategy Consultation

October 2007

1 Summary of this paper

This paper represents the response of the UK Drug Policy Commission (UKDPC) to the UK Government's Drug Strategy Consultation announced in July 2007. The UKDPC launched earlier this year and is not due to complete its work until 2010. Therefore in developing our response we have engaged with key representatives from the academic community and draw upon this feedback as well as a number of important reports and reviews in addition to those commissioned so far by ourselves, most notably the independent report we published earlier this year: *An Analysis of UK Drug Policy*[1]. This process has highlighted a number of key observations concerning the current strategy and key recommendations for its replacement in 2008, which have relevance for many of the questions raised within the government's consultation paper: *Drugs: our community, your say*.

Key observations:

- We acknowledge from the outset the considerable achievements that have been made over the past ten years, particularly the increase in the number of people receiving treatment following a sharp increase in investment.
- However, it remains unclear to what extent many of the interventions under the current strategy have resulted in positive outcomes and represent good value for money. There is a scarcity of knowledge about 'what works' across many strands of the strategy which cannot be overestimated and should be of serious concern.
- This is coupled with a lack of proper understanding of many of the basic processes associated with the initiation of drug use and progression into and out of dependence and problematic use. This hampers both the design and evaluation of interventions within the drug strategy.
- There is a pressing need to address the many implementation and delivery issues which hold back or diminish outcomes when interventions of proven effectiveness, such as drug treatment, are more widely adopted.
- Calls for 'zero tolerance' and so-called 'tough' measures which are not supported by the evidence risk undoing any progress made in the past ten years. Our primary concern must be to adopt approaches backed by good evidence and ensure any new interventions are rigorously evaluated before being rolled out widely.

Key recommendations/conclusions:

1. The new drug strategy should have a dedicated 'pillar' that addresses the critically underdeveloped knowledge base. This should include a framework for regular and independent evaluation of the drug strategy, as well as for commissioning new research and programme evaluations, and be funded appropriately. Consideration should be given to the establishment of an independent body or group charged with leading this work. Key components of such a framework are described in Annex B.

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

2. The greatest return on investment is likely to be found by widening the availability and choice of drug treatment and harm reduction programmes and improving their quality, so that more drug-dependent users are benefiting fully from services. It is here where the evidence of positive outcomes is strongest.
3. This must be coupled with a marked improvement in understanding the requirements for recovery, focusing on 'wrap-around' provision to support community reintegration. We believe this is a major opportunity for a step-change in outcomes for the next strategy.
4. Promising innovations, particularly those supported by international evidence (e.g. heroin-assisted treatment, drug consumption rooms, new treatments for cocaine and crack users), should be trialled and, if successful, adopted in this country. A phased expansion of the drug court model for diverting drug-dependent offenders into treatment and rehabilitation programmes and of injectable opiate treatment for the most severely affected users who have failed to respond to other treatments should also be considered if findings from the pilot evaluations underway are positive.
5. Proven community-based interventions should be trialled in prison settings with the aim of developing a similar level of service if results are positive. Given that prisons have such a high number of problematic drug users, treatment, harm minimisation and aftercare provision (including meeting the challenge of prison-community transfer) are just as vital here as in the wider community.
6. The evidence for prevention programmes is generally weak but there is some limited, mostly international, evidence that can be used for developing the strategy in this area. It is essential that any programmes include rigorous evaluation, covering both process and outcomes, as part of the implementation process to develop the knowledge base in this area.
7. It is far from clear whether current enforcement practice is effective at reducing drug-related harms (the stated aim) or represents value for money, despite taking the lion's share of the total budget[2]. Therefore a comprehensive programme of research and analysis in this area is urgently required.
8. The potential negative impact of variation in delivery of programmes on their effectiveness coupled with the increasing devolvement of responsibilities to local levels makes it important that attention is paid to the effectiveness of approaches to commissioning and delivery. Therefore we recommend that an urgent review of systems and structures for delivery and co-ordination at national and regional/local levels is undertaken.
9. Finally, given the recent history of the classification of cannabis, which illustrates the general confusion surrounding the purpose and function of the classification system, we consider that a review of the entire basis of the classification system and the process for making decisions on drug classifications, including the role of politicians, is required.

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

2 Observations on the current drug strategy

2.1 Achievements from the current drug strategy

Key point
The significant increase in resources for drug-related interventions over the life of the current drug strategy has resulted in some notable achievements. In particular, the sharp increase in investment in the quantity and quality of treatment and the focus on using the Criminal Justice System to get drug-dependent offenders into treatment has led to an increase in the number of people receiving treatment and support to deal with underlying problems.

From the outset we acknowledge the progress which has been made over the past ten years, representing considerable investment, effort and output. For example:

- significant additional resources have been provided across a wide range of programmes, in particular there has been a major expansion in drug treatment provision;
- the increase in treatment provision has been accompanied by efforts to improve the quality of treatment provision through the National Treatment Agency, NOMS, Scottish Government & Welsh & Northern Ireland Assembly initiatives;
- there has been increased provision of drug information to young people through the school curriculum and the FRANK campaign;
- considerable emphasis has been placed on using the Criminal Justice System, which has contact with a large proportion of drug-dependent users, to get people into treatment to deal with underlying problems. This has resulted in some drug-using offenders engaging in treatment for the first time;
- continuing support for tried and tested measures to reduce the health risks, especially from injecting drugs, which may have prevented an epidemic in HIV infection among this group;
- a range of measures to disrupt local drug markets and organised drug trafficking networks have been undertaken.

2.2 Much ignorance has endured

Key points

- Despite the record investment in interventions under the current strategy the extent to which the different components of the strategy have resulted in positive outcomes and provide value for money is unclear - a result of the extremely limited and uncoordinated investment in research and evaluation.
- The need for better understanding of the extent and nature of drug problems and the effectiveness of interventions was recognised in 1998. However, despite some investment in new data sources, e.g. the National Drug Treatment Monitoring System (NDTMS) and the Drug Interventions Record (DIR), and in research, there has been insufficient investment in rigorous independent analysis and most of these gaps remain and continue to hamper the development of an effective drug strategy.

It should be of great concern to the government that despite the increase in investment and outputs, the extent to which this has resulted in an increase in positive outcomes is not clear. This lack of evidence has led to doubts being raised about the efficacy of components within the strategy[3], and will have no doubt hampered the government's as yet unpublished internal value for money review. It will now also hamper the development of the new strategy.

There has been recognition for some time within government that any strategy should be evidence-based and the value of research in policy development is illustrated by the impact of the National Treatment Outcomes Research Study (NTORS). This study highlighted the potential benefits, in terms of improvements in both health and crime outcomes, from drug treatment. The resultant focus on expanding treatment provision, including encouraging more offenders into treatment, is the area where there is most evidence that drug policy has had an impact[4]. Research can show what works well. less well or not at all. The new strategy is likely to be operating in an environment in which resources are increasingly scarce which means that it will be important to use evidence not only to pursue approaches that work and ensure they are delivered efficiently but also to back up potentially more difficult policy decisions to reduce or abandon investment in approaches that don't work.

The 1998 strategy document *Tackling Drugs to Build a Better Britain* explicitly recognised the importance of research, audit and evaluation and also identified 19 key gaps in the evidence where government would, as a priority, commission additional research. However, our consultation with the academic community has shown that, despite the initial commitment and additional investment in research and new data sources (e.g. the British Crime Survey, NDTMS, and the Drug Interventions Management Intervention System), many of the areas identified as key evidence gaps remain. As a result, we know little more than in 1998 about the extent and nature of drug problems, which interventions are most effective in preventing or treating these problems or how these can be effectively delivered.

We believe there are several reasons why the knowledge base around drugs failed to develop significantly under the last strategy:

(i) Serious under-investment in research, information and analysis. The rush to intervention was not matched with relevant investment in R&D.

(ii) A lack of co-ordination and leadership of research under a plethora of funding streams.

(iii) Too little emphasis on funding independent, high quality research and analysis.

(iv) Narrow monitoring & evaluation of the overall strategy that lacked independence.

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[3] House of Commons Science & Technology Committee (2006) *Drug classification: Making a hash of it?* London: The Stationery Office; RSA (2007) *Drugs – facing facts: The report of the RSA Commission on Illegal Drugs, Communities and Public Policy* London: RSA; Reuter P & Stevens A (2007) *An Analysis of UK Drug Policy* London: UKDPC; Rolles S (2007) *After the War on Drugs: Tools for the debate* London: Transform; Social Justice Policy Group (2007) "Addictions: Towards Recovery" *Breakthrough Britain* Vol. 4. London: Social Justice Policy Group

[4] Reuter P & Stevens A (2007), op.cit.

(v) A reluctance to allow a sufficiently long time frame for most evaluations and research projects.

(vi) Weak links between the academic community and policy makers with no clear structures or strategy for developing or transferring knowledge.

These weaknesses have meant that, even in areas where a wide range of research has been undertaken during the current strategy (such as the treatment area), gaps identified as a priority for new understanding remain unfilled. For instance, whereas there has been considerable investment in a range of data sources, such as the British Crime Survey, NDTMS, the Arrestee Survey and the Drug Intervention Record, a corresponding investment in analysis of much of this information to shed light on questions such as the "natural history" of drug use has not followed.

The current drug strategy has had targets against which performance has been monitored and assessed. These have been part of the overall government performance monitoring framework and have had to conform to that approach. However, in many ways these could be perceived as having been bolted on to the strategy, offering little in the way of insight or diagnosis for current policy and implementation. Furthermore, targets were set that were unrealistic, or were superseded by events (e.g. Afghanistan), or where no relevant data was available. Unfortunately by altering the targets over time and through the lack of independent evaluation the government has come under criticism for manipulating, reframing or 'watering-down' the targets and results. This has probably undermined wider public confidence in the government's efforts.

To ensure the weaknesses concerning evidence and evaluation are not carried forward it is important that the need for knowledge development and independent evaluation is addressed within the new strategy. This area is covered in more detail in section 4.1 and Annex B below.

2.3 Ideology versus evidence

Key point

- Calls for 'zero tolerance' and so-called 'tough' measures which are not supported by the evidence risk undoing any progress made over the past ten years. It is essential that the approaches adopted in the new strategy have been proven effective or else are rigorously piloted prior to widespread adoption, since it is possible for intuitively appealing interventions to have unexpected negative consequences.

The drug policy debate has for some time been dogged by polarised perspectives. In particular, public debate in the media tends to revolve around being either 'soft' or 'tough' on drugs issues with no real effort to explore and promote, in a meaningful way, what works. We sense a shifting climate towards 'tough talking' on drug issues by some commentators which may influence the course of policy. For example, growing calls for purely abstinence-based treatment, tougher sentences, shock-horror information, wider use of drug testing, re-classification of cannabis, 'zero-tolerance' etc. Such approaches may seem intuitively appealing, particularly when faced with high levels of drug use in the UK in comparison to most other European countries. However, it is for this same reason that we caution against adopting policies that are not proven to be effective. It is also important to recognise that

such interventions may have unexpected negative effects, for example hard -hitting advertising campaigns have been shown to leave some young people feeling more positive about drugs and more likely to say they would use drugs, or have no effect at all. It is essential, therefore, to be realistic about what can be achieved through some interventions and programmes.

The current state of the evidence for each of the areas identified in the drug strategy consultation paper is considered in section 3 below. We urge the government to have confidence in pursuing 'what works' even if this can, at times, be controversial or counter-intuitive. Without this confidence many successful drug interventions we now employ would have never been established. For example:

- Needle exchange schemes to reduce blood-borne virus risks.
- Methadone substitution programmes to reduce harms and stabilise the lives of drug-dependent users.
- Treatment as an alternative to other sentences to reduce crime and improve health.
- Providing credible drugs information to young people, covering the 'highs' as well as the risks.
- The use of incentives to engage and retain people in treatment.
- Targeting drug trafficking to have the greatest impact on the harms caused by drug markets rather than just concentrating on the size of seizures or number of convictions.

There is strong evidence that 'harm reduction' initiatives can have many benefits for society without sending out a message that society accepts or condones illicit drug use. Whilst the public are rightly concerned about levels of drug-related crime and the health of young people, they have demonstrated support for practical ways to tackle the problem. For example, recent public opinion polls have shown good support for the use of treatment as an appropriate way of dealing with drug-dependent offenders.[5]

As indicated in a recent Cabinet Office discussion paper, changing individual behaviours and cultural norms is a challenging and long-term goal.[6] A successful model for behaviour change will employ a balance of incentives and disincentives and the removal of barriers to change. The risks of following a heavily populist or dogmatic path are that it will not provide an optimum model for behaviour change, it will undo any progress made over the past ten years and will stifle innovations which may be controversial now, but could make significant contributions in the future.

2.4 Problems of implementation

Key point

- There are many implementation and delivery issues that hold back or diminish outcomes when programmes that have been shown to be effective are widely implemented.

[5] RSA (2007) *"Drugs – facing facts. The report of the RSA Commission on Illegal Drugs, Communities and Public Policy"*, pp329-335. London: RSA;
ICM Research (2006) Victims of Crime Survey conducted on behalf of Smart Justice.
http://www.icmresearch.co.uk/pdfs/2006_january_smart_justice_crime_survey.pdf accessed 16/10/07

[6] Halpern D et al (2004) Personal Responsibility and Changing Behaviour: the state of knowledge and its implications for public policy; London: Strategy Unit
http://www.cabinetoffice.gov.uk/upload/assets/www.cabinetoffice.gov.uk/strategy/pr2.pdf accessed 16/10/07

It is well recognised that the outcomes achieved when programmes are implemented widely are likely to be less impressive than those achieved under more controlled and smaller scale trial conditions. For example, there is considerable evidence from the drug treatment field that the factor that most strongly predictive of retention or completion of treatment is the agency attended[7]. This is likely to be a result of a wide range of organisational and staffing issues, such as systems and facilities, workforce training and motivation, and knowledge dissemination.

It is not just in the treatment field where this is the case. Reports from various auditing and inspection bodies have consistently illustrated the challenge of sharing and replicating good practices en masse[8]. We note that the government has recently commissioned an independent review of how existing resources for drug treatment in prisons can be used more effectively. Often the speed of which a programme is rolled-out presents an enormous challenge to implementers, so mechanisms for generating learning and feeding this back must be integral to project design to help optimise outcomes. The Public Accounts Committee's report on the Assets Recovery Agency[9] provides a case in point.

The initial focus under the current strategy was to expand treatment provision and only latterly has the focus shifted to quality of care. There is a need for much more research and evaluation in the area of delivery of interventions. The new Treatment Outcomes Profile will provide an opportunity for some such work in the treatment field but will need to be supplemented by other research. All other intervention programmes, including those relating to prevention, education, public information campaigns and enforcement and market disruption, need research on effective delivery built into the programme from the start.

[7] Millar T., Donmall M. and Jones A. (2004) *Treatment effectiveness: demonstration analysis of treatment surveillance data about treatment completion and retention.* London: NTA
Meier P. (2005) *A national survey of retention in residential rehabilitation services.* London: NTA

[8] Audit Commission (2002) *Changing Habits: The Commissioning and Management of Community Drug Treatment Services for adults* London: Audit Commission;
HMIC (2007) *Enforcement of Community Penalties*: HMIP, HMICA and HMIC Thematic Report London: HMIC;
OfSted (2007) *Developing social, emotional and behavioural skills in secondary schools: A five-term longitudinal evaluation of the Secondary National Strategy pilot*

[9] House of Commons Committee of Public Accounts (2007) *Assets Recovery Agency* London: The Stationery Office Ltd.

3 The evidence base for interventions

As already stressed, the overriding picture is one of scarcity of robust, independent evidence. However, we have considered each of the five proposed strategy themes in turn for supporting evidence, in partnership with the academic community and with reference to key reports and sources.

3.1 Young people, education and families

Key Points

- International evidence of prevention education has shown there is very limited impact on drug-using behaviour although these modest incremental benefits might be cost-effective over the longer term and when implemented on a wide scale.
- Currently there are no examples of good outcome evaluations for targeted early intervention programmes although there is strong evidence for risk and protective factors associated with problematic drug use.
- It is therefore essential that any programmes include rigorous evaluation, covering both process and outcomes, as part of the implementation process to develop the knowledge base in this area.

In general, international evidence on drugs education has shown there is very limited impact on drug-using behaviour. Even the school-based substance misuse programmes that are deemed to be more effective appear to have only marginal impact on behaviour.[10] However, some analysts have suggested using economic modelling that these modest incremental benefits might be cost-effective over the longer term and on a wider scale.[11] It is also important to note that a key aim of drug education, and health education more widely, is to develop the knowledge, attitudes and skills of young people which will build their resilience to a range of negative outcomes. Nevertheless, more research is needed to demonstrate the effectiveness of education in achieving this and the extent this links to behaviour change.

The evidence for school-based education programmes points to better outcomes derived from multi-component programmes, i.e. those involving families and the community, as well as those based on a social-influence model (providing knowledge and skills in a wider social context)[12] rather than those that just provide knowledge or 'just say no'. The Blueprint multi-component drug education research programme[13] was a bold initiative and its findings will no doubt add to our

[10] Gottfredson et al 2000; Foxcroft et al 2004; Faggiano F, Vigna-Taglianti FD, Versino E, Zambon A, Borraccino A, & Lemma P (2005) School-based prevention for illicit drugs' use. *Cochrane Database of Systematic Reviews* 2005, Issue 2. Art. No.: CD003020. DOI: 10.1002/14651858.CD003020.pub2.
[11] Caulkins JP, Everingham SS, Rydell CP, Chiesa J & Bushway S. (1999) *An ounce of prevention, a pound of uncertainty: The cost-effectiveness of school-based drug prevention programmes.* Santa Monica, CA: RAND Corporation
[12] Jones L, Sumnall H, Burrell K, McVeigh, J & Bellis M (2006) *Universal Drug Prevention* Liverpool: National Collaborating Centre for Drug Prevention;
McGrath Y, Sumnall H, McVeigh J, Bellis M (2006) *Drug use prevention among young people: a review of reviews*. National Institute for Health and Clinical Excellence
[13] Baker PJ (2006) "Developing a Blueprint for evidence-based drug prevention in England". *Drugs:education, prevention and policy* 13(1) pp17-22

understanding of best practice when they are published. Unfortunately the project's acknowledged limitations in terms of sample size, linked to resource constraints (an issue we return to later), mean that it is unlikely to have the power to identify impact on drug use. As with the majority of studies, the findings will relate to education at the secondary school level and there is no strong evidence to support (or oppose) expanding on current education on illicit drug use for primary school children.

There may be many reasons as to why substance misuse education has not delivered the results hoped for, particularly with respect to changes in young people's drug use. Amongst these are the significant amounts of curriculum time needed to be devoted to such initiatives.[14] With so many demands and competing priorities for teacher and pupil time it is not surprising that substance misuse education is often curtailed. The limited impact of substance misuse education is therefore perhaps understandable particularly when stacked against many other formidable cultural, social and economic influences.

None of this should be interpreted as suggesting substance misuse programmes in schools should not be carried out nor their quality improved. In the 21st century we believe that young people must have access to information about various substances and the opportunity to explore the issues surrounding their use as well as to develop the skills and attitudes that promote successful outcomes more generally.

As with school-based programmes, there is only limited evidence for effectiveness of prevention programmes delivered in non-school settings[15] and most reported evaluations have methodological problems, in particular high levels of loss to follow-up. The best evidence is for family interventions, such as the Strengthening Families Programme, and for motivational interviewing.

As stated in the drug strategy consultation paper, there is strong evidence that some groups of young people are at considerably increased risk of drug use and that early childhood disadvantage is associated with a range of adverse outcomes, including drug use. In addition to good evidence on risk factors for drug use there is a large body of literature on factors that promote resilience which may be enhanced through appropriate interventions[16]. International evidence shows targeted interventions with vulnerable young people experiencing 'risk factors' can have a positive impact on behaviour.[17] Such programmes typically target at-risk youth (recognising that this is not a homogenous group both in terms of the risk factors they are experiencing and other cultural differences) and their families with generic interventions aimed at

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[14] Ofsted (2007) *Time for change? Personal, social and health education.* London: Ofsted

[15] Gates S, McCambridge J, Smith LA, Foxcroft DR. (2006) Interventions for prevention of drug use by young people delivered in non-school settings. *Cochrane Database of Systematic Reviews* 2006, Issue 1. Art. No.: CD005030. DOI: 10.1002/14651858.CD005030.pub2.

[16] Frisher M, Crome I, Macleod J, Bloor R, Hickman M (2007) Predictive factors for illicit drug use among young people: a literature review. Home Office Online report 05/07. London: Home Office

Dillon L, Chivite-Matthews N, Grewal I, Brown R, Webster S, Weddell E, Brown G, Smith N (2007) *Risk, protective factors and resilience to drug use: identifying resilient young people and learning from their experiences.* Home Office Online report 05/07. London: Home Office

Velleman R & Templeton L (2006) "Reaching Out – Promoting Resilience in the children of substance misusers" in Harbin F & Murphy M (eds) *Secret Lives: growing with substance Working with children & young people affected by familial substance misuse.*Chapter 2 pp2-27 Lyme Regis: Russell House.

[17] Edmunds K, Sumnall H, McVeigh J, Bellis, M (2005) *Drug prevention among vulnerable young people.* Liverpool: NCCDP;

Lloyd C (1998) "Risk factors for problem drug use" *Drugs: education , prevention & policy* 5(3),

preventing a range of negative outcomes, not solely drug use, through the promotion of protective factors and resilience. Currently there is some evidence that such broad programmes may be effective, but few methodologically robust evaluations that show the extent to which they have a specific impact in preventing drug use or misuse. For instance, the Positive Futures programme shows promising evidence of successfully engaging with at-risk young people[18] but no outcome evaluation has been carried out, so there is no evidence of impact on drug use. It is possible that identifying at-risk young people may have unintended negative consequences, particularly if the intervention that follows is inadequate or inappropriate. It is therefore imperative that any programmes introduced as part of the new strategy are properly evaluated, including both process and outcome measures.

Finally, as the consultation document recognises, drug help and treatment services for young people are underdeveloped. There is a need to better understand what works in the management of young people with drug and alcohol problems. There are indications that a family approach is important, and more work needs to be done to understand the positive and negative influences that the family can have on both resilience and recovery. We know little about how the family can contribute towards positive outcomes, and what this often neglected resource equates to in economic terms.

3.2 Public information campaigns

Key point

- The evidence for effectiveness of public information campaigns in preventing drug use is extremely limited and there is potential for negative effects, for example by making drug use seem more widespread, and hence more acceptable, than it actually is. There is better evidence for targeted campaigns aimed at specific high risk populations with information on reducing those risks, often in conjunction with support services, but if such programmes are included in the drug strategy they will need to be properly evaluated.

As with drug education, there is very little evidence that public information campaigns can lead to reductions in drug use prevalence. International examples are very scarce indeed, partly because campaigns are not sufficiently evaluated, and partly because when they are, no such impact is found. For example, a $1.2bn youth anti-drug media campaign in the USA found no beneficial impact on actual drug use. The US Government Accountability Office (GAO) in fact recommended funding be cut and highlighted the potential negative impact of a large-scale campaign if it makes drug use seem more commonplace than it is.[19]

[18] Crabbe T et al (2006) *Knowing the Score: Positive Futures Case Study Research: Final Report* London: Crime Concern

[19] Government Accountability Office (2006) *ONDCP media campaign: Contractor's national evaluation did not find that the youth anti-drug media campaign was effective in reducing youth drug use.* GAO-06-818. Washington DC: General Accountability Office

There is stronger evidence that communication can increase take-up of services. The FRANK helpline and website signpost treatment and support services[20] which might have increased the number of appropriate cases receiving help. However, evidence for this has not been provided and the campaign aim should be clearly stated and evaluated accordingly.

Public information campaigns have been shown to have a positive impact when targeted at specific high risk populations with information on reducing those risks, often in conjunction with support services (for example through various HIV/AIDS campaigns).[21] Given the high numbers of problematic drug users still not in regular contact with services and the corresponding long-term health and social impacts, limited resources for public information campaigns would probably be most usefully directed towards these groups.

Finally, as with drug education, this is not to argue that parents and young people should not be given access to information and advice about drugs. Communications can address ignorance or myth within specific communities or the wider population and this can be valued as an outcome in its own right, even if it is not matched by behaviour change. However, it is important to recognise the potential for unintended negative consequences – particularly when considering extending these programmes, for example to younger children.

3.3 Drug treatment, social care and support for drug users in re-establishing their lives

Key Points

- The evidence for the effectiveness of a range of treatments in reducing drug use and drug-related harms is good. The greatest return on investment is likely to be found by widening the availability, quality and choice of drug treatment and harm reduction programmes so that more drug-dependent users are benefiting from services. To ensure maximum effectiveness more attention needs to be given to understanding how to deliver tailored packages and ensure that treatment is appropriate to individual need.
- This must be coupled with a marked improvement in understanding the requirements for recovery, focusing on 'wrap-around' provision to support community reintegration. We believe the areas of housing and employment offer a major opportunity for a step-change in outcomes for the next strategy. In particular we advocate a major initiative to examine and develop intermediate labour market options as a key element of the new drugs strategy.
- Promising innovations, particularly in the harm reduction field (e.g. heroin-assisted treatment, drug consumption rooms, new treatments for cocaine and crack users), should be trialled and, if successful, adopted in this country.

[20] Home Office (2007) *FRANK review 2004-2006* London: Home Office http://drugs.homeoffice.gov.uk/publication-search/frank/FRANKReview2004-2006?view=Binary Accessed 16/10/07

[21] Lamptey PR, Price JE (1998) "Social marketing sexually transmitted disease and HIV prevention: A consumer-centered approach to achieving behaviour change". *AIDS* 12 (Suppl 2): S1–S9.

The area of treatment and rehabilitation is the one where the domestic and international evidence base on effectiveness is strongest.[22] The challenge is that large numbers of users remain untreated (recent estimates[23] would suggest that around 150,000 problem opiate and/or crack users are not currently accessing treatment services), there is a high rate of relapse, treatment effectiveness is variable and there is a continual influx of new users.[24] There is little doubt that further resources to improve and extend services to those not currently receiving help would bring additional benefits to individuals and the wider community.

The evidence base unambiguously demonstrates that a variety of treatment interventions can have good outcomes in terms of health improvements and reductions in crime. [25] A range of harm reduction initiatives have succeeded in delivering positive outcomes within the UK, and based on this we support the trialling of new innovative approaches such as heroin assisted treatment (for those not benefiting from other substitution programmes) and drug consumption rooms (to help reduce community nuisance and the long term and costly impact of blood-borne viruses and overdoses).[26] With clinical trials of the former underway in England it is essential that the government keeps an open mind on such interventions and actively supports carefully controlled pilot programmes to evaluate its contribution in the UK setting.

As the government has recognised in its consultation paper there needs to be a balance between maintenance and abstinence based treatment to maximise outcomes. Whilst the debate in this area has successfully raised concerns about long-term maintenance, it is important to avoid vilifying effective harm reduction measures. Abstinence may ultimately be a desired outcome but it is not necessarily the case that abstinence-based treatment is the only or best way to achieve it. Indeed, an underdeveloped area which is likely to be critical for treatment and recovery outcomes is 'wraparound' social re-integration routes which tackle wider needs such as mental health problems, employment and accommodation. There is some evidence of the positive impact that programmes designed to help drug users into employment can bring.[27] Unfortunately we have only a few examples

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[22] Gossop M, (2006) *Treating drug misuse problems: evidence of effectiveness* London: NTA;
NICE (2007). '*Methadone and buprenorphine for the management of opioid dependence.'* NICE technology appraisal 114. London: National Institute for Health and Clinical Excellence;
NICE (2007). '*Naltrexone for the management of opioid dependence*.' NICE technology appraisal 115. London: National Institute for Health and Clinical Excellence.
NICE (2007). *Opiate detoxification for drug misuse*. Clinical Guideline 52. London: National Institute for Health and Clinical Excellence.
NICE (2007). *Psychosocial management of drug misuse*. Clinical Guideline 51. London: National Institute for Health and Clinical Excellence.
Amato, L., Davoli, M., Perucci, C.A., Ferri, M., Faggiano, F. and Mattick, R.P. (2005). 'An overview of systematic reviews of the effectiveness of opiate maintenance therapies: Available evidence to inform clinical practice and research.' *Journal of Substance Abuse Treatment*, 28(4), 321–329.

[23] Hay G, Gannon M, Macdougall J, Millar T, Eastwood C, McKeganey N (2006) 'Local and national estimates of the prevalence of opiate use and/or crack cocaine use (2004/05)' in singleton N, Murray R and Tinsley L (eds) *Measuring different aspects of problem drug use: Methodological developments.* London: Home Office

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

[25] Gossop M (2006) op. cit.

[26] Joseph Rowntree Foundation (JRF) (2006) *Report of the Independent Working Group on drug consumption rooms* York: JRF;; Stimson GV & Metrebian M. (2003) *Prescribing heroin: what is the evidence?* York: JRF

[27] Effective Interventions Unit (2001) *Moving On: Education, training and employment for recovering drug users*. Edinburgh: EIU

here in the UK although we await the results of the evaluation of the Progress2Work initiative. We advocate a major initiative to examine and develop intermediate labour market (ILM) options as a key element of the new drugs strategy. Such initiatives can be a vital bridge to employment, through temporary work placements, training and support. However, ILM programmes must also recognise and address the additional barriers to work faced by many recovering drug users, particularly the stigma of previous criminal convictions.

Similarly access to accommodation has been consistently shown to be a significant contributor to enhancing the impact of offender rehabilitation programmes[28] and it is likely that has a similar impact on the long-term outcomes of drug treatment programmes. Anecdotal evidence seems to suggest that the Supporting People programme (to help vulnerable groups secure accommodation) has not been used by local commissioners and treatment providers to the extent one might expect, given local needs profiles. We are aware of the reported impacts of initiatives such as "floating-tenancy" support and rent-deposit schemes. But their application and coverage, as with employment initiatives, seems patchy and dependent on dedicated individuals rather than any systematic national and local strategy. This takes us to a more general point about the treatment and rehabilitation delivery system.

There is no doubt the UK, in comparison with many countries, has a substantial and well-respected treatment system. In England we have the NTA providing important help to local commissioners, providers and practitioners. There are improving information systems aimed at focusing on treatment outcomes and a growing body of knowledge and research. There has been substantial new investment and more people than ever in treatment. And yet there are recurring stories of how the implementation and delivery system lets down those in need. Good treatment policies are undermined by the day-to-day details. There is therefore a need to focus more research and analysis in the treatment field on what types of treatment work best for whom, how care packages can be effectively delivered, why treatment journeys and care pathways breakdown and related issues. This is matter of considerable concern and we return to this later in a broader context.

Families of drug users, as is the case in other fields such as mental health, are frequently an unpaid and unconsidered resource providing economic and other forms of support to their drug using relatives. The consultation paper recognises this in a limited way in the brief section on "Users and carers". The needs of families of drug users (adults and children), both as requiring help in their own right, and as major partners in the treatment and help of those who have problems with their own drug use is a neglected area both in terms of knowledge and provision. Family-focused interventions may work with family members to promote entry and engagement of drug users with the treatment system, or require joint involvement of family members and substance misusing relatives in the treatment of the latter, or respond to the needs of family members in their own right. There is a need for a review of current provision in these areas and for robust evaluations of the effectiveness of these types of interventions[29].

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[28] Home Office (2004) *Reducing re-offending: a national action plan.* London: Home Office; Lewis S, et al (2003) *The resettlement of short term prisoners: an evaluation of seven pathfinders*. HO Occasional Paper No. 83. London Home Office

[29] Copello AG, Velleman RDB & Templeton LJ (2005) "Family interventions in the treatment of alcohol and drug problems" *Drug and Alcohol Review*, 25, 369-385

3.4 Protecting the community from drug-related crime and reoffending

Key points

- Proven community-based interventions should be trialled in prison settings with the aim of developing a similar level of service if results are positive. Given that prisons have such a high number of problematic drug users, treatment, harm minimisation and throughcare and aftercare provision are just as vital here as in the wider community.
- International evidence suggests that drug courts can be effective. If the current UK pilot schemes are successful a phased roll-out might provide significant benefits.

We have commissioned leading experts from the Institute for Criminal Policy Research (ICPR) to review the evidence base for interventions to achieve crime reduction and health improvement outcomes.[30] Much of this parallels and overlaps with the findings from drug treatment more generally. The evidence review notes the paucity of independent evaluations and research of many of the intervention programmes, particularly, but not only, those administered in the prison setting. There is also a need to evaluate and monitor the Drug Interventions Programme (DIP) in terms of value for money following its extensive roll-out, as investment costs are heavy and one evaluation across 20 sites found that cash savings were offset by the costs of the service.

However, it is clear that some interventions can be effective in reducing illicit drug use and offending behaviours with some drug-dependent offenders. While coerced treatment is not a panacea for reducing crime it can have a positive impact but a degree of caution is necessary in the expectations for the realisation of crime reduction benefits through treatment.[31]

The ICPR research review endorses the effectiveness of substitute treatments, therapeutic communities and interventions modelled on the drug courts approach. It finds little evidence for the effectiveness or value for money of drug testing nor for (solely) intensive forms of supervision. They also indicate that, as with the more general drug treatment population, the adequacy of aftercare provision and the limited use of innovative strategies to promote compliance and behaviour change undermine outcomes for this group. This leads us to make three generalised conclusions about interventions through the criminal justice system and where most impact could be made to outcomes over the next few years.

The first is building on the drug courts model whose pilot evaluation is due shortly. If shown to be effective in the UK, this has the potential for not only improving individual outcomes but also as a by-product, relieving some of the pressure on

[30] McSweeney T et al. (in preparation) *The Treatment & Supervision of drug-dependent offenders*. London: UKDPC

[31] Stevens A (2007) *Weighing Up Crime: The estimation of criminal drug-related harm*. Paper presented to the Conference of the International Society for the Study of Drug Policy, Oslo, 22-23 March 2007. http://www.issdp.org/conferences/oslo2007/issdp%20stevens%20paper.pdf accessed 18/10/07

prison places. However, not all drug court evaluations have been positive[32]. Therefore it is crucial that any roll-out is phased and includes research to ensure that the components of effective practice are identified, so that good outcomes continue to be achieved within a wider programme. Sufficient treatment capacity should be an integral component of any new court-initiated programme. It is likely to be a false economy if new drug court initiatives displace existing treatment provision that is being accessed voluntarily.

The second area where evidence would support improved outcomes is in prison throughcare and aftercare provision. Prison-based drug programmes are obviously under considerable stress given prison numbers, resource constraints and competing priorities. As is the case outside prison, detoxification and treatment interventions are too frequently undermined through ineffectual or non-existent throughcare and aftercare. The introduction of the Integrated Drug Treatment System (IDTS) in prisons provides a real opportunity to understand and improve continuity of treatment in custody and on release into the community. However more attention must also be given to the limited capacity of the criminal justice system and drug treatment services to tackle wider social and environmental factors that can facilitate and perpetuate problematic patterns of drug use and offending (e.g. housing and employment needs).

Finally, given high prison numbers and the extent of prisoners drug use we are concerned that despite strenuous efforts by the authorities to reduce the supply of drugs in prisons, high-risk drug use reportedly continues in some places[33] (in a parallel vein we are also concerned about anecdotal reports of drug use in some mental health establishments). Prisoners are a high health risk population and there is international evidence that tightly controlled harm reduction programmes such as methadone prescribing, needle exchange schemes and condom supply could have long term benefits.[34] We recommend that if an intervention has been shown to be effective in the community then it should be extended to the prison population.

3.5 Enforcement and supply activity

Key points

- There is no evidence that enforcement activity alone has any significant impact on street-level drug market stability.
- Given that enforcement activity accounts for the largest portion of spend within the drug strategy, a major programme of research and a return on investment analysis should be a priority in this area.

Despite some indications of success, such as increased drug seizures and prosecutions, enforcement activity alone appears to have little impact on street-level drug market stability (in terms of price and availability), particularly in the medium and long term. As the government recognises, price and enforcement activities are rarely linked although there are some rare (international) examples.

[32] Perry A, Coulton S, Glanville J, Godfrey C, Lunn J, McDougall C, Neale Z. Interventions for drug-using offenders in the courts, secure establishments and the community.. *Cochrane Database of Systematic Reviews* 2006, Issue 3. Art. No.: CD005193. DOI: 10.1002/14651858.CD005193.pub2

[33] Singleton et al (2005) *The impact and effectiveness of Mandatory Drugs Tests in prison*. Findings 223 London: Home Office.

[34] Dolan K, Khoei EM, Brentari C, Stevens A. (2007) *Prisons and drugs: A global review of incarceration, drug use and drug services* The Beckley Foundation Drug Policy Programme Report 12

There may be opportunity for some tactical successes, for example by focusing on organised criminal networks involved in wider criminal activity such as people trafficking, or by disrupting new drug markets before they can establish themselves. Locally driven community enforcement interventions can also help to reduce the visibility of drug markets and associated harms, particularly if they are coordinated with other agencies such as treatment and housing services[35].

Given that enforcement activity accounts for the largest portion of spend, a return on investment analysis should be a priority in this area. It should also be noted that a vigorous approach to enforcing drug laws may have unintended adverse consequences such as heightened community tensions (black people are more likely to be stopped and searched, arrested and imprisoned for drug-related offences than white people), the increased criminalisation of young people and the diversion of police resources, that may outweigh any benefits of such a policy. We recommend that this issue is considered fully and objectively.

For these issues to be considered and interventions in these areas to be monitored and evaluated, a major research programme is required that includes the development of an improved understanding of drug markets, the harms associated with them and how these may be reduced and the effects and indicators of disruption.

[35] Mazerolle L, Soole D & Rombouts S (2005) *Drug Law enforcement: The evidence.* Drug Policy Modelling Project Monograph 05. Fitzroy, Victoria: Turning Point Alcohol & Drug Centre

4 Structures & Systems

One of the most striking omissions from the drug strategy consultation document is any real discussion or analysis about the structures and systems underpinning policy formulation, implementation and delivery. These are critical if the strategy is to be effectively delivered. There are three areas we think would merit systemic review and development over the coming few years:

4.1 Knowledge development and evaluation

Key points

- The new drug strategy should have a dedicated 'pillar' that addresses the critically underdeveloped knowledge base. This should include a framework for regular and independent evaluation of the drug strategy and its delivery components, and the commissioning of research. Consideration should be given to the establishment of an independent body or group charged with leading this work. Key components of such a framework are described in Annex B.
- New structures and systems are required to allow for transparent and independent evaluations, coordinated research programmes and better knowledge transfer, and must be funded appropriately. Consideration should be given to the establishment of an independent body or group charged with leading this work.
- Priority knowledge gaps have been identified (Annex A). These cover basic research and analysis to improve our understanding of the causes and developmental pathways of problematic drug use as well as evaluation and monitoring.

Given the vital importance of knowledge and the serious deficiencies in this area, it is clearly a cause for concern that there is nothing explicit in the consultation document relating to the building of the knowledge base. We therefore recommend that this is identified as a specific strand within the new drug strategy, matched with appropriate targets and appropriate (significantly increased) and dedicated resources.

A coherent and coordinated programme of research and analysis should encompass:

- basic research in to the extent, nature and causes of drug problems;
- evaluation of the effectiveness of interventions and programme delivery and factors that impact on this; and
- monitoring and evaluation of the strategy as a whole.

When there is no clear understanding of the nature of the drug problem and its causes and what interventions work to solve drug problems and how, it is difficult to see how an effective policy can be developed. The 1998 strategy document identified and prioritised key knowledge gaps (many of which remain) that were essential for the development and evaluation of the drug strategy. In partnership with representatives from the academic community we have compiled a similar list for 2008 onwards.
The top ten priority areas for research and analysis we have identified are (see Annex A for more detail):

- Basic longitudinal research and analysis to understand the causes and developmental pathways (relating to initiation and desistance) of problematic drug use
- Use of statistical modelling to provide predicted trends in problem drug use and identification of the likely impact of different interventions.
- Evaluations of targeted generic and drug prevention initiatives
- Understanding the needs of diverse communities.
- Evaluation of interventions in prisons and ways of maintaining services on transfer and release.
- Interventions involving families of drug users within the treatment system.
- Understanding how to deliver effective care packages that promote recovery.
- Evidence of effectiveness of new or less well-evaluated treatment and harm reduction options
- Long-term follow-up of drug using offenders
- Drug supply and enforcement: impact, effectiveness and value for money.

The value of research and analysis for strengthening a strategy and its delivery components can be shown by studies such as NTORS (the National Treatment Outcomes Research Study). This project has been very influential in supporting the emphasis on the Drug Interventions Programme and the expansion of treatment services under the current strategy. There are projects already underway in some of the areas identified but there is a need to build a more coherent research programme.

New PSA targets were published in October 2007.[36] Given the pressure to reduce the number of PSA targets, the indicators identified for measuring progress of the future drug strategy have inevitably been restricted. Therefore, it is important to recognise that these PSA targets are not sufficient for measuring the overall success of the drug strategy. For instance, there are many other outcome measures which are important, such as the level of drug-related deaths and blood-borne viruses, street-level drug prices etc. There will also be a range of other input and output measures which will enable policy makers to assess progress in implementation of the strategy. A distinction can be made between performance monitoring, which would be a more frequent (e.g. annual) and potentially in-house monitor of whether the strategy is being delivered as specified (mainly through inputs and output measures) and evaluation, which would be a less frequent (e.g. three-yearly) and should include independent analysis of outcome measures to determine whether the objectives of the strategy have been met. Further consideration of a framework for monitoring and evaluating the drug strategy is described in Annex B.

A recent conference under the Portuguese Presidency of the European Union focused on the evaluation of drug policies and programmes. A number of examples of the use of interim and final evaluations of drug strategies were presented (from Australia, Spain, Portugal, Hungary, Poland and the EU) and the way in which they had been used to inform the further development of strategies described. The

[36] Available at: http://www.hm-treasury.gov.uk/pbr_csr/psa/pbr_csr07_psaindex.cfm accessed 18/10/07

conclusions of the conference have been published[37] and key themes to emerge were:

- The importance of independent external evaluation, although in some cases an internal evaluation was also conducted alongside an external evaluation which had some benefits;
- The need for the proposals for evaluation and monitoring to be built in from the start of the strategy (to ensure credibility and the availability of appropriate data sources)
- The importance of a commitment to implementation of changes identified as a result of the evaluation; and
- The need for investigation of both systems and processes as well as outcomes within evaluations.

If a proper assessment of progress and achievements for the new drug strategy is to be made it is crucial that clear, realistic and measurable objectives and a full set of input, output and outcome measures are identified and clearly communicated to all stakeholders from the outset. In addition, if the outcomes of any evaluation are to be accepted the system needs to also include:

i. A clear time frame, with dates at which progress will be reviewed;

ii. Independent mechanisms established for evaluating & reporting on progress and to ensure they are conducted to highest professional standards;

iii. Results of reviews need to be communicated to professionals & the general public effectively, & open debate promoted; and

iv. Mechanisms so that the strategy can be reviewed and revised if necessary in the light of evidence of effectiveness.

Adoption of this approach, in particular, the need for independent review and open communication of the results, might help avoid some of the problems surrounding the evaluation of the current strategy. The way in which monitoring and evaluation will be tied-in to policy development reviews and the resource allocation process (i.e. the Comprehensive Spending Review process) should be made explicit to avoid criticism of it being 'bolted-on' to the strategy.

There will need to be new systems of co-ordination and delivery of research funding through an independent body. There are a number of models within the UK and internationally that can be considered, for example:

- A combined funding programme through the UK research councils, as has already happened for infectious disease research. The Drug Addiction Research Initiative in the 1980s is an example of this approach, and the joint funding programmes are undertaken in other topic areas.
- The Scottish Executive has funded a new Criminal Justice Research Centre bringing together departments in several universities to develop a coherent research programme in the criminology field.

[37] See http://www.lisbondrugsconference.com.pt/site.asp?IDIOMA=2 accessed 18/10/07

- A new arms-length research body might be set up to coordinate and commission research, provide analysis and develop and maintain a knowledge bank, with a remit that potentially extends beyond the drugs field.
- Consideration should be given to different international models. For example, the Canadian Centre on Substance Misuse "… has a legislated mandate to provide national leadership and evidence-informed analysis and advice…" and plays a co-ordinating role in the development of an overall research strategy as well as in knowledge transfer[38]. The Australian National Drug Strategy is supported by three dedicated National Research Centres and has a history of regular independent reviews of the strategy that are put out to tender.
- Only recently, the US Substance Abuse & Mental Health Services Administration (SAMSHA) announced the award of a $39m programme over five years to fund 15 Addiction Technology Transfer Centres.[39]

Finally, but by no means least, knowledge development in the drugs field has been historically under-resourced and this must be urgently addressed. We are perplexed as to where the budget identified for research in the 2000 Comprehensive Spending Review (CSR) went to. From the best calculations we can make (from available and inadequate UK governmental data), the UK spends less than 1% of the total drugs strategy resources on research. Compare this, for example, with the federal US treatment & prevention budget which alone devotes over 20% to research.[40]

4.2 Leadership, coordination and local delivery

Key points

- A review of the most appropriate place for leadership of the current strategy should be undertaken with reference to alternative international models.
- The potential negative impact of variation in delivery of programmes on their effectiveness, coupled with the increasing devolvement of responsibilities to local levels, makes it important that attention is paid to the effectiveness of approaches to commissioning and delivery. Therefore we recommend that an urgent review of systems and structures for delivery and co-ordination at national and regional/local levels is undertaken.

Strong national leadership is required to sustain strategy development and implementation. Drug misuse, like many other contemporary social problems, is one that cuts across much of the government administrative machinery. A perennial challenge is where best to locate ministerial leadership for coordination. Some commentators have argued that drug policy should be seen as principally a public health responsibility[41]. Others have proposed local government leadership, especially

[38] See http://www.ccsa.ca/CCSA/EN/About_CCSA/OverviewAbout CCSA.htm accessed 17/10/07
[39] SAMSHA Press Release 14 September 2007 http://www.samhsa.gov/newsroom/advisories/070914awarded3414.aspx accessed 18/10/07
[40] US Office of National Drug Control (2006) National Drug Control Strategy FY 2007 Budget Summary http://www.whitehousedrugpolicy.gov/publications/policy/07budget/partii_funding_tables.pdf accessed 18/10/07
[41] Drugs & Health Alliance (2007) Consensus Statement. http://www.drugshealthalliance.net/ accessed 18/10/07

given developments like local strategic partnerships and local area agreements[42]. The European Centre for Drugs and Drug Addiction (EMCDDA), the EU's formal inter-governmental body on drugs, has examined the different leadership and coordination models for governmental drug strategies[43]. As of 2003 it is significant to note that of the then fifteen EU member states, ten located responsibility for coordination in the health or social affairs ministry. Only in Spain and the UK was leadership located in the justice/ interior ministry. There is a perennial debate about whether the spending and delivery ministries or a central/prime minister's office should provide the coordinating leadership. We remain ambivalent about this but urge a full review be undertaken, especially given the maturing constitutional arrangements for Scotland, Wales and Northern Ireland.

A review must also cover the relationship between central government and local public services with the aim of improving local partnership machinery to support the implementation of national strategy especially the commissioning of local interventions. The Scottish Government recently published a review of Drug & Alcohol Action Teams but since a review in 1997 of Drug Action Teams in England[44] there has been no systematic evaluation of the local partnership machinery apart from a narrow internal review by the Home Office looking at crime and disorder partnerships and allied structures. The Royal Society of Arts Commission report identified many of the challenges facing local drug partnerships and made a series of recommendations designed to enhance their status and operation.[45] Of particular concern to us in the light of various anecdotal reports and those from the various inspection and regulatory bodies, is the mechanism available for colaaboration and resolving the many implementation and delivery problems which seem to continue, and for sharing best practice. This extends across all arms of the strategy and all bodies and not simply drug treatment. In particular it focuses on multi-agency working to address wider needs such as accommodation, mental health and employment. If the step change in the drug strategy desired is to be achieved, attention has to begin to focus on the myriad of system and delivery level issues which frustrate planners, commissioners and deliverers. This will become ever more important as increasing local devolution assumes local solutions.

4.3 Classification review

Key points

- Given the recent history of the classification of cannabis, which illustrates the general confusion surrounding the purpose and function of the classification system, we consider that a review of the entire basis of the classification system and the process for making decisions on drug classifications, including the role of politicians, is required.

[42] RSA (2007) *Drugs – facing facts: The report of the RSA Commission on Illegal Drugs, Communities and Public Policy* London: RSA.
[43] EMCDDA (2002) *Strategies & coordination in the field of drugs in the European Union.* Lisbon:EMCDDA
[44] Duke K & MacGregor S. (1997) *Tackling drugs locally : the implementation of Drug Action Teams in England* . London: HMSO,
[45] RSA (2007) *Drugs – facing facts: The report of the RSA Commission on Illegal Drugs, Communities and Public Policy* London: RSA

The government has asked the Advisory Council on the Misuse of Drugs (ACMD) to review whether cannabis should be reclassified from a Class C to a Class B drug, and asks those responding to the consultation paper: 'Do you think that cannabis should be reclassified and, if so, why?'. We believe this question is too narrow and so risks missing the point. It also raises issues about the process for deciding how to classify drugs, and for what purpose.

Instead of tinkering with one aspect of the classification system we believe there should be a review of the system as a whole, which has been described by some as 'not fit for purpose'.[46] This is something which former Home Secretary Charles Clarke announced in January 2006 but has since been shelved without any clear justification.

The review should examine the classification system's role in deterring drug use and guiding both policing and sentencing policy. There is no evidence that the classification of a particular drug deters use. Classification does, however, provide a guide to the police and sentencers and it may be appropriate to look at the interface between the ACMD and the Sentencing Guidelines Council (SGC).

A review should also look more generally at the process for making decisions on drug classifications which might include the wider role of the ACMD. This follows both the House of Commons Science and Technology report and the Lancet paper which questioned the way drugs are currently classified.[47]

We do not believe the credibility of the current system or clarity of message has been enhanced when, in just the space of seven years, five Home Secretaries have sought one way or another to address the classification of cannabis. Good policy making and implementation has been overshadowed by 'politicking', to the detriment of the government's wider drug strategy. Much of the confusion amongst the public and politicians stems from misunderstandings about the classification system.

We think the opportunity should be taken to review the role of politicians in making decisions about the classification of controlled drugs. For example, to explore whether there are models which place decision-making outside of direct ministerial control and which could embrace more detailed examination of classification and appraisal systems.

UKDPC October 2007

[46] House of Commons Science and Technology Committee (2006) Drug classification: Making a hash of it?, London: The Stationery Office
[47] Nutt & Blakemore

Appendix A: Key research/analysis needs

In consultation with the academic and drug research community the UKDPC has reviewed the current evidence underpinning the proposals for the next strategy and identified key gaps that require addressing for the future development of the strategy.

Although some gaps in the evidence base will exist in any strategy, we have already stressed the severely under-developed state of evidence in the UK and especially England. We have identified the top ten gaps considered most important for advancing the future drug strategy. Some are cross-cutting in nature while others relate to specific themes within the consultation paper. It is notable that many of the gaps identified here were also identified as priority areas for additional research in the 1998 strategy paper, highlighting the need for greater investment in the quantity, leadership and co-ordination of research under the new strategy.

1. Longitudinal research and analysis to understand the causes and developmental pathways (relating to initiation and desistance) of problematic drug use.

There is a need for substantial investment in longitudinal research investigating causal pathways for drug use and problem drug use - delineating how individual risks and protective factors inter-relate within causal pathways for the onset of drug use, and the progression to and desistance from problem drug use. This research would need to cover the period from early adolescence to at least the age of 21 years and might include new studies (possibly targeting high risk groups), support to existing cohort studies to cover drug use, and studies of cohorts of problematic users through follow-up or data linkage.

Such research would look at the underlying causes of different drug-use 'journeys' – for instance why some people progress from occasional recreational use to heavy problematic use whilst others don't and what factors are associated with desistance from problematic use. Such an understanding would help the identification of key points for intervention which may then be targeted by drug policy. Although such studies are relatively expensive and can take time to deliver results, the information is fundamental to the design and implementation of an effective strategy.

Of particular current interest/concern would be cannabis use pathways, including developing knowledge about usage patterns and how they develop and the impact of different types of cannabis on how people use the drug.

2. Use of statistical modelling to predict trends in problem drug use and identify the likely impact of different interventions.

Statistical modelling has the potential to provide a range of essential information for policy development such as predicted trends in incidence and identification of the likely impact of different interventions[48]. The range of data available from new data systems such as NDTMS, the Drug Intervention Record as well as

[48] Office of Science & Technology (2005) *Foresight Drugs Futures 2025? Modelling drug use* London:DTI; See also a range of publications from The Drug Policy Modelling Project, Turning Point Alcohol & Drug Centre http://www.turningpoint.org.au/research/dpmp_monographs/res_dm_monographs.htm accessed 18/10/07

research projects and surveys such as the Drug Treatment Outcomes Research Study, the British Crime Survey, the Arrestee Survey and ongoing cohort studies means that we have more basic data available to provide the basis for such models but robust research is needed to bring these disparate and sometimes conflicting pieces of information together.

The development of statistical models that link various prevalence estimates with data on outcomes would improve our understanding of the likely impact of different policy options and the prediction of outcomes from interventions, which would also greatly improve the setting or realistic targets. The lack of this knowledge is currently a key blockage in effective policy formation.

3. Evaluations of targeted generic and drug prevention initiatives

The strategy suggests a number of new approaches to targeted drug prevention and an expansion of some, such as Positive Futures, which have not been subject to robust evaluations. It cannot be assumed that processes that appear intuitively appealing will result in the positive outcomes intended or be free from negative outcomes. It is therefore essential that all these approaches have a significant programme of evaluative research built in to them, particularly as the information systems in this area are very underdeveloped. Some key areas for evaluation if taken forward are:

- targeted youth support and the impact of identifying at-risk young people for targeted intervention
- extended schools
- family-based programmes
- the expansion of drug education and public information campaigns to cover primary school age children.

For new approaches, early process evaluations should be incorporated to help the development of interventions with a clearly specified underlying model/rationale, which can then be replicated and tested. A co-ordinated programme of outcome evaluations, incorporating an assessment of drug use, can then show whether the interventions have any impact on drug use, and which approaches work best and for whom. These also have to be supported with other knowledge development and transfer resources.

4. Understanding the needs of diverse communities.

There is a need for more consideration of diversity issues in the drugs field, including consideration of patterns of use, service need, access and provision (including information and prevention services) by ethnic minorities and the new communities, gender and disability. These issues need to be considered in all new programme development and research but in particular there is a pressing need for:

- a review of the information currently available on patterns of drug use and service provision by ethnic minorities and the new communities
- consideration of the implications for services and information systems of current patterns of immigration (for example, whether information systems allow the identification of immigrants from Eastern Europe)

- a comparative study of policing, prosecution and sentencing decision making for different communities, where drugs have been the sole or compounding factor.

5. Evaluation of interventions in prisons and ways of maintaining services on transfer and release.

The large proportion of prisoners who are drug dependent make prison interventions very important and there has been a marked improvement in provision over recent years. However, the challenges of intervening effectively and for providing continuity of care to increase the probability of successful outcomes are great. Apparently simple issues, such as the release of many prisoners on a Friday afternoon when many community services close for the weekend, may have an impact on continuity of care on release. Evaluations can help in the development of services, in identifying those that are most effective and in identifying factors that impede of enhance effective delivery.

The Integrated Drug Treatment System and the use of the Drug Interventions Record provide an opportunity for research and analysis of the extent of provision, where this breaks down, what factors are associated with positive and negative outcomes, which needs to be supplemented by research to provide more detail on specific areas. Some key issues to be addressed are:

- provision of continuity of care on release – risk factors for relapse and overdose and use of this knowledge in the development mechanisms for identifying and providing appropriate placement provision in different levels of structured treatment in the community.
- the effectiveness of treatment and harm reduction interventions provided in prisons, including 'drug free' wings.
- the impact of interventions against prison drug markets, especially value for money assessments of testing programmes.

6. Interventions involving families of drug users within the treatment system

The needs of families of drug users (adults and children), both as requiring help in their own right, and as major partners in the treatment and help of those who have problems with their own drug use is a neglected area both in terms of knowledge and provision. Particular areas to examine include:

- A review of current provision of family-focused interventions in the treatment of drug problems covering those that: work with family members to promote entry and engagement of drug users with the treatment system; include joint involvement of family members and substance misusing relatives in the treatment of the latter; and interventions responding to the needs of family members in their own right.
- Robust evaluation of such interventions, including assessment of cost-effectiveness.

7. Understanding how to deliver effective care packages for promoting recovery.

There is a recognition in the consultation document of the need for more attention to be paid to promoting recovery through the provision of a broader range of treatment services and the provision of so-called "wraparound" support

such as housing and employment. For this to occur priority must be given to obtaining evidence on:

- What services/packages of care work best for whom and what individual and service factors impact on outcomes and are responsible for the wide variations in outcomes between services (DTORS and analysis of data from TOP and the DIR may be able to provide some of this information);
- how effective "wraparound" support, particularly employment, can be delivered.

8. Evidence for the effectiveness of new or less well-evaluated treatment and harm reduction options

Although the effectiveness of treatment, particularly for opiate users, is an area where quite extensive evidence is available there is a need for a programme of research to develop a wider range of treatments and harm reduction options, to evaluate some that are being employed but have been less well evaluated, and to provide information on cost-effectiveness, for example:

- Interventions for stimulant users
- Treatment for young people (under 18) for whom the problem substance misuse is more likely to be around cannabis and alcohol use.
- Group work
- Contingency management
- Provision of injecting equipment and other paraphernalia
- New technologies, such as vaccines.

9. Long-term follow-up of drug using offenders to evaluate the impact of interventions

There is a need for long-term follow-up of drug using offenders to identify what the sustained impacts of treatment are on health outcomes and crime careers and what factors help or hinder successful treatment. In particular, an assessment is needed of which components of intervention programmes are most important for successful outcomes and most cost-effective. This information is essential to improve the effectiveness and value for money of the Drug Interventions Programme and prison treatment programmes.

10. Drug supply and enforcement: impact, effectiveness and value for money

This is perhaps one of the areas with the most pressing need for evidence. A major research effort is required to address the lack of knowledge in this area, including:

- Consideration of what a harm reduction approach to enforcement would encompass, both at local and national levels
- A clearer conceptualisation of market disruption and development of measures of this.

Annex B: A framework for the use and development of the knowledge base for the drug strategy

This annex expands on the points raised in the body of our response to the consultation.

Research and evaluation should be an integral part of a drug strategy, not only for providing evidence for success but also for planning, developing and amending the programme in the light of the evidence. Research and analysis can enhance a drug strategy in a number of ways:

(i) An understanding of the extent and nature of the problem is necessary for deciding on priorities, identifying possible interventions and monitoring the overall impact of what is done.

(ii) Evaluations can provide information on whether specific interventions have an effect but can also be useful in programme development, for example in providing information on which models of delivery work best or who they work best for.

(iii) Management information can be useful in showing the extent to which programmes are being implemented as planned.

(iv) Cost-effectiveness studies can indicate which programmes are providing the best return on investment.

(v) Information from a range of sources can be used to assess the success of the strategy, monitoring progress and indicating where it is being successful and where not to provide a basis for changes or greater action as necessary.

However, for the evidence to have credibility, the plans for developing the research base and in particular for monitoring the strategy need to be made explicit and agreed at the outset and perceived as independent. A number of reports have considered the requirements for monitoring and evaluating drug strategies[49]. These and examples from general guidance and areas that are similarly cross-cutting[50] alongside consultation with the academic community have been considered and adapted to produce a suggested framework for incorporating research and evaluation more effectively within the next drug strategy.

Basic principles

A programme for research and evaluation of a drug strategy should adhere to the following basic principles to maximise its value and ensure credibility:

- There should be clarity about the purpose of the research and how it will assist in the drug strategy delivery process;
- It must include: research to improve our basic understanding of drug use and problems; evaluations of new and existing programmes and their delivery; and monitoring and review of the overall progress of the strategy;

[49] For example: Trace M, Roberts M & Klein A (2004) *Assessing drug policy: principles & practice* The Beckley Foundation Drug Policy Programme Report 2; Roberts M, Bewley-Taylor D & Trace M (2006) *Monitoring Drug Policy Outcomes: The Measurement of Drug-related Harm.* The Beckley Foundation Drug Policy Programme Report 9.

[50] Cabinet Office (2003) Magenta Book Guidance Notes on Policy Evaluation http://www.policyhub.gov.uk/magenta_book/ accessed 18/10/07

- It should use a wide range of robust methods as appropriate to the aims of the research and use a wide range of indicators for evaluating progress;
- It should be coherent and co-ordinated so that linkages are made between different projects and a coherent picture developed;
- It should be independent;
- It must be conducted to appropriate professional standards to ensure results are robust;
- It needs to be published and explained to all stakeholders. This effectiveness of the programme will be enhanced if made explicit and is regarded as credible by all stakeholders - politicians, practitioners, users and the general public.

Components of a knowledge development strategy

A drug strategy should contain provision for research and analysis in the following areas.

1. Basic science

There is a need for more research to provide a better understanding of the extent and nature of drug use and problem drug use to assist in deciding on priorities, identifying possible interventions and monitoring the overall impact of what is done. More information on underlying causes and the pathways through escalating drug use are needed to provide the basic information for the statistical modelling to provide projections of trends in use and harms and of the likely impact of different interventions.

2. Evaluation of interventions and their delivery

In developing a new strategy the aim is to base it on the best evidence of what the problem is and what interventions are effective in tackling these. The weakness of the evidence base hampers this but does not mean that nothing should be done but rather that all actions should be accompanied by evaluation and monitoring of effects to allow refinement and development of interventions as the evidence base grows. There is a need for more robust scrutiny of the evidence and a more honest approach to what we do and do not know to allow changes to be made to the strategy if interventions are shown to be ineffective.

Evaluations can provide information on whether specific interventions have an effect but can also be useful in programme development, for example in providing information on which models of delivery work best and for whom.

There is a broad literature on policy and programme evaluation[51]. Different methodologies provide different types of information and the important point is the need for evaluations to use a range of methods appropriate to the particular requirements of the evaluation. Randomised controlled trials (RCTs) are the gold standard for showing whether or not a particular intervention is effective, but they are not always feasible and other approaches may be necessary instead of or in addition to RCTs.

[51] See for example: http://www.evaluation.org.uk/Pub_library/Evaluation%20Bibliography.htm accessed 18/10/07

However, for evaluations to be successful there are a number of conditions that need to be satisfied. The content of the intervention needs to be clear and settled (stability - in the early stages of the implementation of a programme there may be changes and a learning curve which reduces the apparent effectiveness of the intervention) and their needs to be policy / management recognition of the need for integrity and fidelity of programme implementation (eg in prisons priority given to allowing prisoners to complete programmes as far as possible).

Many of the interventions suggested in the new drug strategy have yet to be evaluated so a programme of evaluations should be an essential component of the new strategy.

3. Monitoring and evaluation of the overall drug strategy

The current drug strategy has had targets against which performance has been assessed and performance monitored. These have been part of the overall government performance monitoring framework and have had to conform to that approach. However, in many ways these could be perceived as having been bolted on to the strategy and have been the subject of much criticism (refs). There have been questions over their validity and relevance, as well as their independence.

Some performance targets will be set as part of the government's overall performance monitoring system. However, these are likely to be very limited in number and have to conform to quite rigid guidelines and so will be limited in the extent that they can provide information on the overall impact of the strategy and, more importantly, provide information on exactly which bits of the strategy or what other factors are having an impact. The illicit nature of drug use and markets makes measurement in this area difficult. This is compounded by poorly developed information systems relating to any of the areas in which actions are being taken. Therefore, reliance should not be placed on any single measure to monitor and assess performance, as no single measure is likely to be authoritative. Rather, multiple, appropriate measures should be monitored to build a picture of trends. An additional monitoring and evaluation framework is required to provide this broader information to inform the review and further development of the strategy.

A distinction could be made between performance monitoring, which it could be argued needs to focus on whether the strategy is being delivered as specified and consistently and hence might reasonably focus on inputs and outputs and be carried out with higher frequency, and evaluation, which would focus on whether the objectives of the strategy have been met, which would need to focus more on outcomes and take place less frequently. Both are necessary and would benefit from fitting into a coherent framework which would also need to link to the central PSA target monitoring system.

There are many examples from other countries (for example, the European Union, Australia, Portugal, Spain) where a rational log-frame approach to evaluation is used to develop a template for monitoring and evaluating the progress of drug strategies or action plans. We would recommend this type of approach is adopted in the new drug strategy.

The template would require the specification of:

i. Clear, achievable & realistic policy objectives or outcomes;
   The identification of clear, achievable and realistic outcomes for the strategy is the starting point for any monitoring framework. The aims in the strategy are

rather broad while the outcomes identified mainly relate to outputs rather than outcomes. It will therefore be necessary within the new strategy to identify some other outcomes as a basis for action, monitoring and evaluation.

ii. Appropriate measures of progress against these objectives that relate to the interventions proposed within the strategy;
These should be identified and agreed with key stakeholders. They should cover inputs, process, outputs and outcomes. While outcomes are the gold standard in considering achievement, changes in outcomes may take some time to occur (in the field of prevention an intervention may be aiming to change and outcome several years in the future) and may also result from other causes than the interventions under the drug strategy. Monitoring progress on inputs, processes and outputs can ensure that the programmes are being implemented and might help to shed light on why progress is being made in some areas and not others. Not all measures need to be reported on at very short time intervals. While some might be monitored more regularly, others which might be expected to change less rapidly could be collected over longer time intervals. With this approach not all measures need to come from routine data sources, some could be supplied by special data collections, such as surveys or audits at specified time intervals.

iii. *The specific indicators to be measured and the data sources required to do this;*
These need to be: clear in the way they relate to the outcome and in the direction of change that is expected; valid (that is, measures what it should measure); reliable (gives consistent results); easy to interpret and explain; easy to construct (must reflect the real places they will be used in); consistent with other performance frameworks.
In some cases it may not be possible to identify a good quality indicator for a measure and a proxy measure may be used instead. However, ways to improve this and develop better measures should be identified.

In addition, if the outcomes of any evaluation are to be accepted the system needs to also include:

iv. A clear time frame, with dates at which progress will be reviewed;

v. Independent mechanisms established for evaluating & reporting on progress and to ensure they are conducted to highest professional standards;

vi. Results of reviews need to be communicated to professionals & the general public effectively, & open debate promoted; and

vii. The strategy should be reviewed and revised if necessary in the light of evidence of effectiveness.

Adoption of this approach, in particular, the need for independent review and open communication of the results, might help avoid some of the problems surrounding the evaluation of the current strategy. An example of such a template, although only covering the area of enforcement, is the Australian performance measurement framework for drug law enforcement[52]. This was developed in consultation with a wide range of stakeholders to ensure transparency and acceptability of findings.
An evaluation framework for new strategy there would need to consider evaluation at the local and national levels. Plans for evaluation at these levels need to be complementary but not necessarily identical as, for example, some important

[52] Homel P & Willis K (2007) *A framework for measuring the performance of drug law enforcement* Trends & issues in crime and criminal justice No. 332 Canberra: AIC

outcomes (such as drug-related deaths) may be too rare for monitoring annually at the local level.

Requirements for implementation of a knowledge pillar

For such a framework to deliver an improved knowledge base there will need to be systems and resources in place to implement it. These would need to include:

(a) new systems of co-ordination and delivery of research. There needs to be some body charged with responsibility for developing the knowledge base across the whole strategy;

(b) adequate resourcing for the full range of research, monitoring and evaluation requirements outlined above;

(c) mechanisms for and a commitment to the dissemination and use of research within programme delivery systems, policy development and review.

Whatever system is adopted it will need to be sufficiently independent for its work to have credibility with all stakeholders. There are a number of models within the UK and internationally that can be considered, for example:

- A combined funding programme through the UK research councils, as has already happened for infectious disease epidemic research. The Drug Addiction Research Initiative in the 1980s is an example of this approach, and the joint funding programmes are undertaken in other topic areas.
- A new arms-length research body might be set up to coordinate and commission research, provide analysis and develop and maintain a knowledge bank, with a remit that potentially extends beyond the drugs field.
- The Scottish Executive has funded a new Criminal Justice Research Centre bringing together departments in several universities to develop a coherent research programme in the criminology field.
- Consideration should be given to different international models. For example, the Canadian Centre on Substance Misuse "… has a legislated mandate to provide national leadership and evidence-informed analysis and advice…" and plays a co-ordinating role in the development of an overall research strategy as well as in knowledge transfer[53]. The Australian National Drug Strategy is supported by three dedicated National Research Centres and has a history of regular independent reviews of the strategy that are put out to tender.
- Only recently, the US Substance Abuse & Mental Health Services Administration (SAMSHA) announced the award of a $39m programme over five years to fund 15 Addiction Technology Transfer Centres.[54]

Finally, but by no means least, knowledge development in the drugs field has been historically under-resourced and this must be urgently addressed. We are perplexed as to where the budget identified for research in the 2000 Comprehensive Spending Review (CSR) went to. From the best calculations we can make (from available and inadequate UK governmental data), the UK spends less than 1% of the total drugs

[53] See http://www.ccsa.ca/CCSA/EN/About_CCSA/OverviewAbout CCSA.htm accessed 17/10/07
[54] SAMSHA Press Release 14 September 2007
http://www.samhsa.gov/newsroom/advisories/070914awarded3414.aspx accessed 18/10/07

strategy resources on research. Compare this, for example, with the federal US treatment & prevention budget which devotes over 20% to research.[55]
In a climate of shrinking resources, consideration might also be given to allocating some of the recovered criminal assets to fund a co-ordinated, independent research and analysis programme linked to the drug strategy, since many of these assets are linked to the illegal drugs trade. During 2006 it is estimated that £125 million of criminal assets were recovered and a Home Office Draft Action Plan (May 2007) proposes that by 2010 this level should have doubled to £250 million.

[55] US Office of National Drug Control (2006) National Drug Control Strategy FY 2007 Budget Summary
http://www.whitehousedrugpolicy.gov/publications/policy/07budget/partii_funding_tables.pdf accessed 18/10/07