CONSERVATIVE
DRUG POLICY
REFORM GROUP

MAKING UK DRUG POLICY A SUCCESS: REFORMING THE POLICYMAKING PROCESS

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PUBLIC RELEASE
DECEMBER 2021

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FOREWORD

This paper is the culmination of over two years' work by the Conservative Drug Policy Reform Group. It was shared privately with ministers and officials with an interest in the reform of our nation's drug policy, before the release of the national drug strategy. I am indebted to our team of policy researchers and to the policy council whose advice and insight has been crucial in shaping this work, which I hope will be useful to those engaged with the next ten years of drug strategy.

The focus here is on improving the policymaking process. This is a crucial foundation for producing better drug policy in years to come, and for producing drug policy that can learn, change, and adapt as it goes, rather than repeating the mistakes of the past.
I welcome the recognition of the Drugs Minister and his Senior Officials of our seriousness of purpose and quality of analysis in a meeting last week. Kit Malthouse is the first to accept that policy must be sustained by evidence and there is a positive commitment in the new 10 year strategy to improve our analysis of evidence, not least examining international experience which will form part of the approach to be presented in a white paper next year.

An examination of the CDPRG's recommendations set against the new 10 year strategy shows substantial and welcome advances in respect to treatment, reflecting much of Part 2 of Dame Carol Black's report. However, the confusion between approaches to problematic and non-problematic drug users potentially places yet more burden on a criminal justice system that is already swamped by drugs-related work, serving to drive drug users even closer to their criminal supply chain and away from the treatment and security the state should offer.

Whilst criminal justice initiatives and the treatment of problematic drug users determine this latest strategy, other key public interests must be considered in future. The lost opportunities in health treatments, our bio-sciences sector and the economic cost over the last half a century provide at least as grim a roll call as the casualties and drug deaths suffered by the UK, caused by illegal drug misuse and the appalling criminal cost created by current policy. How does one score the suicides of the depressed, and those in pain that could have been prevented, the economic return foregone, the treatment of so many conditions, if our policy had been based on evidence and research, not prejudice and ignorance from the middle of the last century.

I commend this excellent paper from my expert colleagues at the CDPRG, pointing the way to a better future for our nation's drug policy.

Crispin Blunt MP, unremunerated Chairman of the CDPRG

EXECUTIVE SUMMARY

This proposal for the structural reform of drug policymaking has been written for circulation for Ministers ahead of the publication of the Government's new drugs strategy, in view of the fact that its creation process echoes previous iterations. We are correspondingly proposing possibilities for the structural reform of UK drug policymaking process, which this analysis identifies as a necessary precursor to the attainment of better drug policy outcomes and the reversal of the trends associated with the UK's drugs crisis.

A crack has deepened over successive decades between the aims of the UK's drug policies and their actual outcomes, the most salient of which continue to worsen or stagnate. The UK has been established for consecutive years as the overdose capital of Europe. Such phenomena themselves make the headlines, and are increasingly accompanied by expert commentary identifying that the UK's drug policies are ineffective from fields including addiction treatment, medicine, social care, psychiatry, and law enforcement, as well as by increasing numbers of MPs from all parties.

Evading the focus of critics, the unseen cause of every undesirable outcome of UK drug policies remains unchecked; this report identifies that behind the UK's drug crisis and its drug policies themselves sits a methodologically flawed policymaking process, consistent only in its inconsistency. The principal problem that unilaterally affects existing drug policymaking is that there is inadequate Governmental capacity to carry out research that can inform policy creation. This is compounded by there being no specification on the extent to which policymaking must make use of evidence. The policymaking process needs an urgent and tailored update that is responsive to current needs, but our proposal I builds on the existing and highly valuable 2012 analysis by the UK Drug Policy Commission (UKDPC), most of the structural limitations they identified remain highly relevant today. (See Appendix 2 (pp. 59-65) for a summary of findings from the reports of the UKDPC.)

Polling data commissioned by the CDPRG reveals the majority of MPs align with the general public in acknowledging current drug policies are not working and calling for change. Polling of MPs in June 2021 by the CDPRG reveals that increasingly evidence-based drug policies would be welcomed by the majority of MPs, including the majority of Conservative MPs, the Parliamentary demographic traditionally associated with the greatest resistance to innovation in this area — in fact, 72% agree the process of making policy about controlled drugs should make more use of evidence and research and 85% (and 90% of all MPs) agree that improved cross-departmental coordination would better help to tackle the health crime and social problems associated with controlled drugs. Polling of the general public carried out in 2019 showed that only 1 in 4 adults believe that current UK policy is effective at preventing harm to health and wellbeing. Around 3 in 4 believe that criminal sanctions do not deter either drug use (76%) or supply (69%). There is more room for manoeuvre than is usually believed. (See Appendix 1 (pp. 56-59) for a full breakdown of polling data commissioned by the CDPRG.)

The British public deserve better drug policies, with outcomes that can be attained and predicted. Drug policy is complex and inherently political, but it must make a stronger habit of incorporating evidence about what works if it is to have any success. By identifying the requisite components of evidence-based policymaking process, this proposal for the structural reform of current practices aims to support the realisation of the recommendations made by key consultant on the forthcoming drugs strategy, Dame Carol Black, in her *Independent Review*. Reviewing the methodology for devising drug policy appears so far to be outside the remit of the nascent Joint Combating Drugs Unit (JCDU), a new unit housed in the Home Office with staff seconded from five other key departments: DHSC, DfE, DWP, MHCLG and MoJ to "help end illegal drug-related illness and deaths" and "tackle demand."

Two consultative roundtable discussions inform this proposal: "Delivering cross-cutting drug policies," (July 2021) and "Building Evidence: Data Systems, Research Strategy, and Evaluation" (September 2021). The CDPRG commissioned the Institute for Government to explore the issues at play when structural changes are made to the way Government formulates and delivers cross-cutting policies, followed by a second roundtable in collaboration with Drug Science, the leading independent scientific body on drugs in the UK, to explore the UKDPC's recommendation for a new independent body to coordinate national drug research. We aim to synthesise and update this body of knowledge and apply it to the shifting current situation. (See Appendix 3 (pp. 65-70) for key insights from the consultative roundtables.)

The principles of good governance of drug policy are well understood, yet lessons have not been learned. Analysis by the UKDPC in 2012 identified a number of good principles for drug policy governance, and they remain applicable today. Today's situation is marked by an absence of clear system-wide goals with broad support; muddled recognition of the complementary roles of politics and evidence; resistance to change, innovation, and learning from past failures; opacity in policy design; lack of clear evaluation strategies and outcomes frameworks; and limited accountability for both design and delivery processes. It remains an area where political posturing can take precedence over the wise use of public funds and the views of stakeholders. We analysed in depth the current governance landscape, the problems it can create, and the tangible opportunities for improvement, and our key points are summarised below.

Good policy needs a better understanding of the problem to be solved. The current understanding of what works in drug policy is highly variable, our research community fragmented, and there is no coherent national agenda for improving this. The UK does not adequately resource or consistently respect the bodies positioned to advise on areas where there is robust evidence to guide a decision. We fail to iterate through the policy cycle and learn from past mistakes. This is behind many of the blindly chosen interventions in recent years.

Clearer overarching policy goals are needed. Their absence, opaque development, immeasurability, or limited correlation with what matters to the people affected has been an avoidable feature of many past drug strategies and impeded the evaluation of their outcomes. The challenge of improving drug policymaking practice is reduced by

the existence of an extensive body of academic research on goal setting and the importance of agreeing on how to measure goals across different areas of policy to draw on. Policymaking in the absence of sufficient understanding of the reality of the landscape has an established tendency towards unrealistic aims — for example, the eradication of drug use — which increases the probability of unintended outcomes.

A policy deriving from an unevidenced premise will not achieve its outcome. An example of this is given in this year's annual report by Drug Recovery Champion Dr Ed Day; the unhelpful misconceptualization that recovery from addiction equates to abstinence, which led to policy decisions that disastrously hampered the provision of 'harm reduction' approaches such as opioid agonist treatment (e.g. with methadone or buprenorphine), resultantly driving up drug death and addiction rates. Recognising the extent to which accepted thinking goes unchallenged and continues to unduly influence UK policy, former New Zealand Prime Minister Helen Clark has criticised the UK Home Office's "fixation with a costly and self-defeating strategy." Increasing the use of evidence in policymaking will obviate further need to draw on untested assumptions about what effects a policy may have.

Policymaking must balance politics with technocracy; policy makers and citizens alike would like to believe that policy is proportionate to the evidence, not inversely proportionate. Covid-19 has irrevocably increased awareness that the political and collective response to public health crises is best when guided by good science. However, the gap between what evidence indicates and what is specified in related legislation is particularly marked within the field of drug policy, as many leading academics in the field of drugs and drug policy, including independent evaluators (sought by the UK government itself) argue. This paper has also sought to demonstrate the severity and impact of this for those affected.

Tough-sounding government rhetoric about drug use often contradicts evidence, including its own policies and evaluations of its own drug strategies. The UKDPC observed from participants in their research that "a consensus exists around a view that it is politically essential to 'be tough' no matter the effect". Recent policy proposals including calls to "Test on Arrest," calls for companies to drug test employees as part of a wider call to "name and shame" middle class cocaine users, and calls to control Nitrous Oxide under the Misuse of Drugs Act 1971 are examples of proposals that have been advanced in the service of a 'tough on crime' stance, despite the existence of sufficient evidence to confidently anticipate that each will exacerbate drug-related harms without driving down drug-related crime or reducing use. Factoring the evaluation of policy outcomes into their overall design at inception will serve the creation of policies that can better achieve these policy aims.

Strong leadership on drugs policy that leads to robust cross-government coordination will result in improved drug policymaking and improved outcomes. It was noted in our roundtable on delivering cross-cutting drug policies that senior officials must be invested in efforts to improve the drug control system and able to coordinate the involved departments' contributions and resolve tensions. This can support the increased cross-departmental engagement on drugs that 90% of MPs polled by the CDPRG agree would

help the UK to tackle drug-related issues more effectively, endorsing Dame Carol Black's recommendation for a central cross-cutting Drugs Unit, which led to the launch of the Joint Combating Drugs Unit in July 2021, which, if it is adequately resourced and proves to be effective, will represent the most significant advancement of cross-government coordination of drug policy-making and delivery in twenty years.

Enhancing the scope for cross-cutting drug policymaking will improve its correspondence to the landscape on a local level. If drug policy is cross-cutting centrally, it is even more so locally. Groups involved in implementation include commissioners, health and wellbeing boards, and elected representatives of local authorities; public health bodies, NHS services, private healthcare providers, recovery communities, and the third sector; police and crime commissioners, courts, prosecutors, prisons, probation services, police forces, and other law enforcement agencies; social services, Jobcentres, housing partners, and schools. Effective joined-up working at the local level is essential.

Distinct elements of drug policy (i.e. prevention, treatment, and enforcement) can function at cross-purposes when they operate without sufficient coordination. For example, enforcement activity near treatment centres can discourage engagement with those services. Poor coordination can also result in duplication of work and missed opportunities for increased effectiveness. Dame Carol Black's part two report makes a number of welcome recommendations to improve joined-up working at the local level, ensuring cross-cutting regional strategies, commissioning, and implementation. Importantly, a Local Outcomes Framework is proposed, against which local performance can be evaluated. This framework would benefit from a wide scope, ideally covering the impact of interventions across the full spectrum of local partners. Insights yielded will assist in the promotion of an overall structure in which policymakers have accountability for the end results of any drug strategy.

Drug policy must be subject to adequate scrutiny and evaluation as it is enacted, and the decision-makers involved must be accountable. There has been a historic lack of commitment to making outcomes clearly measurable, notable among them being the review by the National Audit Office of the 10-year drug strategy announced in 2010, which stated that "Neither the current Strategy, nor the supporting action plan for 2008-2011, set out an overall framework for evaluating and reporting on the degree to which the Strategy is achieving the intended outcomes or the value for money provided." While recognising that some outcomes are complex to measure, an early commitment here is essential if involved parties at the highest and lowest levels are to be held to account, or credited for their efforts. Much stronger accountability to Parliament for progress towards drug policy goals is required, as well as internal quality control processes and decision-making transparency.

This report draws the following conclusions about current drug policymaking practices and impacts, which inform its ultimate recommendations (see table below).
Policy development begins with identifying the problems to be addressed, the contributing causes of those problems, and the options for intervention. This phase of the policy cycle is most effective when supported by a robust empirical evidence base. There is an absence of clear core drug policy goals. There are diverse stakeholders with different

needs and visions, as well as different understandings of the fundamental nature of the problem, and these stakeholders are not adequately consulted in the development of high level goals. There has been a lack of good outcome frameworks with clear evidence-based logic models to justify them, and this has been the subject of much criticism within government. We welcome Dame Carol Black's recommendations on this matter and hope they are implemented in an effective manner. Policy making is inherently political but the debate and reasoning must be more open and robust, and political considerations must be balanced with the evidence. The debate must be broadened, and this can be done without reducing the freedom of Ministers.

On the basis of the CDPRG's assessment of current drug policymaking practices and their relationship to the intensifying severity of unintended policy outcomes, we make the following recommendations for the structural reform of drug policy making. These recommendations do not promote any singular course of action, but rather introduce possibilities for flexibility in Governance relating to drugs and for fostering a culture of mutual support between the many different departments. These departments' expertise, drawn on appropriately and supported by a significantly enhanced research capacity, can fulfil its potential for elevating the UK from its current position as the longstanding overdose capital of Europe to a country with drug policies that are studied abroad by those seeking to emulate its policy outcomes.

RECOMMENDATIONS FROM MAKING UK DRUG POLICY A SUCCESS: REFORMING THE POLICYMAKING PROCESS

Recommendation 1: Develop a National Drug Research Strategy to better understand issues relevant to policy design.

Recommendation 2: Establish a National Institute for Drug Science to coordinate research into substance misuse (see DCB2 #31), including behavioural science innovation (see DCB2 #30), social needs of people with substance misuse problems (see DCB2 #23), peer-led recovery support services, recovery after leaving the treatment system (see Recovery Champion's Annual Report),[1] and awards for companies or organisations whose developments advance addiction treatment (see DCB2 #32).

Recommendation 3: Increase funding and administrative support for the ACMD to improve its capacity and workrate.

Recommendation 4: Empower the ACMD to commission work through the National Institute for Drug Science, so that relevant knowledge gaps for current policymaking can be filled.

Recommendation 5: The upcoming Drug Strategy should define specific, measureable, and achievable goals, so that it can be clearly evaluated and held to account.

Recommendation 6: The process of setting policy goals should be unilaterally transparent and supported by robust stakeholder engagement with genuine opportunity for public dialogue to influence decisions, as detailed in the UK Drug Policy Commission's work.

Recommendation 7: Publish terms of reference to accompany future drug strategies, clarifying the scope and limit of policy options considered at the stage of policy design.

Recommendation 8: The upcoming Drug Strategy should include a robust outcome framework with evidence-based logic models informed by an open consultation (see DCB2 #1).

Recommendation 9: The upcoming Drug Strategy should clearly and simply outline the responsibilities of every involved department for achieving each specific commitment.

Recommendation 10: Review options for stronger delegation of classification and scheduling decisions by the ACMD.

Recommendation 11: The upcoming Drug Strategy should outline the total projected expenditure including budgetary commitments of each spending department, and any funding which is to be ring-fenced for specific purposes, with these indicated in full.

This improves scrutiny of whether departments met their commitments and enables better oversight of spending as events unfold.

Recommendation 12: There should be robust bookkeeping throughout the policy cycle, to allow better assessments of cost-effectiveness, where applicable.

Recommendation 13: Actively encourage and support local pilot schemes of new and innovative approaches, with robust evaluation and sharing of findings. E.g. new multi-sector partnerships, harm reduction initiatives, new approaches to integrated care.

Recommendation 14: Establish an annual national conference for local implementation partners to share data and knowledge of joined-up commissioning, with awards for innovative approaches.

Recommendation 15: A National Institute of Drug Science should coordinate national outcome data tracking, as per the national research strategy.

Recommendation 16: Expansion of DataFirst to include linkage to the Police National Computer and NDTMS to track reoffending and drug treatment.

Recommendation 17: National Institute for Drug Science to develop standardised methods of measuring recovery and social support, as described in the Recovery Champion Ed Day's first Annual Report.[2]

Recommendation 18: National Institute for Drug Science to coordinate full, transparent, and independent evaluations of drug strategies against the National Outcome Frameworks at the close of each strategy cycle. This process should consider stakeholder feedback alongside outcome data to ensure that data is representative of the experience of partners and service users. The evaluation should also review data collected by the Office for Health Improvement and Disparities on local performance against the Local Outcomes Framework (see DCB2 #8) and identify factors that contribute to regional disparities.

Recommendation 19: In addition to the sponsoring minister of the JCDU reporting annually to Parliament, the minister should also report to a joint panel of select committees and relevant ALBs following the publication of each independent drug strategy evaluation (including Home Affairs; Health and Social Care; Public Accounts; Business, Energy, and Industrial Strategy; Treasury; Justice etc).

Recommendation 20: Operational delivery units dealing with licences for controlled drugs should be transparent, subject to periodic independent audits, and implement an appeals process if applications are rejected. This would improve interactions and increase stakeholder understanding of requirements.

Recommendation 21: Identify any data gaps that prevent full evaluation of effectiveness and cost-effectiveness of interventions against policy goals and ensure that subsequent drug strategies commit to improving the collection of relevant data.

Recommendation 22: Commit to phasing out or modifying policies and interventions shown conclusively to be ineffective at achieving their stated goal(s).

Recommendation 23: Ensure that JCDU has open channels of communication with BEIS, DIT, FSA (etc) to ensure identification and rapid response to emerging regulatory issues concerning licensed business and research activities.



1. INTRODUCTION

Dame Carol Black was appointed by the Home Secretary to undertake an independent review of drugs.

Part 1, published in February 2019, focused on drug markets and the toxic combination of violence, poverty and exploitation that underpins supply and demand. The report identified serious shortcomings in governance. It recognised that enforcement activity can have unintended consequences such as "increasing levels of drug-related violence and the negative effects of involving individuals in the criminal justice system. It also states that government interventions to restrict supply have had limited success" and "even if these organisations were sufficiently resourced it is not clear that they would be able to bring about a sustained reduction in drug supply, given the resilience and flexibility of illicit drug markets". Part 1 did not provide any recommendations and the parameters excluded any review of the legislation.

Part 2 of Dame Carol Black's review, commissioned by the Secretary of State for Health and Social Care and published in February 2020, focused on drug treatment, recovery and prevention. Central to the second part of Dame Carol Black's review was the recommendation for a new central Drugs Unit with strong analytical capacity which would develop a National Outcomes Framework and hold departments to account to coordinate and develop the governments' objectives and targets. She recommended that the sponsoring minister should report annually to Parliament on progress in tackling drug misuse, including publication of relevant data. HMG announced, to coincide with the release of part 2 on the 8th July 2021, the formation of the Joint Combating Drugs Unit (JCDU), a new unit housed in the Home Office, with staff seconded from five other key departments: DHSC, DfE, DWP, MHCLG and MoJ to "help end illegal drug-related illness and deaths" and "tackle demand".

The Government produced an initial response and says it will respond to Dame Carol Black's recommendations in full by the end of this year when the long-term strategy will be laid out.[3] Collective Voice, a national charity working to improve life for families affected by substance use, notes that the policy programme would – if implemented – save the lives of over 3,000 opiate users, bring 95,000 new people into recovery and prevent 2.8 million crimes. But Dame Carol has made clear that the recommendations must not be "cherry picked" and that the government must commit to itself the full, long-term project.[4] It will also require the outcome of the spending review to commit to the 5 year baseline spend and additional treatment funding. Black has warned that the government is left with "an unavoidable choice" to "invest in tackling the problem or keep paying for the consequences".

Dame Carol Black's recommendations signify a dramatic overhaul of drug treatment, recovery and prevention services in the UK which has suffered from a prolonged shortage of funding due to significant cuts to Local Government budgets and a lack of central Government oversight, resulting in a loss of skills, expertise and capacity in the sector. The 32 recommendations must be met in full and the JCDU must deliver joined

up working which requires commitment and leadership, to reverse the impact of long term disinvestment and evolve the treatment space in line with new developments in science, evidence and policy, which we very much hope the JCDU will rise to the task of. This will of course take time, reflected by Black's 5 year plan.

The focus of part 2, as per the brief and a health secretary commissioned directive is centered on drug treatment, recovery and prevention and also refrained from looking at specific policies, with the recommendations focusing on how to foster an environment that can overturn treatment services that are currently "on their knees" and reinvigorate the sector with expertise and research. Dame Carol Black has been very clear in the presentations of her reports that the parameters that she was allowed to look at deliberately excluded any review of the legislation that frames the matter. Black has stated that she was grateful to have the terms restricted because the scale of the terms alone and the problems at hand were vast and anything more would have swamped the review.

Building on Dame Carol Black's findings from both reports and her recommendations, this report takes a holistic view of the drug policy field, drawing attention to existing challenges and opportunities found there.

While the JCDU is under construction, the time is ripe to engage with these wider aspects to maximise the impact of Black's recommendations and develop areas the review could not consider. We argue that ultimately, there is much more than can be done to meet the broader needs of the drug policy field, the necessary independence of research and the need for a UK research strategy through effective use of independent bodies, review of legislation, classification and scheduling, to ground the entire field in best available evidence and evidence generation.

1.1 **The majority of MPs have come to recognise that UK drug policy is insufficiently evidence-based.**

Q2. IF WE ARE TO IMPROVE THE WAY WE TACKLE PROBLEMS CAUSED BY CONTROLLED DRUGS, **WE NEED TO CHANGE HOW WE MAKE DRUG POLICY**

	Agree (Strongly Agree + Agree scores)	Disagree (Strongly Disagree + Disagree scores)	Don't Know
All MPs (n=109)	71%	18%	11%
Conservative MPs (n=59)	61%	24%	14%

Primary Research by Savanta for CDPRG (June, 2021)

The results of 2021 polling commissioned by the CDPRG of UK MPs reveals that only 22% believe that the UK's current policies are effective in tackling the problems caused by controlled drugs. 71% agreed that to improve things we need to change the way drug policy is made and 79% agreed that the process of making drug policy in the UK needs to make more use of evidence than it currently does.

79% also agree that fifty years on from the royal assent of the Misuse of Drugs Act 1971, it is time for the Government to update UK drug control laws, based on the best evidence

available today on what works. However, 70% also agreed that policy about controlled drugs was such a controversial issue, that it can be difficult to have an objective debate about the best solutions. These results were broadly consistent across political parties – see Appendix 1a for full results.

1.2 Public confidence in UK drug policy is correspondingly low

A survey commissioned by CDPRG in 2019 showed that only 1 in 4 adults believe that current UK policy is effective at preventing harm to health and wellbeing. Around 3 in 4 believe that criminal sanctions do not deter either drug use (76%) or supply (69%). These results are consistent across the political spectrum.



2. CONSULTATION

This report draws on interviews with key stakeholders and two roundtables organised by the CDPRG covering:

2.1 DELIVERING CROSS-CUTTING POLICIES – JULY 2021

The CDPRG commissioned the Institute for Government to explore the issues at play when structural changes are made to the way government formulates and delivers cross-cutting policies, using drug policy as a case study among individuals who have experience of managing a range of cross-cutting areas in government, alongside experienced veterans of drug policy in the UK.

2.2 BUILDING EVIDENCE: DATA SYSTEMS, RESEARCH STRATEGY, AND EVALUATION – SEPTEMBER 2021

Building on the initial roundtable with the Institute of Government (see Appendix 3), the CDPRG coordinated a second roundtable in collaboration with Drug Science, the leading independent scientific body on drugs in the UK, to to explore the UKDPC's recommendation for a new independent body to coordinate national drug research who suggest using a proportion of the money raised by the forfeiture of assets from drug-related crime might be used to fund such a body and/or research (see Appendix 3).

2.3 WE ARE ADVOCATING FOR STRUCTURAL REFORM, NOT INDIVIDUAL POLICIES

While we at the CDPRG have our own perspectives on the most suitable policies, and these necessarily appear in our arguments or are implied in our reasoning, they are not included for their own sake. We endeavour to include them in the spirit of providing illustrations of the outcomes (positive or negative) of structural factors in current policymaking. To the extent that the reader disagrees with our assessment of these outcomes, we would urge them to look at the points we make about the policymaking machinery that led to them. Improved governance in this area should be of interest to representatives across the political spectrum and with different values.



3. PRINCIPLES OF GOOD GOVERNANCE IN DRUGS POLICY

In the most comprehensive evaluation of British drug policy governance to date, the UK Drug Policy Commission (2006-2012) identified key areas for improvement in drug policy governance. Consultations conducted by CDPRG to inform the present report revealed that most of the structural limitations identified by the UKDPC a decade ago still negatively impact drug policy governance today. (See Appendix 2.)

While many organisations have weighed into the drugs policy debate, the most comprehensive evaluation of drug policy governance to date was conducted by the UK Drug Policy Commission (UKDPC) in partnership with Rand Europe, the Institute for Government, and other organisations. Over a six year period (2006-2012) the UKDPC, established with charitable funding specifically to address the perceived deficiency in the use of evidence and analysis in the drug policy process, provided an objective analysis ofthe evidence concerning drug policies and practice. It brought together senior figures from policing, public policy and the media, along with leading experts from the medical and drug treatment fields. Principally funded by the Esmée Fairbairn Foundation, other funders have included the Home Office and the former National Treatment Agency. This paper will draw on many of the commission's learnings and lessons, supported by our own consultative roundtables and interviews in light of the current context of UK drug policy and proposed plans for how it is governed.

The UKDPC concluded that the way that drug policy is made and implemented was limiting the effectiveness of attempts to address the consequences of drug use. Their work included a review of potential lessons for drug policy governance from other policy areas, specifically in regard to repositioning the issue so that longer-term, evidence-based, expert-led drug strategies become more politically advantageous for governments, thereby avoiding defensive leadership influenced by short-term political considerations. A summary of the key themes of good governance are as follows:

1.**Clearly articulated overarching goals** that are realistic but aspirational; and have cross-party support where possible.

2.**Leadership that provides authority and resource**, that is ‘evidence-imbued’ (i.e. recognises the importance of evidence in policy development and of policy evaluation including willingness to make changes based on feedback) and seeks consensus and cross-departmental support

3.**Coordination of policy efforts** that begins at a high enough level of office to ensure commitment and resources; provides clarity of roles and responsibilities of those involved in policy development and delivery and involves those responsible for implementation in agreeing objectives based upon an agreed upon policy framework.

4.**Balanced policy design** that balances scientific evidence with other types of evidence (eg public and expert views, politics, innovative practice) in a way that is transparent; generates ideas and options which have clear logic models underpinning them and incorporates clear mechanisms for evaluation and feedback and incorporation of learning.

5.**Development and use of evidence** that is supported by mechanisms that continually promote its development and expansion; is based around agreed upon standards for what 'counts' as evidence; and includes mechanisms to facilitate knowledge-building and sharing between researchers and policymakers;

6.**Flexible implementation** that for allows for variation based on local needs and has sufficient financial resources and access to the evidence base

7.**Accountability and scrutiny** that holds policymakers to account for their decision-making, including their decisions to use or not use evidence in their policy; measures success based on outcomes set through a system of transparent performance management; relies on rigorous, objective processes of evaluation and review; and is transparent itself.

8.**Stakeholder engagement** that includes wide consultation during the policy development and policy evaluation stages; has fora to facilitate healthy debate between stakeholders; and promotes understanding of the evidence base among policymakers, the media and the public.

The commission characterised UK drug policy as a mix of cautious politics and limited evidence and **required both a recasting of how we structure our response to drug problems and an analysis of the evidence for how policies and interventions can be improved** (citing very little evidence that existing policies work or are cost-effective). The report said some progress could be made by improving existing programmes (e.g. enhancing drug treatment and recovery) but a new approach needed to go further, focusing on twin goals of how society and government can support and enable people to behave responsibly, as well as how they can stimulate and help individuals recover from drug dependence. An evidence-based approach is needed to enable UK drug policy to meet existing and future needs in a rapidly changing and highly contested environment.

Rarely are such commissions and independent reports actioned in the UK, including those commissioned by its own government. The commitment to meet Dame Carol Black's 32 recommendations and the creation of a new unit which formally brings together other departments such as DHSC and DFE is significant. There is an opportunity therefore to seize on this appetite for structural reform, ensuring that engagement with wider areas of the drug policy field beyond the parameters of the Black review as well as opportunities to maximise the impact of it's 32 recommendations.

This report draws from consultations conducted by CDPRG and the work historically undertaken by UKDPC to review characteristics of good governance in drug policymaking.

3.1 UNDERSTANDING THE PROBLEM

Policy development begins with identifying the problems to be addressed, the scope, contributing causes of those problems, and the options for intervention. This phase of the policy cycle is most effective when supported by a robust empirical evidence base. It is also an iterative process informed by evaluation of local, national, and international policy outcomes, and thorough stakeholder engagement involving all relevant sectors and communities which we covered in more detail throughout subsequent sections.

Q1. THE UK'S CURRENT POLICIES ARE EFFECTIVE IN TACKLING THE PROBLEMS CAUSED BY CONTROLLED DRUGS

	Agree (Strongly Agree + Agree scores)	Disagree (Strongly Disagree + Disagree scores)	Don't Know
All MPs (n=105)	22%	68%	10%
Conservative MPs (n=59)	32%	57%	11%

Primary Research by Savanta for CDPRG (June, 2021)

3.1 (a) A field in flux

Calls for evidence-based policy in the case of drug policy are especially strong given its relation to the medical field, from which evidence based ideas originally stemmed. But what does the application of evidence look like in the realm of drug policy? It is best to begin with a schematic overview of what evidence-based policy (EBP) is. EBP has roots in the development of Evidence Based Medicine (EBM) which accelerated in the 1980s and 1990s in a bid to close the gap between research and practice, ensuring that medical decisions and practices were firmly rooted in robust evidence and variation between different health care providers was reduced. After its dissemination in the medical field, the wider EBP movement followed as governments were keen to buy into a culture of linking policy in a variety of areas to proof, thus securing wider public support. However, the realities of evidence-based policymaking were found to be very unlike evidence-based medicine.[5][6][7]

In flux and new and emerging policy fields require less linear, more flexible ways of conceptualising the problem and implementing policy. EBM or EBP is often conceptualised as a rational or linear model whereby a problem is defined, research is conducted to fill a gap in knowledge and the resulting evidence is utilised to provide policy options. Linear or rational models of EBP have been strongly influenced by the medical and scientific fields where hierarchies of evidence are well-established but this linear model has been widely criticised for providing an over-simplistic view in new and emerging policy fields which are in a state of flux. In Geoff Mulgan's 2005 work on governments' use of knowledge and evidence in policymaking, the author identifies three distinct policy fields:[8]

- **Stable Policy Fields** where knowledge is reasonably settled, governments broadly know what works and there is a strong evidence base. This field is closer to the natural sciences, where linear models of EBP are most relevant.

- **Policy fields in flux** where the knowledge base is contested and there is disagreement over the most basic theoretical approaches. Many recognise that things need to change and that policies that once worked are no longer working, but fewer can agree on either the diagnosis or the solutions.

- **Inherently novel policy fields** whose very newness often precludes the existence of a strong evidence base. No one knows for sure what works or what doesn't because these are virgin territories and the pioneers are likely to make the most mistakes.

Drug policy neatly fits in the definition of a policy field in flux, based on polarisation and contested interpretations of the evidence regarding both the problems and the solutions despite cross party consensus that the current approach is costly and ineffective. However, the drug policy field is also generating new and emerging sub fields - such as how non-controlled cannabinoid products like CBD and hemp products should be effectively regulated, the study and development of promising medicines derived from controlled substances, as well as the emergence of New Psychoactive Substances (NPS) and the threats posed by some Human Enhancement Drugs (HED). It should be kept in mind that some of these novel policy fields present economic and health benefits if governed properly and in a timely manner. Likewise, there are potential threats to health by failure to properly engage with them.

3.1 (b) Drug research

The current UK drug research landscape is highly fragmented. There is no national drug research strategy, nor is there central coordination and monitoring of research funding and output.

The Cross-Government Research Programme on Drugs in 2008 (supported by a Strategic Board which included the Economic and Social Research Council, the Medical Research council, and a Delivery Group) and its successor the Drug Strategy Research Group in 2010 published a research strategy but it was abandoned when the coalition Government came in.

As noted by Keith Humphreys, who worked closely on the Dame Carol Black's Independent Review of Drugs, in an opinion piece for the British Medical Journal shortly after the review's release - *"The government needs the best independent research to guide instructions for commissioners and practitioners. Touters of miracle solutions attract media interest, but the rhetoric must be challenged and subjected to objective study."* He also cautions that the recommendations will only succeed if addiction science receives proper attention, which needs to come from a properly independent source with a solid link to policy makers and with the proper capacity.[9] The UKDPC also called for a new independent body to coordinate national drug research. Organisations at arm's length from the government have also been deemed to be a necessary structure to organise the communities of learning in the case of novel policy fields in particular,[10] into which drug many aspects of drug policy fall.

Responding to threats and opportunities in this broad and complex area requires a

dedicated office or department with significant expertise and capacity. We can learn from the approaches of some of our allies.

Australia's own Office for Drug Control (ODC) is part of Health Products Regulation Group (part of their Department of Health) and also includes the Australian Therapeutic Goods Administration (TGA) and funds The Australian Centre for Cannabinoid Clinical and Research Excellence (ACRE). The ODC regulates and provides advice on the import, export and manufacture of controlled drugs, as well as the cultivation of cannabis for medicinal purposes to support Australia's obligations under International Drug Conventions. The Australian ODC (via the department of health) regulates the cultivation and manufacture of medicinal cannabis including the import of "bulk" medicinal cannabis products, following the amendment of their Narcotic Drugs Act in early 2016 to allow cannabis to be treated as a medicine (about two years before the UK amended the MDA in 2018). By January 2020, more than 18,000 patients had been approved to access medicinal cannabis products in Australia, with most access to medicinal cannabis products occurring since 2016.[11] The approval scheme covers three distinct access pathways in which patient access can occur. The scheme is more streamlined than the UK, which has made it difficult for even the most reputable companies to gain licenses in a reasonable time frame. Furthermore, Australia plans to overhaul their preliminary system on the basis of learnings from those first licensing processes. Elisabetta Faenza, who is on the boards of both the Medicinal Cannabis Industry Australia and the UK Cannabis Industry Council comments on the importance of having *"a dedicated body, outside of a prohibition agency that can grow and become really au fait with the complexities of emerging categories like medicinal cannabis in all its forms. Such a body crucially needs to move with new developments in these industries, and provide a framework that encourages research and development, whether it's clinical research, plant-based research, or research into delivery mechanisms. A body like this needs to be able to learn very quickly, adapt to new and emerging evidence, without an entrenched investment of sunk costs in prohibition, and staffed by people with medical, pharmaceutical, and regulatory backgrounds. Regulatory personnel should be supplemented by those with expertise in food standards and agriculture, who understand the difference between controlled drugs and consumer applications like hemp foods where these are not already regulated by agricultural agencies"*. As well as being responsible for the regulation of medicinal cannabis and ensuring Australians have access to essential medications, it also reports on activities to the International Narcotic Control Board (INCB), applying amendments to international drug controls in Australia.

The United States also has an Office of National Drug Control Policy (ONDCP) which aims to reduce substance use disorder and its consequences by coordinating the nation's drug control policy through the development and oversight of the National Drug Control Strategy and Budget. As part of Biden's new drug policy agenda, the ONDCP recently announced a $2.5 million grant to be awarded to an independent nonprofit to support research in harm reduction, *"as well as promoting equity in access to treatment and drug enforcement efforts for underserved communities"*. The new grant is expected to directly encourage more policy innovation by supporting people researching and writing legislation. The ONDCP states that the funding will support the drafting of evidence-based model legislation on topics including: Ensuring access to harm reduction services

such as syringe service programs; equitable enforcement of drug laws and access to treatment; stigma reduction for substance use disorder and strategies to address fentanyl, cocaine and methamphetamine trafficking and use. Ensuring racial inequality in drug policy in particular is highlighted as a key priority. These offices or their activities are not necessarily perfect but the US ONDCP alongside the Biden Administration's drug policy reassures the public that something is being done about the unintended consequences of a drug control approach which has led to significant racial and economic inequalities.

In regard to novel policy fields, Mulgan notes that traditional formal bodies may not be effective ways of organising knowledge. Here, he says, *"the task of good government is to keep a very close eye on what is and isn't working so that it can at least reduce the proportion of mistakes that are made and traditional formal bodies may not be effective ways of organising knowledge"*. Furthermore, while systematic investment in innovation in novel policy fields is vital, fast-learning models are needed rather than the piloting of fixed approaches/policies. Organisations at arm's length from government are seen to be appropriate structures to organise such communities of learning. Novel fields in drug policy can include new substances (such as New Psychoactive Substances and Human Enhancement Drugs drugs), the impact of new technologies in drug markets, and new fields emerging from controlled drugs such as new medicines from cannabinoids and psychedelics and commercial markets such as the hemp and non-controlled cannabinoid wellness market.

3.1 (c) Stakeholder engagement

It is generally recognised as good practice to have formal consultations before formulating policy. Public consultation is an important mechanism for accessing and considering the views of experts and non-experts alike, assessing core social values and identifying any areas of divergence or consensus.

The 2010 Drug Strategy included a formal consultation, which it published with the strategy.[12] The 2010 Strategy acknowledged that it did not support anything in the consultation that advocated for decriminalisation or liberalisation. The 2017 Drug Strategy did not include any formal consultation process. The upcoming 2021 strategy has been developed very much behind closed doors, and it is unclear if a formal consultative process has been followed. Responses to written parliamentary questions seeking clarity on this were not forthcoming about the detail.[13, 14, 15]

The responses to these written questions state that "the forthcoming Drug Strategy has been informed by extensive consultation with partners key in the field" and also cites Dame Carol Black's own extensive programme of consultation. Given the limitations on the scope of Black's review, we believe a much broader formal consultation would be required, in the spirit of better scrutiny and accountability, and in line with the Government's own 2018 consultation principles. It is not clear if any response will be formally published to ensure clarity in how the government has responded to the consultation, or to explain the responses that have been received from consultees, including how these have informed the policy.[16]

Good engagement of stakeholders is one of the eight characteristics of "good governance" established by the UKDPC, during an international expert consultation. This consultation took the form of an iterative modified Delphi process, and was carried out by Rand Europe. Supporting these eight characteristics was an exploration by the Institute for Government of potential lessons for drug policy governance from other areas of policy, which included a gold-standard example of Stakeholder engagement from the Department of Health in 2006. The Department ran a large public consultation exercise as part of "*Your Health, Your Care, Your Say*", and reportedly engaged around 40,000 people on the future of care services through a mix of techniques including an online survey (29,808 people), local listening exercises (8,460 people), deliberative regional events (254 people) and a national citizens' summit (986 people). The participants were all given background information and evidence to inform their discussions which included policy options for improvement, and trade offs that needed to be considered. Polling on key questions took place throughout the process. Jill Rutter, who authored the paper on behalf of the IfG, notes that public involvement only works if people can see a "line of sight between their input and where the Government ends up", which this particular example also delivered.[17]

Due to the complexity of the drug policy field and the wide range of stakeholders in drug policy, which has grown with the development of increasingly novel areas, an on-going dialogue about the evidence and the implications for policy is more necessary than ever.

Deliberative methods are a respected method for the government to involve the public in decision making in a meaningful way. There is a strong case for developing and testing this in the drug policy field.

3.2 CLEAR POLICY GOALS

Goals provide the criteria for determining whether a policy has been a success or not and setting goals requires understanding the problem (as discussed above). Lack of clarity over the goals of drug policy is an entrenched problem. Evidence submitted to the Home Affairs Committee in 2002 found that goals in drug policy had been criticised for being unmeasurable and insufficiently grounded in evidence.[18] The UKDPC's 2012 expert consultation on good governance of drug policy (see Appendix 2c-i) also emphasised the need for clarity of core drug policy goals. CDPRG's own expert consultations both raised the issue of clear, meaningful goals, indicating that this very much remains a key issue.

> *"For various institutional and historical reasons, we've never had absolute clarity on what we're trying to achieve, and who is responsible for it."*
>
> Mike Trace, CEO of Forward Trust and former Deputy Drug Tzar

In the Government's initial response to Dame Carol Black's review, a commitment to "a clear set of measurable" goals is made.[19] However, as observed in our 2021 survey of MP attitudes - 70% of UK MPs (and 75% of Conservative MPs) still find it difficult to have an objective debate about drugs and the best solutions. This suggests the need for a

transparent process supported by robust stakeholder engagement with genuine opportunity for public dialogue in the development of such goals, as detailed by UKDPC. (See Appendix 2)

Best practice in goal-setting and measuring practice has been explored in a range of policy areas. Richard Rumlet, author of Good Strategy/Bad Strategy, said that to avoid bad strategy, we must acknowledge the challenges being faced and offer straightforward approaches to overcoming them, rather than defining goals that no one really knows how to achieve and pretending that they are feasible. Rumlet chose to illustrate this with the 'war on drugs', stating that *"no matter how desirable it might be to stop the use of illegal drugs, it is not a proximate objective because it is not feasible within the present legal and law-enforcement framework"*. The UKDPC observed that one of the factors that has undermined confidence in drug policy has been the widely expressed aim to 'eradicate' illegal drugs. This same observation came recently from Helen Clark, the former prime minister of New Zealand and chair of the Global Commission on Drug Policy. She stated that the UK Home Office needed to stop pursuing the "fantasy" of a drug-free society and that it's fixation with a costly and self-defeating strategy has bred misery. Clark concluded that the "UK Home Office is a major problem" and is refusing to think "outside the box."[20] It should be noted that an increasing number of ex-international leaders and public servants are becoming more vocal about the shortcomings of current drug policy, including individuals from the UK[21]. The language employed in the Government's initial response to Dame Carol Black's review suggests a continued commitment to what Clark refers to as 'self-defeating' goal, by citing "driving down demand" with "tough approaches" and "expansion of police activity to tackle those individuals who break the law". However, the consideration of "meaningful alternatives" suggests the possibility of new approaches,[22, 23] which we will discuss later.

Michael Barber is the author of several books on governance and founder and chairman of an advisory firm which helps government and other organisations to deliver improved outcomes for citizens. He discusses in detail how to define and develop well designed, realistic goals. One of his points, of particular relevance here, is his discussion of unintended consequences and the importance of returning to the moral purpose when setting goals. In other words, if a given target has perverse or unintended consequences which might defeat the wider moral purpose, then the target must be reevaluated.[24] We must allow for flexibility, rather than avoiding targets or goals altogether. Dr Ed Day recently acknowledged one such example in this year's annual report as UK Drug Recovery Champion–about 10 years ago recovery became equated with abstinence, and was presented as being in opposition to 'harm reduction' approaches such as opioid agonist treatment (e.g. with methadone or buprenorphine). This led to further divisions between people with expertise through training and experience. Day notes that serious substance use disorders are chronic conditions that can involve cycles of abstinence and relapse, often over several years, which requires a system of care blending both professional treatment services and peer-led recovery support services to bring about remission. The goal of being 'drug free' is thus identified here as unrealistic and causing negative consequences for the sector.[25]

Dame Carol Black acknowledges other unintended consequences that have arisen from the application of police enforcement, including the negative effects of involving individuals in the criminal justice system. The emphasis of the link between drugs and crime (a link made the first line of the Government's initial response to Black's recommendations)[26] has led historically to support for the provision of treatment for addiction, but it has also led to the assumption that all people who use drugs are suffering from substance use disorder and will inevitably fall into addiction and commit crime. Thus UK law treats all unauthorised use of controlled drugs as misuse by default and is guided by the principle that law enforcement measures affect levels of drug use.[27] Contrary to initial expectations, many independent and governmental reviews such as the Runciman Inquiry (2000), Home Affairs Committee (2002), Prime Minister's Strategy Unit (2003), Science and Technology Committee (2006), British Medical Association (2013), and the Home Office (2014) have all found an absence of solid evidence that increased enforcement reduces drug availability or demand.[28, 29, 30, 31, 32, 33] In fact, a meta-analysis of 40 studies found that harsher criminal sanctions were associated with higher probabilities of drug-related crime and a comparative analysis of 17 countries concluded that "drug use is not distributed evenly and is not simply related to drug policy, since countries with stringent user-level illegal drug policies did not [on average] have lower levels of use than countries with liberal ones".[34, 35]

In conclusion, it must be unilaterally accepted that none of the different approaches employed around the globe, whether repressive or liberal have created a drug free world. Changing trends in drug use seem more related to generational drug preferences, cultural determinants, shifting drug markets and socioeconomic conditions. While evaluating the success of a given drugs strategy, the degree to which the reader concludes that an approach is successful depends on what the primary goal of the policy is–to reduce the overall number of drug users, or to reduce the harm experienced in communities and to those who use drugs. The initial response from the government in terms of goals still appears to be weighted towards the former.

The Government estimates that a third of UK adults aged 16 to 59 have taken drugs at some point in their life.[36] Drug use is higher among younger adults; around one in five adults aged 16 to 24 years had taken a drug in the last year. UK law treats all unauthorised use of controlled drugs as misuse by default but the majority of drug users do not become dependent, do not commit other crimes, and do not cause harm to themselves or others.[37] In reality, the potential harmfulness of drug use depends not only on the substance, but also on the pattern and context of use. Most drug use is episodic, transient and generally non-problematic, suggesting a policy role for risk communications and other prevention-focused strategies that seek to minimise risks.[38] It also calls into question whether a punitive approach is a proportionate response to drug use, particularly when some groups, particularly some ethnic minorities, are more heavily policed than others.

Negative findings should not simply be viewed as an admission of failure but important lessons in a system that has the capacity to engage with those lessons and adapt. Acknowledging the failure of prohibited based approaches in particular does not necessarily mean doing away with prohibition policies altogether or that reducing the

demand (and thus supply) of illicit substances is not a worthy goal. One can defend strictly prohibition and enforcement oriented policies on the basis that reduction of harm to health would be much higher if drugs were not criminalised but it then ignores the unintended consequences that the pursuit of policies focused on criminalisation and enforcement have created.[39] These include policy displacement from a health based approach to a law enforcement based one, and substance displacement to less controllable and more dangerous substances (NPS); and the stigmatisation and marginalisation of drug users around the world, creating additional barriers to advice, help and treatment.

During our roundtable on building evidence in September 2012, many participants welcomed the inclusion of 'people with lived experience' of addiction in Dame Carol Black's review. They also felt that there should be better representation of people who use drugs, and that we should not treat people who use drugs as a homogenous mass, which is also in line one of the UKDPC's fundamentals for good policymaking - to engage individuals who are affected by the policies in the process of policy making through stakeholder engagement.[40] Roundtable participants also felt that the review's recommendations on reducing recreational drug use were unlikely to lead to improvements, and that the focus or goal should be on reducing harms of use and changing behaviour. This discord demonstrates the need for clarity of goals, and the need to return to Michael Barber's 'moral purpose'. Having seen the unintended consequences of our initial goals, and persisted with them, we have the opportunity to reconsider. In modifying them or in creating new goals, we must build in careful evaluation so that we can monitor for unintended consequences and adjust as required– we explore this in more detail in later sections.

An expert consultation by RAND Europe and UKDPC on good governance recommended actively engaging groups and individuals involved in the implementation of drug policies in the process of goal setting during policy development. (See Appendix 2.) Interactions between politics, moral viewpoints and evidence makes setting goals in the drug policy field complicated. Values and politics are important to the goal-setting process, since they are the process by which we decide what kind of society we want to live in, but there is a clear role for evidence in the consideration of what might be appropriate and realistic goals.[41] The drug policy field needs overarching goals that are realistic but aspirational.

There are unintended consequences of policies that have a narrow focus on restriction and assume all use is misuse. This rigid view has hampered the development of new medicines from controlled substances as well as stifling some legitimate commerce in adjacent fields.

Scientific and medical research with controlled drugs has been overregulated, particularly those in Schedule 1 of the Misuse of Drugs Act 1971, limiting growth of the UK life sciences sector.

The CDPRG report *Medicinal Use of Psilocybin* presents in detail the barriers associated with Schedule 1 drug research. There is little evidence of a social benefit to these

excessive controls, but clear evidence that they have slowed the development of new medicines, to the detriment of industry and patients. These barriers have been known to Parliament since at least 1998, when the House of Lords Select Committee on Science and Technology reported on the "daunting and excessive bureaucratic control" obstructing research and development. Clinical trials on medical psychedelics such as psilocybin have been very promising and attracted corresponding high levels of investment. There are hundreds of private companies engaging in medical psychedelic research and development in Q4 2021 alone Delix Therapeutics raised $70m and CaaMTech raised $22m (both in Series A) and Beckley Psytech closed at $80m in Series B. With over 50 psychedelics companies publicly listed across a number of exchanges, including the NYSE and NASDAQ, their combined market caps exceed $6bn. One of the largest of these companies is the UK based Compass Pathways, but despite this and due to the harsh regulatory environment, there are currently no psychedelic companies at all listed on the London stock exchange. In the United States, the National Institute on Drug Abuse (NIDA) has awarded $4 Million USD to researchers at Johns Hopkins University for studies using psilocybin in smoking cessation. Australia's Therapeutic goods Association (TGA) have awarded $15 Million AUD in grants to study psilocybin-assisted therapy as a mental health treatment. Meanwhile, the slice of a pie set to grow in value to $10 Billion USD by 2027, deserved by the UK for initiating this most promising new field of research, is being abdicated to those jurisdictions taking active steps to facilitate the research rather than stifle it. The CDPRG have been campaigning 24 months for a simple change to legislation, the rescheduling of psilocybin from Schedule 1 of the MDR 2001 to Schedule 2 with restrictions to mitigate inappropriate prescribing, during which time the window of opportunity has been closing. Participating in clinical trials of promising drugs is a key opportunity for patients whose needs are not adequately met by existing treatments, and this opportunity is not being maximised. There are also an estimated 1.4 million UK citizens who unlawfully access cannabis products in the belief that they provides them medical benefit[42] but cannabinoid-based drug development is still in its infancy, due in part to decades of strict regulatory control. **Returning to the 'moral purpose' and the spirit in which they were written, our drug laws should not inhibit the development of medicines.**

Drug policy has also raised barriers to legitimate commerce. For instance,the regulations involved with the production, sale and distribution of non-controlled cannabinoid wellness products containing CBD. These regulatory issues mainly relate to ambiguities in the legal status of CBD products. These were incompatible with scientific convention, inconsistent with case law, and unenforceable in practice, and have not been addressed in a timely or consistent manner. Again, **drug laws should also allow for authorised/licensed activities through appropriate regulation** - failure to do so not only puts the UK at a commercial disadvantage but also allows an unregulated market to continue to thrive.

3.3 BALANCED POLICY DESIGN

3.3 (a) Balancing Politics and Technocracy

Policy makers and citizens alike would like to believe that policy is proportionate to the

evidence, not inversely proportionate. The public expects, as a matter of course, to see rational and scientific policies that are rooted in evidence. Covid-19 has irrevocably increased awareness that the political and collective response to public health crises is best when guided by good science.[43, 44] However, the gap between what evidence indicates and what is specified in related legislation is particularly marked within the field of drug policy, as many leading academics in the field of drugs and drug policy, including independent evaluators sought by the UK government itself, argue. This paper has also sought to demonstrate the severity and impact of this for those affected. In 2012, the UKDPC's final report emphasised in a dedicated section, "Use of the Evidence Base" that a shift in the UK's relationship with evidence would be the most valuable change, and a commitment to improve how research and science informs policy, as per Dame Carol Black's review, presents an opportunity.

Q3. POLICY ABOUT CONTROLLED DRUGS IS SUCH A CONTROVERSIAL ISSUE, IT CAN BE DIFFICULT TO HAVE AN OBJECTIVE DEBATE ABOUT THE BEST SOLUTIONS

	Agree (Strongly Agree + Agree scores)	Disagree (Strongly Disagree + Disagree scores)	Don't Know
All MPs (n=105)	70%	26%	5%
Conservative MPs (n=59)	75%	22%	4%

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The UKDPC observed from participants in their research that "a consensus exists around a view that it is politically essential to 'be tough' no matter the effect". This means tough-sounding government rhetoric about drug use often contradicts evidence, including its own policies and evaluations of its own drug strategies. We provide three recent examples:

Example 1. Calls for companies to drug test employees as part of a wider call to "name and shame" middle class cocaine users with the assertion that this will have an impact on county lines and street crime[45]

Transform Drug Policy Foundation note that "county lines networks do not simply exist because some middle-class users buy cocaine. They exist because young people with few life chances are easily exploited by criminal gangs who exist only because the illegal market in drugs is so lucrative".[46] Furthermore, the Government's own research clearly states that drug gang violence and county lines are most closely linked to heroin and crack markets - this was recently acknowledged in response to a written parliamentary question answered on the 6th July 2021 by the Minister of State for Crime and Policing[47] The majority of harms associated with drug markets in London, including violence and child exploitation, occur in the part of the market that serves daily users of heroin and crack - most of these people are not employed. Evidence that drug testing employees would reduce violence and child exploitation is non-existent. Furthermore, evidence of the general effectiveness of employer-led drug testing to reduce the adverse effects of substance use is also lacking, based on a systematic review conducted in the US in 2019[48] The recent proposals contain no mechanism which could actually reduce drug use, with no consideration for the cost involved in properly engaging with such a scheme and the unintended consequences for the livelihoods of people who test positive, potentially

pushing them further into mental health problems and towards more problematic substance use. While politicians are of course right to be worried about the violence and child exploitation that occurs around drug markets, what isn't needed is ill-considered, ill-advised ideas that are impractical, ineffective and potentially damaging.

Example 2. Recent Calls for Test on Arrest

Appealing to the continued preoccupation with the red herring of "middle class cocaine users" and recreational drug users in general, the Home Secretary has also decided to 'target wealthy users' by introducing drug testing upon arrest, under a £15 million plan rolled out across all 43 police forces in England and Wales. Again, this ignores the disproportionality of policing, the fact that 'wealthy' users of drugs are unlikely to be policed or found committing street crime, and ignores a UK independent review which found that compulsory drug testing wasn't successful in engaging people in effective treatment and did not significantly reduce reoffending: "results from this review offer little justification for extending test on arrest".[49] Interestingly, the Home Office's own announcement for drug test on arrest[50] notes that as part of it's "comprehensive strategy to tackling the problems associated with drug misuse it has:

- Appointed Dame Carol Black as an independent adviser – whose independent review part 1 states that "enforcement activity can sometimes have unintended consequences, such as increasing levels of drug-related violence and the negative effects of involving individuals in the criminal justice system".

- Set up Project ADDER – which is being used to fund diversion schemes, which are recommended in Dame Carol Black's review along with several previous reviews, including David Lammy's in 2017,[51] and are noted in the government's initial response as part of their 'meaningful consequences' approach mentioned earlier.[52] Drug testing on arrest is a punitive environment whereas the purpose of diversion is to negate the need for an arrest, interview or an admission in the case of low level drug offences, and to divert the individual away from the criminal justice system. It enables police to lawfully and meaningfully turn a previously incriminating encounter into a positive health outcome which ensures the individual receives an assessment of their drug use on that day, and tailored education, awareness and harm reduction to reduce their drug use and the scheme has already been adopted by some police forces in the UK.

Example 3. Calls to control Nitrous Oxide under the MDA

Although the ACMD already concluded back in 2015 that the abuse of nitrous oxide does not warrant control under the Misuse of Drugs Act 1971, highlighting existing legal measures and public health safety advice in the form of four recommendations, the current Home Secretary has again, in September 2021, requested the ACMD to review the harm that nitrous oxide causes (on the basis of a 'slight increase' in use) and is ready to take "tough action." Nitrous oxide has consistently been found to be one of the least harmful drugs in terms of relative harms in the views of experts and researchers and is certainly not as harmful as tobacco and alcohol - a view shared by the public, who also do

not believe making a drug illegal is an effective way of preventing people from taking it. This view is consistent across party lines – 60% of Conservative voters and 67% of Labour voters believe criminalising drugs is futile for prevention. Nitrous Oxide is a recent example of what is clearly a social problem (reflected in the ACMD's recommendations back in 2015), requiring public health messaging that reliably conveys the harms of its use and promotes sensible and responsible behaviour. This includes related problems such as littering which can be better enforced with existing laws where acute issues occur. Simply banning it could create new problems whilst still failing to improve the current situation.

Serious action is required to tackle the UK's drug problems, but misguided attention to singular aspects of the drug policy challenge undermine what should be an overall strategy committed to building evidence and a conviction to adopt an evidence-based approach to policy. As the UKDPC observed: ***"The problems of unintended consequences and the prevailing orthodoxy of being seen to be tough on criminality continually generate clashing policy objectives and contradictions between aims and outcomes"*** (For more on the UKDPC's findings, see Appendix 2). As the examples above, and many more not included show, the temptation to engage in reactive policymaking is still hard to resist. The rest of this chapter will explore lessons and recommendations for a system that engenders coherence and complementarity and protects against political interference with short term interests.

In complex and unstable policy fields, it is acknowledged that evidence is only one among many competing factors influencing the policymaking process. There is also a mismatch between the slow pace of the linear model of evidence-based policy and the need for rapid implementation of policy so policy makers can be seen to be doing something about a problem. Mulgan warns that the professions working in policy fields in flux may be resistant to criticism and therefore be as much part of the problem as the solution, and also that their usual networks may be the last to recognise the need for change, and the most promising innovations are as likely to come from the margins. In these areas, new mechanisms are often needed to make use of knowledge, facilitating collaborations between stakeholders, practitioners, researchers and decision makers.

The problem of time-inconsistency is a recognised issue in policymaking, in which short term decisions are made that negate long-term goals. Jill Rutter, of the Institute for Government, notes that there are "commitment devices" designed to mitigate against this risk. The most studied sort of commitment device is to hand power to make decisions over to an independent technocratic institution. This type of model has been used to remove Ministers from having to make day-to-day decisions about the cost effectiveness of treatments in the NHS. The National Institute for Health and Clinical Excellence (NICE), established in 1999, makes decisions on what treatments should be offered. Its decisions can be overruled by Ministers but this only happens in rare cases.

During CDPRG's consultation on delivering cross-cutting policies, participants discussed the feasibility of moving decisions about drugs out of politics – it was compared to Gordon Brown's decision to give the Bank of England independent powers to set interest rates. Some panellists were sceptical that ministers would ever give up control over drugs

policy–one commented that this made it a matter of political art rather than organisational structure–although it was noted that the same views were previously held about interest rates. Some suggested that this approach might be most appropriate for specific areas of drug policy governance such as classification and scheduling of individual drugs, which can be more technical decisions. They have also been widely and consistently criticised as currently lacking scientific validation.[53, 54, 55]

The Misuse of Drugs Act provides no clear criteria of harm or danger to inform classification decisions. The government's proclivity for using the classification system as a means of 'sending out signals' to deter potential users and society at large is at odds with the stated objective of classifying drugs on the basis of harm.[56] The Home Office has confirmed that there has been no assessment of harmfulness for many controlled drugs, and that there are no plans to commission a comprehensive review.[57] Drug scheduling is closely associated with drug classification, as both systems are concerned with the potential harmfulness of drugs when misused. The UK scheduling system has also been criticised for lacking scientific validity, particularly in regard to some drugs in Schedule 1, many of which have not been reviewed by HMG since they were first scheduled in 1973. The UK has made insufficient efforts to keep regulations up to date with the evidence base, and has been slow to respond to emerging information. This has contributed to the aforementioned holding back of research involving potential future medicines derived from substances that find themselves in Schedule 1 of the Misuse of Drugs Act–the most restrictive schedule for substances thought to have no therapeutic value. The Home Office has been resistant to commissioning the ACMD to review the scheduling of psilocybin, a compound which has received breakthrough status in the United States for its early stage promising results in the treatment of depression (and potentially a number of other conditions)[58] This is despite the personal approval of this solution by the Prime Minister. Meanwhile, the Australian Therapeutic Goods administration has already established an Expert Panel to review the case for rescheduling both psilocybin and MDMA (which also has "breakthrough therapy" designation by the US FDA for the treatment of PTSD)[59]

We explored options for delegation of some decisions in drug policy in more depth. This can take the form of complete delegation of the decision (perhaps with legislated goals, such as we see in inflation targets for the Monetary Policy Committee), or it can take the form of *de facto* delegation, in which adherence to the recommendations is not required by law, but usually respected. In the case of drug policy, only narrow areas were thought by our consulted experts to be suitable for decision-making by an Arms Length Body (ALB), such as scheduling and classification decisions for individual drugs. The ACMD is requested to advise on these decisions, but as is described later in this section, their advice is not always accepted.

Drugs' positions in the schedules and classes is determined by law, and it would not be appropriate to give an ALB legislative powers, so of these options, only de facto delegation is currently available. One solution to this would be to remove the lists of individual drugs from the legislation, leaving legal definitions of the criteria for schedule or class membership. The decisions could then be completely delegated.

We consulted, through our roundtable with the Institute for Government, on how an ALB could be most effective. Firstly, all involved parties must understand the reasons for and advantages of delegating a decision, such as scheduling, to an ALB. It must also be seen internally to be necessary, competent, representative of a range of views, trustworthy, and subject to appropriate transparency and oversight requirements. The ACMD fulfils these latter criteria well, and the former would certainly be achievable—the public are receptive to evidence-based decisions in drug policy, and the political advantages of formally delegating this decision could be substantial.

Q4. THE PROCESS OF MAKING POLICY ABOUT CONTROLLED DRUGS IN THE UK SHOULD MAKE MORE USE OF EVIDENCE AND RESEARCH THAN IT CURRENTLY DOES

	Agree (Strongly Agree + Agree scores)	Disagree (Strongly Disagree + Disagree scores)	Don't Know
All MPs (n=105)	79%	6%	16%
Conservative MPs (n=59)	72%	9%	19%

Primary Research by Savanta for CDPRG (June, 2021)

3.3 (b) The Role of the Advisory Council on the Misuse of Drugs (ACMD)

Processes do already exist to guide policymaking in relation to drugs. The Advisory Council on the Misuse of Drugs (ACMD) is a statutory advisory non-departmental public body established under the provisions of the Misuse of Drugs Act 1971. The Government is required to consult with the ACMD before amending drug legislation. The ACMD has two core functions. One is advising Ministers about the harms of particular substances and hence whether and how they should be controlled; the other, enshrined in legislation, is that of providing advice about how the social harms of drugs can be addressed. This has led the ACMD over the years to provide policy advice about educational, preventive, treatment and criminal justice measures aimed at reducing those harms.

The ACMD has undertaken much valued work and provides excellent value for money but its members are overworked, unremunerated and are supported by a very limited secretariat. It is also disadvantaged by not being able to commission research[60] In 2006 the House of Commons Science and Technology Committee, as part of a broader inquiry into the government's handling of scientific evidence, found that the *"the Government's total reliance on the ACMD for provision of scientific advice on drugs policy gives the Council a critical role to play in ensuring that policy in this area is evidence based. It is, therefore, vital that the Council is fit for purpose and functioning effectively."*[61] The Committee found that while the ACMD is at liberty to set its own agenda (in addition to any tasks requested of it by the Government) it tends to operate as more of a "reactive body, where the Minister dictates its agenda and the scope and remit of its inquiries."[62] In 2012 the UKDPC found that the ACMD was increasingly dedicated to investigating and making recommendations on new drugs (in part due to the rapid development of new psychoactive substances) rather than a comprehensive programme of wider research and policy analysis. The commission recommended that the government should initiate a formal review of the powers and remit of the ACMD and explore different options for the assessment of harms and the classification process.[63]

A more recent analysis (March 2021) from a former member of ACMD highlights that many of the same issues persist and discusses how agenda-setting and self-censorship has reinforced the exclusion of other forms of knowledge, further narrowing the range of people and ideas that shape evidence for policy.[64] The ACMD has also suffered from claims of political vetting (which compromises their necessary objectivity).[65, 66]

While the government is required to consult with the ACMD before amending drug legislation, it is not obliged to follow the ACMD's advice and often does not. It has faced increasing criticism over the way in which policy related to drugs is made in the UK, particularly around the use of evidence.[67, 68] A prime example is the classification of cannabis, which the ACMD has consistently recommended should be controlled as a class C drug.[69]Currently, the Home Office have been resistant to consulting the ACMD on the aforementioned scheduling of psilocybin for the purposes of facilitating medical research in the substance in the UK, despite the Home Office confirming that the substance (and a number of other controlled drugs) have not been not been subject to analysis or recent analysis of harm.[70, 71]

The issue of the relationship between the Home Office, ACMD and use of evidence in general is contentious, with concerns that short term political priorities are taking precedence over evidence. This has led to high profile policymakers and academics disagreeing publicly with government advisors.[72, 73] A previous home secretary has been publicly accused of toning down a government report that recommended decriminalisation of low-level drug possession on the basis of extensive evidence that enforcing tough drug laws doesn't necessarily reduce levels of drug use and that decriminalising the possession of drugs doesn't necessarily increase levels of use[74, 75, 76] This year (March 2021) Public Health England was similarly accused of making a number of amendments that modified the thrust of the original report, which had set out the benefits of medically supervised Overdose Prevention Centers including evidence that stated that the model has contributed to lower rates of fatal overdoses.[77] The timing of the accusation undermined the integrity of Public Health England during a recognised drug death crisis in Scotland where there is interest in piloting these schemes in affected cities. More recently still (October 2021), an anonymous researcher claimed to have seen a 2016 report by the ACMD which explicitly recommended the decriminalisation of low-level drug possession (likely in the form of diversion from the criminal justice system for those that comply with the police-led scheme) including a recommendation to the repeal of the subsection of the Misuse of Drugs Act. According to the researcher who has seen the report, speaking under the condition of anonymity due to reputational fears: "The Home Office is nervous about it being published because it goes so contrary to their line on decriminalisation: that they're not going to do it, and that there's no reason to"[78] Attempts to access the contents of the report through Freedom of Information requests were met with long delays and were ultimately rejected on the basis that the contents are subject to "active consideration"[79] (nearly 5 years since the report was written). This is part of broader accusations that the UK government has been blocking the release of information to the public following a recent report which alleged that last year was the worst year for transparency since the Freedom of Information Act came into force in 2005.[80]

The Home Office's outright rejection of the term decriminisation is interesting, because it appears to be a matter of semantics. A taxonomy of alternatives to criminalisation for simple possession of drugs produced six different categories, many of which are simply prohibition with civil sanctions - a type of decriminalisation. Diversion schemes would fit this description; they are growing in popularity across the UK and the Home Office's own ADDER scheme supports them.[81]

The role of the ACMD in relationship to the new JCDU has not been made clear but given the history between the ACMD and the Home Office, and the fact the ACMD is under-resourced, this relationship should not go ignored if the link between drug policy and the Government's creation and use of evidence is to develop. Furthermore, the ACMD's contribution towards policy design is, in reality, very limited. While we acknowledge that this is a sensitive policy area where scientific advice is just one input into decision making, the Home Office should be more transparent about the various factors influencing its decisions.[82] If ministers do not act transparently it creates the perception that evidence is being ignored which creates division between academics and researchers, and no doubt lends itself to view that drug policy does not make good use of evidence and is governed poorly.

3.3 (c) Considering Wider Policy Options

Q2. IF WE ARE TO IMPROVE THE WAY WE TACKLE PROBLEMS CAUSED BY CONTROLLED DRUGS, WE NEED TO CHANGE HOW WE MAKE DRUG POLICY

	Agree (Strongly Agree + Agree scores)	Disagree (Strongly Disagree + Disagree scores)	Don't Know
All MPs (n=105)	71%	18%	11%
Conservative MPs (n=59)	61%	24%	14%

Q6. FIFTY YEARS ON FROM THE ROYAL ASSENT OF THE MISUSE OF DRUGS ACT 1971, IT IS TIME FOR GOVERNMENT TO UPDATE UK DRUG CONTROL LAWS, BASED ON THE BEST EVIDENCE AVAILABLE TODAY

	Agree (Strongly Agree + Agree scores)	Disagree (Strongly Disagree + Disagree scores)	Don't Know
All MPs (n=105)	79%	13%	8%
Conservative MPs (n=59)	74%	17%	9%

Primary Research by Savanta for CDPRG (June, 2021)

The UKDPC notes that policy design needs to be able to balance scientific evidence with other types of evidence (e.g. public and expert views, politics, innovative practice) in a way that is transparent. Policy cannot ever claim to be evidence-based if there is no methodology or explanation of how conclusions were reached. They also state that policy design needs to generate ideas and options which have clear logic models underpinning them and incorporate clearer mechanisms for evaluation and feedback and incorporation of learning (See Appendix 2).

One example of an alternative model of policymaking better suited to the complexities of

such new and in flux policy fields is proposed by Sanderson (2009) who shows how evidence can most appropriately be used in areas where there is uncertainty about the best way to proceed. Sanderson urges us to *"treat our policies as hypotheses to be tested in practice, to be piloted where feasible and appropriate and to be subject to rigorous evaluation"*. Even where policy areas are more established, we still need to implement rigorous monitoring and evaluation processes "to test the validity of the assumptions upon which the policy is based" (Sanderson 2009: 714).[83] If we apply this approach to drug policy, such as the many different ways adult-use cannabis markets have been implemented internationally, or varying forms of decriminalisation, it would suggest that these innovations will only ever be truly useful if their attempts are carefully and comparatively evaluated to see what is and isn't working, taking into account how different settings will impact the effectiveness and suitability of different approaches. For example, a member at our Building Evidence roundtable observed that the evaluation of Portugal's decision to decriminalise all drugs in 2001 (possession became a civil matter, rather than criminal) missed an opportunity to gather more robust data on drug harms and deaths, focusing instead on other outcomes, such as HIV transmission.

Drug policymaking is of course not alone in being complex, cross-cutting, and requiring a coherent central strategy. This year's Integrated Review of Security, Defence, Development and Foreign Policy is a demonstration of the ambition and commitment available, and there are numerous other areas of UK policymaking from which lessons can be learned.[84]

The UK is also signatory to a number of international conventions which impact our approach . These place some obligations and restrictions on the policy options available, although there is considerable 'room to manoeuvre' within these, and there is national discretion as to the domestic policymaking structures and processes.[85, 86]

The Public Health Institute, part of Liverpool John Moore's University, was the coordinating UK arm of European Monitoring Centre for Drugs and Drug Addiction's (EMCDDA) early warning system on psychoactive drugs, also feeding into UK monitoring systems.[87] However, the UK recently left the EMCDDA in line with the Brexit Withdrawal Agreement, and no longer takes part in the annual reporting process.[88] The UK is able to rejoin EMCDDA, and it would absolutely be in our interests to do so - no other international organisation makes the same commitments to thorough and consistent evaluation of drug issues. Extensive and detailed monitoring of availability and purity of drugs, and forecasting the emergence and consequences of new psychoactive substances, are crucial functions that we cannot adequately replace. It is vital that the new Office for Health Improvement and Disparities (OHID) are engaged through the JCDU in relation to intelligence sharing and public health responses to international drug threats, particularly considering the emergence of novel opioids and benzodiazepines on the European drugs market.

The UKDPC, in a submission to Sir David Omand's review of the ACMD, noted that the ACMD did not have the capacity to engage in issues of international drug control. International partners' insight and experience is an important source of learning from other contexts, and liaison with international officials provides input into the process.[89]

Withdrawal from the EMCDDA will have reduced the overall UK capacity further.

Dr Caroline Chatwin, a Reader in Criminology at the University of Kent whose research focuses on global drug policy, reinforces many of the UKDPC's recommendations on the importance of international engagement from a research perspective. Many countries collect data, this is often encouraged by a regional agency such as the EMCDDA, which collects the data and produces annual reports on the state of the drug problem. Regional agencies like the EMCDDA can also feed up to UNODC who facilitate comparisons between countries and regions, and apply it to current issues. These reports help countries see their issues and approaches in context, and improve the quality of debate and governance. Essentially, the EMCDDA offers much of the key data British policy makers need to draw up informed drug laws and strategies.[90]

The main focus of this report has been on domestic policymaking processes but UK drug policy cannot move forward it is not willing to innovate, and some ideas for innovation may come from overseas examples and learnings. Drug policy innovations should be, as per Sanderson's remarks, treated as 'hypotheses to be tested in practice'. In Mulgan's discussion of 'in flux' policy fields in general, he states that such fields will need to support heterodox ideas by piloting promising innovations. Building on this, Dr Caroline Chatwin, notes that evaluation of innovative strategies of drug control only becomes worthwhile if the results are compared and evaluated for effectiveness across a variety of settings and then accurately and comprehensively disseminated to the wider world, so those seeking to make improvements to their own national or regional policies can make an informed choice from a range of options.[91] Localities wanting to pilot new approaches in the UK, such as those suffering from particularly severe drug-related problems, should therefore be supported in doing so in a way that robustly contributes to the evidence base. However, UK drug policy researchers, during the Building Evidence roundtable stated that they felt stuck in a Catch-22 scenario, whereby the Home Office often cite international evidence as not being applicable enough to permit trialing new things in the UK, but in order to get the necessary evidence the schemes would need be piloted and tested in the UK. An example of a particularly contested topic at the moment is the case of medically supervised Overdose Prevention Centers (OPCs). In the view of this government *'A range of crimes would be committed in the course of running such a facility, by both service users and staff' and the actions of the staff would 'encourage or assist these and other offences'*.[92] The Government's interpretation of UK legislation in regard to OPCs is contested by individuals in legal fields but this government will not clarify whether or not it has received written legal opinion on the provisions in law that would be engaged by the operation of an OPC.[93, 94] In order to pilot and evaluate the utility of alternative approaches on UK soil, a license, temporary license, or change to secondary legislation is needed to generate the evidence. This would help determine their suitability for the UK more broadly and contribute UK-specific learnings about the UK drug problem. One roundtable participant noted as an academic and a researcher, "I am more than happy to provide the evidence needed by policymakers and for my evidence to be challenged, that is my job, but let me provide you with the evidence". They hoped that this evidence would be constructively and transparently engaged with in return. This particular case comes to the frustration of Scotland who have the highest drug death capital in Europe and want to pilot innovative schemes which have

performed well in other international settings. The threat of criminalisation of the individuals who use these services is also problematic because it creates obstacles to such health interventions. This is the premise behind the increasing number of health bodies such as the World Health Organisation, as well as the Royal Society for Public Health and the Royal College of Physicians in the UK that support the removal of criminal sanctions for drug use (possession) alone (typically replaced with civil penalties through diversion). It should be noted that one goal of harm reduction is to connect individuals who use drugs with other health services and education–the outcomes either being prevention of substance-related problems or engaging the individual in treatment. To be clear, the point or goal here isn't necessarily to introduce OPCs or introduce broad decriminalisation, and certainly not from a top-down central government level, but to demonstrate how unfertile the grounds are in the UK for a transparent and honest debate about such topics. The UKDPC's work on the characteristics of good drug policy governance also note that to maximise effectiveness and value for money, a wide range of options must be considered. (See Appendix 2)

The solution is not to water down evidence and evaluation but to create a delivery model that is able to compromise between competing needs, admit uncertainty, find flexibility and be adaptive to new evidence or evaluations of existing programmes. The capacity is needed to turn disparate bodies of knowledge into multiple sets of evidence that inform and influence policy rather than determine it. This could be expressed by creating a clear framework for piloting policy innovations in areas of high need. This could also relieve tensions in the areas of the UK that are intending to proceed with testing new schemes regardless of the current government's view that it is in contravention of the Misuse of Drugs Act (legal opinions differ). A notable example is Scotland's plan to set up OPCs in defiance of the UK government.[95, 96] The CDPRG are also aware of other Local Authorities prepared to introduce OPCs and other schemes designed to reduce harm that are deemed by the Government to be in contravention of the Misuse of Drugs Act. They are taking this step because they see them as a viable route to addressing drug-related harm and risk in their areas, and they see the Government as ignoring the evidence in their favour and denying them the chance to be proactive within their own communities.

Part of Dame Carol Black's recommendations are that local authorities commission a full range of evidence-based harm reduction and treatment services to meet the needs of their local population in line with the new national Commissioning Quality Standard.

Critical questions for the JCDU — will it have the capacity and political backing needed to support the piloting of approaches new to the UK? Will it have the confidence to direct drug policy on the basis of what is shown to work, and respond effectively to new evidence?

As previously discussed, the parameters of the Dame Carol Black review deliberately excluded any review of the legislation. At a Westminster hall debate following the review on the 27th October 2021, this was raised as a concern on several occasions by MPs in attendance.[97] Several of those at the debate wanted to see a review of the Misuse of Drugs Act 1971,[98] to ensure the legal framework is fit for purpose 50 years on from it's royal assent. 75 MPs

currently support a review of the Misuse of Drugs Act 1971, and as our polling of MP attitudes revealed: 79% (of a representative sample) think it is time for the Government to update UK drug control laws, based on the best evidence available today. It is not yet clear whether the JCDU has the scope or intention to review legislation and address these additional matters (see Appendix 1 for a full breakdown of polling data commissioned by the CDPRG).

3.3 (d) Designing for Evaluation

Government Strategy has lacked logic models or evaluation framework to monitor and evaluate outcomes of its drug strategy meaning effectiveness and value for money cannot be reliably assessed.[99, 100, 101] These are not policies that have been designed to be reviewed or have clear outcomes. A theme that came up from policymakers in the UKDPC's review was a reluctance to evaluate and learn lessons, as observed by one interviewee: *"if you're not doing evidence-based policymaking, you're not following up to see whether the evidence you were using has been good enough to inform the right policy decisions"*. Ambiguity means no-one is quite sure what effectiveness would look like. Failure to implement systems to monitor and evaluate outcomes and investment in research, particularly the social sciences, means the UK has missed opportunities to gather valuable data to improve upon its own policymaking. This needs redressing if policy makers are to be able to identify and introduce effective measures[102] Existing policies need to have rigorous monitoring and evaluation processes to test the validity of the assumptions upon which the policy is based, with innovative policies treated as hypotheses to be tested in practice.

The commitment to have a new National Outcome Framework, which should be able to publish annual data on areas such as the 'impact of enforcement action on supply' is welcome. However it is not clear how this impact would be measured, which has historically presented an on-going resistance to measure properly. Drug seizures have been the default which do not reflect success in reducing the availability of drugs, while outcome measures that more closely link to availability such as price, purity and user questionnaires have been avoided.[103, 104] The 1998 drug strategy did introduce targets for drug availability, but it failed to include a baseline and methodology for measurement and it was dropped in 2004. Based on these past events we are not convinced that the introduction of a new National Outcomes Framework will be a success without a clear commitment to guarantee the development of appropriate indicators. If the upcoming drug strategy does not include a clear framework for assessment, we are concerned that "impact on supply' will continue to not be measured in a way that is useful to our understanding and ultimately for the use of policymakers. This is a contentious issue. When the NAO reviewed the UK drug Strategy in 2010 it said it struggled with the absence of evidence of effectiveness of many areas of the strategy, in particular around the impact of enforcement and some prevention interventions. Following the NAO's findings, the Public Accounts Committee concluded that: *"Given the public money spent on the strategy and the cost to society, we find it unacceptable that the Department has not carried out sufficient evaluation of the programme of measures in the strategy and does not know if the strategy is directly reducing the overall cost of drug-related crimes. Following a recommendation made by*

the National Audit Office, the Department has agreed to produce an overall framework to evaluate and report on the value for money achieved from the strategy, with initial results from late 2011." - which never materialised.[105, 106, 107]

We welcome the call's in Dame Carol Black's report for an increased focus on primary prevention and early intervention, and for the JCDU to engage with the minister for the Department for Education to seize the major prevention opportunity presented by the statutory guidance for Relationships, Sex and Health Education (RSHE). This certainly signals a step in the right direction, but without clarity on principal policy goals and sensible metrics, there is a serious risk of maintaining the same focus on self-defeating goals which perpetuate flawed notions and can lead to unintended consequences. In the past, programmes which try to prevent people from using drugs through fear-mongering and scare tactics have been shown to make drugs seem more alluring and increase the risk of use, not decreasing it.[108] Harry Summnal, a Professor in Substance Use at the Public Health Institute adds that campaigns which suggest that people who use drugs are morally corrupt often make the problem worse by increasing stigma and creating barriers to help-seeking.[109, 110] Drugs information and education is best when it provides factual information. Current member of the ACMD, Harry Shapiro, advises that a *"intuitively, a better approach is not to isolate drugs as something outside normal experience, but instead incorporate any discussions into other areas concerning alcohol, smoking, relationships and sex, diet and nutrition, body image and bullying"*[111]. Universities may have to deal more directly with substances that feature in unique ways on their campuses, including alcohol and non-prescribed prescription drugs such as adderall, modafinil, and benzodiazepines.

The goals for primary prevention must learn from Dr Ed Day's examination of the unintended consequences of some drug treatment goals. Engaging Michael Barber's recommendations, if we hope to avoid these, the process should include well designed targets and benchmarking, apply the best available evidence to target setting (what we know works and what we know doesn't work) and check for unintended consequences, returning to the 'moral purpose' as part of the policy evaluation stage.[112]

It is unclear how the new National Outcomes Framework will incorporate the discussion in Dame Carol Black's report about suitable outcome measures. It is also unclear if previously used outcomes will be continued or modified, or if novel outcome measures will be explored. There is growing recognition internationally that there are a lot of missing indicators in the current data used for assessing the drug situation. Dr Carline Chatwin notes the "increasing calls, from a variety of countries and regions and from NGOs for the development of new metrics to improve evaluation of policy effectiveness - metrics that measure outcomes that really matter to individuals and communities - which should be overseen by an advisory group". International stakeholders need to commit to revising the existing metrics used to evaluate drug control policies and outline a detailed set of alternative indicators (drawing on the existing work of the World Health Organisation and other international organisations).

Proposals for metrics have included: access to sterile injection equipment and opioid substitution treatment, prevalence of drug-related emergency room presentations, the

proportion of people with drug dependence that have access to stable housing, incidences of drug-market related homicide and violence, and drug use-related traffic accidents.[113] A common problem is also not collecting data on the substance involved – this includes the drugs recorded in cases of hospitalisations, where coding is not always detailed enough, such as the family of drug, rather than the precise substance(s), particularly in the case of adulterated drugs and New Psychoactive Substances. This is also a problem in the Criminal Justice System. Engaging in this area ensures robust benchmarking and outcome frameworks can be developed. Expansion of the DataFirst initiative by the MoJ, who further support unlocking existing but unused data, could generate new relevant measurable outcomes, as well as helping evaluate the utility of existing outcomes frameworks.

Improvement therefore requires directive engagement with a number of departments. It is not yet clear how the government's new unit will work with the ACMD and vice versa. Under the Misuse of Drug Act, the ACMD is based in the Home Office but it's supposed to be responsive to all departments. Clarity of the relationship between the ACMD and JDCU and other departments is therefore needed.

Another concern expressed by parliamentarians at the Westminster hall debate in October, and more broadly across the drug policy field, is regarding the JCDU being housed under the Home Office, which has typically been resistant or slow to react to emerging evidence and in the light of repeated and fresh accusations of interference with government reports. The commitment to Dame Carol Black's 32 recommendations is a notable change, but it is not clear, given that the recommendations focus heavily on re-building the provision of treatment across the country and not on drug policy issues beyond their remit, whether the new unit will have the capacity or the drive to engage with these wider challenges.

There is a difference between the overarching goals discussed earlier and the more detailed objectives or metrics that need to stem from these such as those discussed here. Better metrics will improve our ability to understand the drugs issue and design effective responses to it. However, it needs to be kept in mind that it will never result in universal or concrete 'solutions' to the problem. This might seem like it undermines the usefulness of drug policy evaluation but it is the notion that this is a problem that can be solved if we try enough that is problematic. Social problems are never solved. At best they are only re-solved over and over again. Particularly in the drugs field where new substances and patterns of use change over time and are in a constant state of flux. As David Bewley-Taylor, founding Director of the Global Drug Policy Observatory and Professor of International Relations and Public Policy at Swansea University observes, metrics relating to drug policy outcomes have been dominated by the activities of law enforcement agencies, which are resilient in part because they provide politically useful certainty within a complex, fluid and ultimately problematic policy domain. More appropriate and holistic indicators should be developed, and this would require the creation of new data capturing mechanisms. Better data would allow more informed conclusions about the overall effectiveness of the drug strategy, comparisons between areas that have adopted specific policies, and enable proper benchmarking.

As per Dame Carol Black's recommendation, the JCDU should have strong analytical capacity including both National and Local Outcomes Frameworks with annual reporting from the sponsoring minister to Parliament on progress. It is unclear how the JCDU would initiate the process of determining additional, more appropriate metrics or whether it intends to. CDPRG recommends data gaps that prevent full evaluation of effectiveness and cost-effectiveness of interventions against policy goals need to be identified and to ensure that that subsequent drug strategies commit to improving the collection of relevant data.

Based on the findings presented in this section and from other reports and evaluations including our own consultations, we believe there is an urgent need for an independent research body to help coordinate research, provide appropriate frameworks to monitor and assess drug policy innovations at local levels, and keep the government alert to new threats and opportunities. We think the UK would benefit from a hub and spoke model connecting existing research centres into a single network with pooled funding prioritised by a national drug research strategy to coordinate and facilitate research, including –

A Centre for Drug Disorders (e.g. addiction research, drug-related psychoses, drug-related diseases) which would advance research into the causes and features of drug-related harms and drug-use disorders, including addiction and drug-related psychoses. The Centre would coordinate research and pilot programmes to improve the identification, management and treatment of problematic drug use, in line with Dame Carol Black's recommendations for greater investment and innovation in that area. A dedicated research programme in drug toxicology would improve understanding of the short- and long-term risks of drug exposure, informing the regulatory development of new drug markets such as hemp-based food and consumer products.

A Clinical and Experimental Research Centre (e.g. genomics, informatics, pharmacology, biomarkers & therapeutics, drug development) which would advance clinical, experimental and translational drug science, with a focus on innovative research methodologies. With research streams in genomics and informatics, the Centre would accelerate understanding of drug pharmacology and human physiology, supporting the development of new targeted therapies. As some other countries have done, this could include a 'Centre for Cannabinoid Science', which would advance research into the human endocannabinoid system, cannabinoid pharmacology, and the phytochemistry and agriculture of Cannabis species. This centre would play a key role in identifying targeted cannabinoid biomarkers and therapeutics, accelerating drug development in this area to improve patient access to safe and effective medicines. There are clear medical, ethical and economic benefits to reducing reliance on unlawful routes of access to cannabis products among patient populations seeking symptomatic relief, and investment in cannabinoid science will play an important role in developing the necessary evidence base. The 100,000 UK citizens currently growing their own cannabis to self-treat medical conditions represent a vast resource of untapped data lying dormant; systematic study of this population may reveal important insights for cannabinoid science.

A Centre for Social Drug Research (e.g. education, sociology and criminology of drug use, social and medical anthropology, behavioural and social psychology; which would coordinate social science and humanities research in drug use. With programmes integrating sociology, criminology, sociology, anthropology, psychology and history, the Centre would be a global hub of expertise in the sociocultural determinants of drug use trends and outcomes. These research outputs would provide a nuanced understanding of drug-related behaviours and attitudes to improve trend monitoring, identify high-yield areas for educational and prevention interventions, and predict policy outcomes.

A Centre for Risk Management and Monitoring (e.g. evaluation of national policy and local approaches, operational delivery audits, emerging issues of concern) which would establish a hub for the evaluation of drug policy outcomes, identifying unintended adverse consequences and tracking measures of the effectiveness of new policy interventions. Working alongside the Controlled Medicines Unit, the Centre would monitor UK controlled drug prescribing trends to identify rates of diversion, dependence and inappropriate prescribing. In collaboration with the Drug Crime Team and the Centre for Social Drug Research, the Centre would review and make recommendations on the effectiveness of drug law enforcement measures. The Centre would also play a key role in strengthening local, national and international early warning systems, such as the New Psychoactive Substances Watch List and the Trans European Drug Information (TEDI) network.

As this framework demonstrates, such an institution would have the capacity to bridge the gap between diagnostics, disease, natural sciences and social sciences, addressing a long-standing under-representation of social sciences as well as proper evaluation of existing drug control strategies. A National Institute for Drug Science (NIDS) would be the body that to provide such support to local areas wishing to implement new approaches to existing drug problems; in addition to helping to coordinate a "*very fragmented*" research landscape (as it was described in our September roundtable) — *(see Appendix 3)*. This would also support the need for structures and processes to scrutinise and evaluate emerging local approaches, to highlight and spread good practice and identify problems early, and to strengthen local accountability in support of the National Outcomes Framework. This would be particularly pertinent to areas most affected by drug-use problems which will benefit from Project ADDER funding. Local authorities in development of their own drug strategies would be able to engage with a body able to advise best practice based on the best available evidence and minimum requirements informed by an already in place drug research strategy plan. All-encompassing oversight from a NIDS would mean research across localities is also better coordinated. In cases of proposals for more controversial proposals such as OPCs, festival or city-based drug testing, or the provision of diamorphine assisted treatment for addiction from the third sector, would mean a formal, transparent process for pilot projects which allow the pilot providers to engage proactively with a system and framework designed to provide support. This would ensure at the off-set that evaluation sufficient to meet the expectations of policymakers would be built in at the start and therefore assist in determining whether the project should continue, adapt, or end, as well as how their learnings can be shared. This approach also ensures that local areas retain the power to design and commission services which meet the needs of those in

their communities, with expert support and clear goals, and reduces the prevalence of pockets of poor practice. The results will support the UK's wider understanding of drug-related problems and which approaches are most promising and offer the best value for money.

Such a model would not only serve to root drug policy governance and drug policy in the best available evidence, it could launch the UK back into the international sphere of evidence generation about drugs and treatment, and unlock opportunities in life sciences and other sectors as well as horizon scanning for new opportunities and new threats based on emerging data. With support from the newly established National Institute for Drug Science, the ACMD would be given greater flexibility and resources to independently review and advise on drug control issues.

3.4 STRONG LEADERSHIP

There was consensus among participants at the Institute for Government (IfG) roundtable that successful drug policymaking requires strong political will and leadership from the Prime Minister and the sponsoring minister of the drugs unit to secure and maintain buy-in from involved departments and, crucially, the Treasury. Several participants observed that the current Prime Minister has demonstrated a particular interest in this policy area. It was noted that senior officials must be invested in efforts to improve the drug control system and able to coordinate the involved departments' contributions and resolve tensions. Participants highlighted the issue of differing departmental cultures obstructing good working relationships. To reduce this friction it was recommended that differences in values and approaches to the relevant evidence base must be resolved early in the policymaking process, with common frameworks agreed on.

In a four-part expert consultation on good governance in drug policy, published in 2012 by RAND Europe and the UKDPC, effective leadership was associated with three primary characteristics:[114]

1. Creation of consensus and cross-departmental support;
2. Sufficient authority and access to resources;
3. Recognition of the importance of evidence and evaluation, including willingness to make changes based on feedback.

Effective leadership was a high priority for respondents in the RAND consultation, but there was no consensus support for any particular leadership structure, so long as it demonstrated these attributes. Most respondents favoured some form of hybrid leadership structure in which a centralised senior leader was linked to a cross-departmental structure and an independent advisory body responsible for evaluation of policy outcomes. The cross-departmental JCDU and its sponsoring minister fit these broad structural criteria, with the ACMD providing advisory input. The minister and the unit's senior officials will need to exhibit the above characteristics of leadership if there is to be a lasting positive impact on the drug policymaking process.

Participants at the IfG roundtable raised the example of the Central Drugs Coordination Unit under the Blair Government (later the Anti-Drugs Coordination Unit) to show how efforts were hindered by limited engagement from involved departments and a lack of levers to improve engagement. The Unit was established in 1994 partly in response to concerns about the coordination and collaboration of drug control interventions, but it was seen to have limited effectiveness in practice due to an inability to push through its recommendations, often linked to involved departments declining to fund proposals. Similar obstacles may be faced by the JCDU if firm commitments are not made by spending departments to meet the recommendations for new investment made in Dame Carol Black's Part 2 report, which totalled £1.78 billion from the DHSC and £64.5 million from the DWP over five years. It remains unclear how much has been allocated for these purposes in the recent spending review.

3.5 CROSS-GOVERNMENT COORDINATION

Q5. IMPROVED CROSS-DEPARTMENTAL COORDINATION OF DRUG POLICY WOULD HELP THE UK TO MORE EFFECTIVELY TACKLE THE HEALTH, CRIME AND SOCIAL PROBLEMS CAUSED BY CONTROLLED DRUGS

	Agree (Strongly Agree + Agree scores)	Disagree (Strongly Disagree + Disagree scores)	Don't Know
All MPs (n=105)	90%	4%	5%
Conservative MPs (n=59)	85%	6%	8%

Primary Research by Savanta for CDPRG (June, 2021)

Drug policy is an unusually complex and cross-cutting policy area, with at least six departments directly involved in interventions to tackle the problems of drug misuse (i.e. Home Office, DHSC, MoJ, DfE, DWP, and MHCLG). Several further departments and public bodies have an interest in sectors involved in the licensed or otherwise authorised uses of controlled drugs and their derived products for research, medicine, agriculture and commerce (e.g. FSA, MHRA, DBEIS, DIT, DEFRA).

A variety of governance structures for coordinating cross-departmental input have been established over the past few decades, including the Central Drugs Coordination Unit attached to the Privy Council Office in 1994, the Anti-Drugs Coordination Unit and its corresponding Cabinet Sub-Committee on Drug Misuse in 1997, the Inter-Ministerial Group on Drugs in 2010, the Drug Strategy Board in 2017, and subsequently the Crime and Justice Taskforce. These structures ranged widely in terms of leadership, effectiveness, and consistency. Only four meetings of the Drug Strategy Board took place over its two-year existence and there was no fixed representation from the DHSC, DWP, DfE or MHCLG on the membership of the Crime and Justice Taskforce. CDPRG polling in May-June 2021 found that 90% of MPs overall and 85% of Conservative MPs agreed that improved cross-departmental coordination of drug policy would help the UK to more effectively tackle the health, crime and social problems caused by controlled drugs.

Over recent years, communication and coordination between and within departments on drug policy issues has been inadequate. In previous CDPRG reports, we have covered some of these issues relating to the regulatory frameworks for the non-controlled cannabinoid cannabidiol (CBD). The Drugs and Firearms Licensing Unit (DFLU) at the

Home Office reported emerging challenges experienced by their staff in the operational delivery of unclear policies on CBD to the Home Office Drugs Policy team, but these issues were not subsequently raised to the level of ministers for several years on the presumption that they would be considered low priority. Without ministerial input, no policy clarification was made, leaving the DFLU effectively unable to issue licenses for activities relating to CBD supply chains or provide a reasonable explanation to applicants.

This lack of clarity and operational capability contributed to complex quality and supply issues in the market, with associated risks to consumer health and underregulation of the developing industry. When CBD regulation became a higher priority for the Home Office at the end of 2020, a policymaking process was initiated with a commission to the ACMD. This process was designed to clarify purity thresholds at which CBD could be considered a non-narcotic. At the same time, the Food Standards Agency was implementing its own regulatory pathway for the authorisation of CBD-based novel foods. Inadequate communication between the Home Office and the FSA in regard to the controlled status of CBD formulations under UK drug law led to widespread confusion and instability in the consumer CBD market. The ACMD commission and the corresponding Home Office policy is now almost half a year overdue.

The four-part RAND Europe / UKDPC consultation on good governance in drug policy identified several key themes relating to effective cross-government coordination. It found that good coordination must begin at a high enough level of office to ensure resources and cross-departmental engagement. Assigning clear, transparent responsibilities to individuals and departments for delivering specific policies and outcomes was found to be essential for avoiding 'passing the buck' between policymakers and inappropriate distribution of power, including the possible exclusion of interested parties. Thirdly, it recommended that coordination should begin at the point of goal setting, including individuals and sectors involved in implementation. (See Appendix 2 for key insights.)

Dame Carol Black's recommendation for a central cross-cutting Drugs Unit is most welcome and the new JCDU, if it is adequately resourced and proves to be effective, will represent the most significant advancement of cross-government coordination of drug policymaking and delivery in twenty years. The unit will be housed in the Home Office with officials seconded in from five other departments. However, participants of our roundtable consultations raised the need for oversight of cross-department relations. Shortcomings in effective joining up are a longstanding critique of government and respondents cautioned that interdepartmental frictions and competing priorities may impede collaboration.

Some respondents–though not all–felt that the Home Office was not the appropriate department to lead on drug strategy. Justifications for this position included the view that substance misuse and treatment were principally health issues; that law-enforcement interventions, while necessary for tackling organised drug crime, were not supported by strong evidence of effectiveness for reducing possession and low-level supply offences; and a departmental culture at the Home Office that was felt to be historically closed-minded about widening policy options and embracing evidence-

based process. Some respondents felt that the Home Office acted obstructively in various areas of drug policy, such as discounting data on interventions conducted overseas while blocking the generation of data through pilot schemes domestically. Similar views were reported in the consultations conducted by the UKDPC, and among the commission's final recommendations was transfer of the political lead for drugs policy from the Home Office to DHSC on the basis that Home Office leadership skewed and restricted the types of policy options considered.[115]

However, former CEO of the NTA, Paul Hayes, noted that drug policy and drug treatment has historically never been a priority for the DHSC or NHSE due to the number of competing health priorities these bodies face. One participant in our roundtable consultation observed that the Home Office has traditionally been more supportive of treatment than other departments, including innovative (and sometimes controversial) schemes such as heroin assisted treatment. This was felt to be because drug treatment is among the most effective tools to reduce crime, as was recently corroborated in Dame Carol Black's review, and that approaching drugs policy through the lens of crime reduction unlocked additional resources.[116, 117]

3.6 JOINED UP IMPLEMENTATION

If drug policy is cross-cutting centrally, it is even more so at the local level. Groups involved in implementation include commissioners, health and wellbeing boards, elected representatives of local authorities, public health bodies, NHS services, private healthcare providers, recovery communities and the third sector, police and crime commissioners, courts, prosecutors, prisons, probation services, police forces, and other law enforcement agencies, social services, Jobcentres, housing partners, and schools. Effective joined-up working at the local level is essential.

In its final report, the UKDPC observed that distinct elements of drug policy (i.e. prevention, treatment, and enforcement) can function at cross-purposes when they operate without sufficient coordination. For example, enforcement activity near treatment centres can discourage engagement with those services. Poor coordination can also result in duplication of work and missed opportunities for increased effectiveness.

Dame Carol Black's part two report makes a number of welcome recommendations to improve joined-up working at the local level, ensuring cross-cutting regional strategies, commissioning, and implementation. Meeting these recommendations will improve continuity of care as people with substance use problems move within and between criminal justice and healthcare systems, and provide for the possibility of integrated processes to more effectively reduce demand, manage use-related harms, and improve access to and uptake of services. Importantly, a Local Outcomes Framework is proposed, against which local performance can be evaluated. This framework would benefit from a wide scope, ideally covering the impact of interventions across the full spectrum of local partners.

Regional and local collaborations also expand opportunities for innovation and experimentation. Local authorities and integrated care systems should be encouraged to trial novel approaches to meet local needs in line with the policy goals laid out in the national strategy. Appropriate means should be in place for local partners to apply for and/or pool funding for innovative projects, particularly those that improve collaboration between underconnected sectors. Recovery communities and people with lived experience should be actively involved in local commissioning plans, joint needs assessments, and coordinated system modelling.

There should also be central recognition that some small-scale pilot projects may require bespoke licenses to lawfully operate. In circumstances of exceptional unmet need at the local level, there should be adequate regulatory flexibility for innovative proposals. Whether under the auspices of a Centre for Addictions - as recommended by Dame Carol Black - or another national body, improved inter-regional sharing of data and knowledge should be encouraged by all means possible, including an annual conference with awards for innovative approaches to service provision or evidence development.

3.7 ACCOUNTABILITY AND SCRUTINY

Drug policy must be subject to adequate scrutiny and evaluation as it is enacted, and the decision-makers involved must be accountable. There has been a historic lack of commitment to making outcomes clearly measurable, notable among them being the review by the National Audit Office of the 10-year drug strategy announced in 2010, which stated that "Neither the current Strategy, nor the supporting action plan for 2008-2011, set out an overall framework for evaluating and reporting on the degree to which the Strategy is achieving the intended outcomes or the value for money provided."[118] While recognising that some outcomes are complex to measure, an early commitment here is essential if involved parties at the highest and lowest levels are to be held to account, or credited for their efforts.

The sponsoring minister must also be formally accountable to Parliament. We agree with Dame Carol Black's recommendation that they should report to Parliament and publish relevant data, and we think that additional accountability is also required given the breadth of drug policy, the number of actively involved parties, and the failures of previous systems to improve results. Select Committees that might take an interest include Justice; Home Affairs; Health and Social Care; Human Rights; Housing, Communities and Local Government; Public Accounts; Public Administration and Constitutional Affairs; Science and Technology; Scottish Affairs. A panel of representatives of these committees would be well suited to a robust examination of the progress against defined outcomes, and may drive improvements more effectively.



4. CONCLUSIONS AND RECOMMENDATIONS

For ease of reference, we will indicate recommendations from Dame Carol Black's recent Review of Drugs Part Two with "DCB2" followed by the recommendation number.

4.1 UNDERSTANDING THE PROBLEM

Policy development begins with identifying the problems to be addressed, the contributing causes of those problems, and the options for intervention. This phase of the policy cycle is most effective when supported by a robust empirical evidence base. It is also an iterative process informed by evaluation of local, national, and international policy outcomes, and thorough stakeholder engagement involving all relevant sectors and communities.

The current UK drug research landscape is highly fragmented. There is no national drug research strategy, nor central coordination and monitoring of research funding and output, and many fundamental gaps in our knowledge have remained unanswered. The ACMD is not adequately resourced to promptly respond to requests.

1 - Develop a National Drug Research Strategy to better understand issues relevant to policy design.

2 - Establish a National Institute for Drug Science to coordinate research into substance misuse (see DCB2 #31), including behavioural science innovation (see DCB2 #30), social needs of people with substance misuse problems (see DCB2 #23), peer-led recovery support services, recovery after leaving the treatment system (see Recovery Champion's Annual Report)[119], and awards for companies or organisations whose developments advance addiction treatment (see DCB2 #32).

3 - Increase funding and administrative support for the ACMD to improve its capacity and workrate.

4 - Empower the ACMD to commission work through the National Institute for Drug Science, so that relevant knowledge gaps for current policymaking can be filled.

4.2 SETTING GOALS

There is an absence of clear overarching policy goals. There are diverse stakeholders with different needs and visions, as well as different understandings of the fundamental nature of the problem, and these stakeholders are not adequately consulted in the development of high level goals.

5 - The upcoming Drug Strategy should define specific, measureable, and achievable goals, so that it can be clearly evaluated and held to account.

6 - The process of setting policy goals should be unilaterally transparent and supported by robust stakeholder engagement with genuine opportunity for public dialogue to influence decisions, as detailed in the UK Drug Policy Commission's work.[120, 121]

4.3 POLICY DESIGN

There has been a lack of good outcome frameworks with clear evidence-based logic models to justify them, and this has been the subject of much criticism within government. We welcome Dame Carol Black's recommendations on this matter and hope they are implemented in an effective manner. Policymaking is inherently political but the debate and reasoning must be more open and robust, and political considerations must be balanced with the evidence. The debate must be broadened, and this can be done without reducing the freedom of Ministers.

7 - Publish terms of reference to accompany future drug strategies, clarifying the scope and limit of policy options considered at the stage of policy design.

8 - he upcoming Drug Strategy should include a robust outcome framework with evidence-based logic models informed by an open consultation (see DCB2 #1).

9 - The upcoming Drug Strategy should clearly and simply outline the responsibilities of every involved department for achieving each specific commitment.

10 - Review options for stronger delegation of classification and scheduling decisions by the ACMD.

For instance, remove schedule and class membership for individual drugs from legislation, and formally delegate the decision to the ACMD. There has been limited interest in updating these decisions despite clear changes in the evidence base to support them.

4.4 COSTING

11 - The upcoming Drug Strategy should outline the total projected expenditure including budgetary commitments of each spending department, and any funding which is to be ring-fenced for specific purposes, with these indicated in full.

This improves scrutiny of whether departments met their commitments and enables better oversight of spending as events unfold.

12 - There should be robust bookkeeping throughout the policy cycle, to allow better assessments of cost-effectiveness, where applicable.

4.5 LOCAL COMMISSIONING

13 - Actively encourage and support local pilot schemes of new and innovative approaches, with robust evaluation and sharing of findings.

E.g. new multi-sector partnerships, harm reduction initiatives, new approaches to integrated care.

14 - Establish an annual national conference for local implementation partners to share data and knowledge of joined-up commissioning, with awards for innovative approaches.

4.6 OUTCOME MONITORING

Robust outcome frameworks have not been a consistent priority. Their evaluation must be independent and transparent. Much relevant data is unused, but ongoing efforts to modernise use of data in government, such as those in the Ministry of Justice led by Administrative Data Research UK are well-positioned to change this.

15 - A National Institute of Drug Science should coordinate national outcome data tracking, as per the national research strategy.

16 - Expansion of DataFirst to include linkage to the Police National Computer and NDTMS to track reoffending and drug treatment.

17 - National Institute for Drug Science to develop standardised methods of measuring recovery and social support, as described in the Recovery Champion Ed Day's first Annual Report.[122]

4.7 EVALUATION

18 - National Institute for Drug Science to coordinate full, transparent, and independent evaluations of drug strategies against the National Outcome Frameworks at the close of each strategy cycle. This process should consider stakeholder feedback alongside outcome data to ensure that data is representative of the experience of partners and service users. The evaluation should also review data collected by the Office for Health Improvement and Disparities on local performance against the Local Outcomes Framework (see DCB2 #8) and identify factors that contribute to regional disparities.

4.8 ACCOUNTABILITY

Much stronger accountability to Parliament for progress towards drug policy goals is required, as well as internal quality control processes and decision-making transparency.

19 - In addition to the sponsoring minister of the JCDU reporting annually to Parliament, the minister should also report to a joint panel of select committees and relevant ALBs following the publication of each independent drug strategy evaluation (including Home Affairs; Health and Social Care; Public Accounts; Business, Energy, and Industrial Strategy; Treasury; Justice etc.)

10 - Operational delivery units dealing with licences for controlled drugs should be

transparent, subject to periodic independent audits, and implement an appeals process if applications are rejected.

This would improve interactions and increase stakeholder understanding of requirements.

4.9 POLICY IMPROVEMENT

21 - Identify any data gaps that prevent full evaluation of effectiveness and cost-effectiveness of interventions against policy goals and ensure that subsequent drug strategies commit to improving the collection of relevant data.

22 - Commit to phasing out policies and interventions shown to be either ineffective or inadequately cost-effective.

23 - Ensure that JCDU has open channels of communication with BEIS, DIT, FSA (etc) to ensure identification and rapid response to emerging regulatory issues concerning licensed business and research activities. This would help avoid unnecessary stifling of innovation and missed economic opportunities.

Taking these recommendations forward

Our recommendations do not promote any singular course of action, but rather introduce possibilities for flexibility in Governance relating to drugs and for fostering a culture of mutual support between the many different departments. These departments' expertise, drawn on appropriately and supported by a significantly enhanced research capacity, can fulfil its potential for elevating the UK from its current position as the longstanding overdose capital of Europe to a country with drug policies that are studied abroad by those seeking to emulate its policy outcomes.

If the JCDU proves inadequate in scope, resource, coordinating ability or political power to address the problems inherent in drug policy and identified here, then the UK must look further. The UK Government is aware that the United Nations requires global leaders to address the key causes and consequences of the world drug problem in a coherent and coordinated manner. They state that this requires a commitment to developing and implementing truly balanced, comprehensive, integrated, evidence-based, human rights-based, development-oriented and sustainable responses to the world drug problem.[123] The creation of the JCDU shows a commitment to better coordination of UK departments, but strengthening inter-agency cooperation and collaboration is also needed on an international scale, making the best use of expertise across all United Nations entities. Furthermore, this report has highlighted significant opportunities in broadening the scope of drug policy initiatives beyond the narrow focus on the misuse of drugs, particularly in the field of promising medicines derived from controlled drugs. While there is momentum to change the way in which drug policy is governed and shaped, and if current plans do not prove effective, we should seize the opportunity to build on broader visions for an Office for Drug Control, as many of our international partners are doing.

ACKNOWLEDGEMENTS

Making UK drug policy a success: reforming the policymaking process identifies increased cross-departmental participation between more Government departments as a vital precursor to enacting better drug policies. It is commensurate with its recommendations that the making of this report has itself been an interdisciplinary, cross-cutting consultative process.

The 23 recommendations we make for increasing Governmental capacity to devise evidence-based drug policy derive from insights gathered through two roundtables — "Delivering Cross-Cutting Policies," hosted by the Institute of Government (July 2021); and "Building Evidence: Data Systems, Research Strategy and Evaluation," hosted in Collaboration with DrugScience (September 2021). Both roundtable conversations put into concert expert perspectives from a multiplicity of fields that would not otherwise intersect, and this report is the product of their combined insight.

We are deeply indebted not only to the orchestrators and participants of these roundtables but to a great many individuals who enabled the development of its arguments with supplementary feedback —and by the same token, the CDPRG takes full responsibility for any flaws or oversights in its content as we have had ultimate responsibility for its synthesis. Equally fundamentally, feeding into this report are the preceding findings of the UK Drug Policy Commission, whose *Analysis of UK Drug Policy* (2012) identifies shortcomings in UK drug policymaking that persist today. We intend this report to build on their recommendations for better governance in drug policy, which remain pertinent to redressing the steadily worsening outcomes of current policies.

It is entirely in the spirit of promoting evidence-based drug policymaking to collect evidence on whether the political climate is hospitable to it. We commissioned Savanta to conduct polling on MPs' attitudes to drug policy in June-July 2021 and it is the result of their fieldwork that we have been able to incontrovertibly dispel the myth that has historically functioned as a barrier to drug policy reform there is predominant political resistance to change in this area, with more than three-quarters of MPs (even within the Conservative party) agreeing that it is time to update UK drug laws based on evidence.

Finally, the authors would also like to thank the unremunerated chairman of the Conservative Drug Policy Reform Group, Crispin Blunt and hisParliamentary Chief of Staff and CDPRG Managing Director Tarsilo Onuluk, both of whose guidance and support are instrumental to the relevance and realisation of the CDPRG's independent research.

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APPENDIX AND NOTES

APPENDIX 1: PUBLIC AND MP ATTITUDES

1a. Polls of Westminster MPs (June 2021)

This note sets out the findings of polls of Westminster MPs, Members of the Scottish Parliament, and Welsh Assembly Members, conducted for the Conservative Drug Policy Reform Group by ComRes as part of research examining how we make drug policy in the UK.

Methodology:

The polls were conducted using online questionnaires sent to the ComRes panel of parliamentarians as follows:

- 105 Members of Parliament took part in the survey
- Data were weighted by party and region to reflect the composition of the House of Commons.
- Respondents were shown five statements about drug policy, and asked to respond to each on the scale: Agree strongly, Agree, Disagree, Disagree strongly, Don't know.

Results:

Q1. THE UK'S CURRENT POLICIES ARE EFFECTIVE IN TACKLING THE PROBLEMS CAUSED BY CONTROLLED DRUGS

	Agree (Strongly Agree + Agree scores)	Disagree (Strongly Disagree + Disagree scores)	Don't Know
All MPs (n=105)	22%	68%	10%
Conservative MPs (n=59)	32%	57%	11%

Q2. IF WE ARE TO IMPROVE THE WAY WE TACKLE PROBLEMS CAUSED BY CONTROLLED DRUGS, **WE NEED TO CHANGE HOW WE MAKE DRUG POLICY**

	Agree (Strongly Agree + Agree scores)	Disagree (Strongly Disagree + Disagree scores)	Don't Know
All MPs (n=105)	71%	18%	11%
Conservative MPs (n=59)	61%	24%	14%

Q3. POLICY ABOUT CONTROLLED DRUGS IS SUCH A CONTROVERSIAL ISSUE, IT CAN BE DIFFICULT TO HAVE AN OBJECTIVE DEBATE ABOUT THE BEST SOLUTIONS

	Agree (Strongly Agree + Agree scores)	Disagree (Strongly Disagree + Disagree scores)	Don't Know
All MPs (n=105)	70%	26%	5%
Conservative MPs (n=59)	75%	22%	4%

Q4. THE PROCESS OF MAKING POLICY ABOUT CONTROLLED DRUGS IN THE UK SHOULD MAKE MORE USE OF EVIDENCE AND RESEARCH THAN IT CURRENTLY DOES

	Agree (Strongly Agree + Agree scores)	Disagree (Strongly Disagree + Disagree scores)	Don't Know
All MPs (n=105)	79%	6%	16%
Conservative MPs (n=59)	72%	9%	19%

Q5. IMPROVED CROSS-DEPARTMENTAL COORDINATION OF DRUG POLICY WOULD HELP THE UK TO MORE EFFECTIVELY TACKLE THE HEALTH, CRIME AND SOCIAL PROBLEMS CAUSED BY CONTROLLED DRUGS

	Agree (Strongly Agree + Agree scores)	Disagree (Strongly Disagree + Disagree scores)	Don't Know
All MPs (n=105)	90%	4%	5%
Conservative MPs (n=59)	85%	6%	8%

Q6. FIFTY YEARS ON FROM THE ROYAL ASSENT OF THE MISUSE OF DRUGS ACT 1971, IT IS TIME FOR GOVERNMENT TO UPDATE UK DRUG CONTROL LAWS, BASED ON THE BEST EVIDENCE AVAILABLE TODAY

	Agree (Strongly Agree + Agree scores)	Disagree (Strongly Disagree + Disagree scores)	Don't Know
All MPs (n=105)	79%	13%	8%
Conservative MPs (n=59)	74%	17%	9%

Primary Research by Savanta for CDPRG (June, 2021)

1b. Public Poll of Great British Adults (September 2021) | "Britons across the political spectrum agree that criminalising drugs is ineffective"

Available here:
https://docs.cdn.yougov.com/dst8x5o1s4/YouGov%20-%20Drugs%20Results.pdf

Q1. HOW EFFECTIVE OR INEFFECTIVE DO YOU THINK MAKING USE OF A DRUG ILLEGAL IS IN PREVENTING PEOPLE FROM TAKING IT?

	Ineffective	Effective	Don't Know
All (n=1690)	60%	24%	16%
Conservative Voters (n=575)	59%	28%	13%

1c. Public Poll of Great British Adults (June 2019) | "Britons across the political spectrum agree that criminalising drugs is ineffective and UK Government is not dealing well with the country's drug problems"

Materials were designed by the Conservative Drug Policy Reform Group in conjunction with YouGov. Interviews were conducted with a nationally representative sample of n=1690 respondents in Great Britain (GB) aged 18+ and took place online between the 16th and 19th June 2019 with quotas set on age, gender, region, social grade and voting profile. Results have been weighted to ensure they are representative of GB.

Q. HOW EFFECTIVE, IF AT ALL, DO YOU THINK THE THREAT OF CRIMINAL PUNISHMENTS (SUCH AS A CRIMINAL RECORD OR PRISON SENTENCE) IS AS A DETERRENT TO INDIVIDUALS WHO: UNLAWFULLY USE DRUGS

	Effective	Not Effective	Don't Know
All (n=1690)	11%	76%	13%
Conservative Voters (n=558)	12%	80%	8%

Q. HOW EFFECTIVE, IF AT ALL, DO YOU THINK THE THREAT OF CRIMINAL PUNISHMENTS (SUCH AS A CRIMINAL RECORD OR PRISON SENTENCE) IS AS A DETERRENT TO INDIVIDUALS WHO: UNLAWFULLY SELL DRUGS

	Effective	Not Effective	Don't Know
All (n=1690)	17%	69%	13%
Conservative Voters (n=558)	16%	76%	8%

Q. THINKING ABOUT CURRENT UK DRUGS POLICY, HOW SUCCESSFUL OR UNSUCCESSFUL DO YOU THINK IT HAS BEEN IN TERMS OF REDUCING THE HARM DONE BY DRUG ABUSE?

	Successful	Unsuccessful	Don't Know
All (n=1690)	7%	70%	22%
Conservative Voters (n=558)	8%	74%	16%

IN YOUR OPINION, HOW WELL OR BADLY DO YOU THINK THE UK GOVERNMENT IS COPING WITH THE COUNTRY'S DRUG PROBLEMS?

	Well	Not Well	Don't Know
All (n=1690)	5%	79%	16%
Conservative Voters (n=558)	7%	82%	12%



APPENDIX 2: THE UK DRUG POLICY COMMISSION (UKDPC)

Over a six year period (2006-2012) the UK Drug Policy Commission, a independent charity, provided an objective analysis of the evidence concerning drug policies and practice by bringing together senior figures from policing, public policy and the media, along with leading experts from the medical and drug treatment fields and provides the most comprehensive evaluation of drug policy governance in the UK to date.

Principally funded by the Esmée Fairbairn Foundation, other funders have included the Home Office and the former National Treatment Agency.

This work, spanning across several reports in partnership with RAND Europe, the Institute for Government and others, included a review of potential lessons for drug policy governance from other policy areas, specifically in regard to repositioning the issue so that longer-term, evidence-based, expert-led drug strategies become more politically advantageous for governments.

2a: UKDPC (2012) A fresh approach to drugs - The Final Report of the UK Drug policy Commission

1. Supporting Responsible Behaviour	1a. Tackle structural problems that increase risk of drug problem. 1b. Develop and evaluate early interventions to help families and communities build resilience to drug problems alongside other problems 1c. Provide evidence-based prevention programmes to support less risky choices 1d. Promote interventions which reduce the harms of drug use 1e. Involve local communities in law enforcement and assess its impacts
2. Stimulating and promoting recovery from drug dependence	2a. Tackle stigma towards people with drug problems and their families 2b. Make the criminal justice system more focused on recovery 2c. Provide greater support to families of people with drug problems

	2d. Continue to develop treatment systems, mutual aid networks and communities that support those recovering from drug dependence
3. The laws on drug production, supply and possession	3a. Review the process for classifying controlled drugs 3b. Reduce sanctions for drug possession 3c. Address production and supply 3d. Review penalties for all drug offences 3e. Establish consistency in controls over all psychoactive drugs
4. Improving structures and processes for how we make and implement drug policy	4a. Introduce independent decision-making on drug harms 4b. Improve research and policy analysis 4c. Move the political lead for drug policy 4d. Create a cross-party political forum to progress dialogue about future policy 4e. Evaluate local approaches

2b. UKDPC (2012) How to make drug policy better: key findings from UKDPC research into drug policy governance

This study of drug policy governance, or how drug policy is made, involved a wide range of people including current and former ministers, parliamentarians, senior civil servants, practitioners, think-tanks, advocacy bodies and academics.

The report identified 7 important issues for good governance, where the system seems to be going wrong, and options for improving the way policy is made

1	Issue	The polarised and contested debate around drug policy is preventing an open discussion about the goals of drug policy and the options for achieving these
	Recommendation	Create a cross-party political forum to progress discussion about future policy, including engagement with the public

2	Issue	Within drug policy there is an overemphasis on enforcement and view of drugs as a criminal justice issue which is skewing the responses.
	Recommendation	Move the political lead for national drug policy from the Home Office to the Department of Health.
3	Issue	The public debate about drug policy has become dominated by disagreement over the assessment of harms of different drugs much of which occurs in the media using partial and unevaluated evidence. This hampers sensible discussion about drug policy
	Recommendation	The government should initiate a formal review of the powers and remit of the ACMD and explore different options for the assessment of harms and the classification process.
4	Issue	Drug policy making is insufficiently evidence-imbued. There is a lack of coordination, drive and adequate resourcing, which has resulted in large gaps in our knowledge in a range of areas, and strategies and policies are rarely evaluated.
	Recommendation	Evaluation needs to be embedded into the policy process. Drug strategies should include a commitment to their evaluation from the start.
5	Issue	The need for a new independent body which could take on new functions of providing independent leadership and coordination of research and policy analysis
	Recommendation	A new independent body should be established to co-ordinate the drug research effort and to provide policy analysis and dissemination. A proportion of the money raised by the forfeiture of assets from drug-related crime might be used to fund this body and/or research
6	Issue	Within drug policy there is an overemphasis on enforcement and view of drugs as a criminal justice issue which is skewing the responses.
	Recommendation	Move the political lead for national drug policy from the Home Office to the Department of Health.
7	Issue	Within drug policy there is an overemphasis on enforcement and view of drugs as a criminal justice issue which is skewing the responses.
	Recommendation	Move the political lead for national drug policy from the Home Office to the Department of Health.

2c UKDPC (2012) Characteristics of good governance for drug policy: findings from an expert consultation

CHECKLIST OF KEY CHARACTERISTICS OF GOOD GOVERNANCE FOR DRUG POLICY

i. Overarching goals that are:

- Clearly articulated;
- Realistic but aspirational;
- Consensual or have cross-party support, where possible.

ii. Leadership that:

- Seeks consensus and cross-departmental support;
- Provides authority and resources;
- Is 'evidence-imbued' (i.e. recognises the importance of evidence in policy development and of policy evaluation including willingness to make changes based on feedback).

iii. Coordination of policy efforts that:

- Begins at a high enough level of office to ensure commitment and resources; · Provides clarity of roles and responsibilities of those involved in policy development and delivery; Involves those responsible for implementation in agreeing objectives based upon an agreed upon policy framework.

iv. Policy design that:

- Balances scientific evidence with other types of evidence (eg public and expert views, politics, innovative practice) in a way that is transparent;
- Generates ideas and options which have clear logic models underpinning them;
- Incorporates clear mechanisms for evaluation and feedback and incorporation of learning.

v. Development and use of evidence that:

- Is supported by mechanisms that continually promote its development and expansion;
- Is based around agreed upon standards for what 'counts' as evidence; · Includes mechanisms to facilitate knowledge-building and sharing between researchers and policymakers;
- Is available in accessible ways for all stakeholders in order to improve accountability.

vi. Implementation that:

- Has some flexibility for variation based on local needs;
- Has sufficient financial resources and access to the evidence base.

vii. Accountability and scrutiny that:

- Holds policymakers to account for their decision-making, including their decisions to use or not use evidence in their policy;
- Measures success based on outcomes set through a system of transparent performance management;
- Relies on rigorous, objective processes of evaluation and review;
- Is transparent itself.

viii. Stakeholder engagement that:

- Includes wide consultation during the policy development and policy evaluation stages;
- Has fora to facilitate healthy debate between stakeholders;
- Promotes understanding of the evidence base among policymakers, the media and the public.



APPENDIX 3: CONSULTATIVE ROUNDTABLES

4.1 Roundtable on delivering cross-cutting policies - July 2021 (Chaired by the Institute of Government)

Key insights from the event that have informed our proposals

1. Need for Cross-Cutting body
   a. Despite the unpopularity of Machinery of Government change, drug policy is particularly recognised as requiring a cross-cutting approach.

2. Clarity of Goals and Evaluation
   a. For various historical reasons, there has been a lack of clarity on what the goals of drug policy are and who is responsible for them, which makes them difficult to evaluate. This was also reflected in the UKDPC's similar expert consultation (see Appendix 2c-i).
   b. A careful and considered multi-criterion decision analysis approach is favoured in promoting effective goal-setting.
   c. It must be clearly set out what is and is not the scope of every involved body.
   d. The benefits to each department from cooperation must be clearly communicated from the start.

3. Depoliticisation
   a. Even previously highly politicised issues like the Bank Rate can be successfully depoliticised. The political role of drugs has changed greatly in the past and will continue to do so.
   b. Our recent polling Appendix 1a-Q3 found that 70% of MPs (75% of Conservative MPs) still felt that policy about controlled drugs is such a controversial issue, it can be difficult to have an objective debate about the best solutions.

4. Effective use of Arms Length Bodies
   a. Must be seen internally to be necessary, competent, representative of a range of views, trustworthy, and subject to appropriate transparency and oversight requirements.
   b. ALBs can be of particular use in drug policy due to the technical nature of many decisions.
   c. All involved parties must understand the reasons for setting up an ALB, exactly which functions it should be responsible for, and why this might be advantageous in the long run.
   d. This is crucial if its decisions are to be respected and its recommendations adopted by the ultimate decision-makers, otherwise it will fail in its purpose.

5. Effective Accountability
   a. Clarity of responsibilities is crucial to avoid hiding behind other departments, and to allow credit and progress to be fairly attributed.
   b. There must be high level accountability for responsible ministers, for instance to explain progress to a meeting chaired annually by the Prime Minister.

6. Political Will and coordination
    a. The Prime Minister must support sustained efforts to improve drug policy - and there are signs that this is the case, providing a valuable window of opportunity.
    b. Senior Cabinet Office officials must be invested, and must be able to coordinate the involved departments' contributions and resolve tensions.
    c. Understanding and buy-in from the Treasury is crucial.
    d. Differences in values and approaches to the relevant evidence base must be resolved early, and common frameworks must be agreed upon. Obstructive cultural differences have been particularly noticed between the Home Office and the DHSC.
    e. The example of the Central Drugs Coordination Unit (later the Anti-Drugs Coordination Unit) shows how limited buy-in from involved departments can hinder efforts. It was set up in 1994 partly in response to concerns about coordination and collaboration, but was hampered by an inability to push through its recommendations, often based on departments declining to fund the proposed projects.

7. JCDU
    a. Participants felt that the proposed JCDU integrating several departments was promising, but that housing it in the Home Office could perpetuate many of the existing tensions and conflicts of values.

4.2 Roundtable on Research Strategy: Building Evidence: Data Systems, Research Strategy, and Evaluation – September 2021
(Co-Chaired by the CDPR and Drug Science)

Key insights from the event that have informed our proposals

1. Coordination
    a. The Research landscape is highly fragmented and individual researchers struggle to see the big picture. We need a coherent central research strategy.
    b. Local autonomy and innovation must be preserved and supported
    c. A central body that has an overview of what research is already being conducted and how much money is being dedicated to it from what disparate sources was supported.
    d. A central body coordinating research must be multidisciplinary from the start and must resist creating a hierarchy of disciplines based on historic academic prestige.
    e. There is failure to realise the potential of UK research on drugs and addiction, and our research ecosystem is unfavourably compared in resource and vision to others, such as Australia.
    f. We must emphasise that there is a crisis to be responded to, and that research is part of the necessary response. We must be ambitious, as the USA was when setting up the NIDA.
    g. Dissatisfaction expressed in being unable to use evidence from overseas but also unable to collect evidence from the UK for new policy schemes.

h. Just as the sector has been de-skilled over the last 20 years, it will take time for investment to result in flourishing research communities.

i. We should encourage closer cooperation between academia, think tanks, and NGOs active in drug policy and treatment.

j. We should develop deeper expertise within the UK Government in the role of drug markets in foreign policy decisions, in global drug supply lines, and in instability and violence overseas.

2.Translation into action

a. Drug use is inherently political and we should recognise that the process of informing this changing and culturally important area with evidence is complex and nuanced.

b. There are consistent failures to translate the results of gathered evidence into action, in many successive governments.

c. In practice, many policies have already been selected by the time advice on its likely impact is solicited internally. The advice should be provided before a final decision is made.

3.Drug Research Network Scotland

a. We should develop deeper expertise within the UK Government in the role of drug markets in foreign policy decisions, in global drug supply lines, and in instability and violence overseas.

4.Obstruction

a. Innovation and research in addiction treatment is sometimes curtailed by obstruction from the Home Office, whether it relates to research on controlled drugs or interventions such as drug consumption rooms.

b. A lack of domestic evidence for a new intervention is sometimes used by the Home Office to obstruct running a pilot study, which of course precludes the production of the necessary evidence. Suitable evidence from other countries is not judged applicable, despite clear arguments that it is relevant.

c. There is a chilling effect on trying new things produced by the need for protracted legal arguments with local authorities before starting a study that they see as controversial.

5.Evaluation of government interventions

a. Evaluation of government interventions must be independent, and must not be suppressed if the results are unfavourable. This violates the ethical principles of informed consent, in which the participants are told that they are contributing to knowledge generation, despite a pre-existing inherent publication bias.

b. Subtle biases exist in the selection of the researchers to evaluate a given policy's impact, and it is felt that this results in more favourable evaluations.

6.Future research directions

a. We urgently need investment in addiction research, as the evidence base is lacking in many key areas required for decision-making. We need better understanding of which interventions work for which drug addictions, their cost-effectiveness and required intensity.

b. As we slowly develop better data for understanding drug problems, we need to improve the data science capabilities we bring to bear on it.
c. People who use drugs should be represented in policy research, but individuals should not be portrayed as speaking for all drugs users, as can be the case.
d. Many psychoactive drugs, most notably alcohol, can play positive social roles as well as negative. This is generally neglected in research priorities, but is required for accurate assessments of policy impacts on individuals and communities.

7. Scope
   a. The division between alcohol, nicotine, caffeine, and the various illicit drugs is arbitrary and hampers good policy-making.
   b. The research community must be involved in evaluating policy outcomes
   c. This is particularly lacking in the evaluation of policing interventions.
   d. Disciplinary hierarchy and divide
   e. There is significant expertise and potential research capacity in the UK on the social context for drug use - whether this is on cultural factors, criminology, medical anthropology, the influence of education, or behavioural psychology. Progress in this field could rapidly lead to improved outcomes for large numbers of people.
   f. Despite this, relevant social research is seen as lower in the hierarchy of disciplines for funders and universities. Latin American countries tend to have better integration, globally, between these sectors.

8. AMCD
   a. Not adequately resourced and recommendations not adequately respected by Government.

9. Data
   a. Progress on making data from criminal justice system available to researchers is welcome, but it can still be a slow process.

10. Portugal
   a. Portugal missed an opportunity to gather excellent data and allow more in-depth analysis of its decriminalisation and public health policies on drug deaths, while doing a better job on other outcomes, such as HIV transmission.

11. Wider issues influencing research
   a. Education
      i. Education about drugs in schools and universities is underdeveloped relative to the size of the problem. Fear-based education on drugs does not work. We must give young people accurate information and a sense of personal responsibility.
   b. Home office vs DHSC positives
      i. Because many of the costs of drugs to society are not health-related, and many health problems are larger in scope and consequences, dominance of DHSC in drugs policy may result in some areas being less of a priority, so the influence of the Home Office remains important.

c. Government Attitudes

i. The Home Office have been champions of the importance of treatment in the past, and are seen to have positively influenced DHSC in this regard when they were moving slowly on some issues. In some cases they have been supportive of otherwise controversial interventions, such as the heroin-assisted treatment programme in Glasgow

d. Availability of harm reduction interventions such as drug consumption rooms can be limited in its effect if treatment services remain inadequate, and if drug users remain highly stigmatised and disadvantaged socially.

e. Vulnerable ex-users are under-represented in research.

f. There have been health economic models for a long time showing that there should be no ceiling on the delivery of opioid agonist treatment, based on its cost-saving nature, but funding has gradually been withdrawn despite this.



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PUBLIC RELEASE
DECEMBER 2021