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UK DRUG POLICY COMMISSION

Essays on the governance of drug policy

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Preface

These four essays were commissioned as part of a wide ranging and unique study looking at how drug policy is made in the UK. The full outputs from the research programme can be found on our website: www.ukdpc.org.uk

Drug use and dependence is a very complex area, which impacts in different ways on many people and has ramifications throughout society. It is also a particularly controversial area. Successive commentaries have noted that drug policy is often driven by a mix of reactivity, polarised, position-driven analysis and campaigning interests, emotive media reporting, adversarial relationships between scientists, experts and policy makers along with a contested and limited evidence base.

These essays, written by respected drug policy and research experts, shine a light on some key issues and challenges that face policymakers and those seeking ways to improve drug policy.

The first issue, examined by Professor Susanne MacGregor, is how Parliament holds the Executive to account through the process of scrutiny.

The next by Dr Neil McKeganey explores how language and framing can shape political and public understanding of issues leading to evidence and policy becoming 'disconnected'.

Dr Mark Monaghan then looks at how the debate about cannabis has become embroiled in controversy over recent years and what this can tell us about the efficacy of the governance process.

Finally Dr Marcus Roberts considers the contribution that consultation processes make to the process of public engagement in drug policies and how these might be made more effective.

We are grateful to the authors for accepting our invitation to write these essays. Along with other contributions and research they have helped the UK Drug Policy Commission being able to make specific recommendations about making drug policy better.

Roger Howard
Chief Executive
UK Drug Policy Commission

Abbreviations

ACMD - Advisory Council on the Misuse of Drugs
APPGs – All Party Parliamentary Groups
BRIC – Building Recovery in Communities
CSOs – Community Sector Organisations
DWP – Department of Work and Pensions
EMCDDA – European Monitoring Centre for Drugs and Drug Addiction
HASC – Home Affairs Select Committee
HoC – House of Commons
HoL – House of Lords
MDA – Misuse of Drugs Act
NTA – National Treatment Agency
OST – opiate substitution treatment
PDU – Problem Drug User

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Parliamentary Committees and Drug Policy Governance

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Introduction

Parliamentary committees have the potential to play an important role in the drug policy making process, holding government to account and scrutinising policy. To assess their current effectiveness, this essay reviews how they have obtained and used evidence, and whether their recommendations have been acted upon. It draws conclusions about their effectiveness and impact, and evaluates their contribution to policy development. The essay reflects on how parliamentary committees have performed, when compared to the good governance principles developed by UKDPC (see appendix).

With changes in society over the past thirty years and the shift from 'government' to 'governance', the demands made on parliamentarians to contribute to co-ordination have increased. Parliamentary processes are now expected to link decision-makers to wider networks in a pluralistic and diverse civic society. Certainly in the drugs field, the policy networks involved in decisions have become larger and more complex. Because of this, ensuring accountability has become more difficult too.

The UCL Constitution Unit has written extensively on parliamentary processes, including an assessment of the impact of select committees in the British House of Commons (Benton and Russell 2012). These authors note that the establishment of select committees in 1979 was a key event in British parliamentary history and that their role in scrutinising the work of government has attracted increased media attention. Benton and Russell observe that select committee reports are generally very good and detailed.

Earlier studies, such as the seminal work of Gavin Drewry (1989), judged that much select committee influence was indirect, invisible and long-term. From their detailed empirical study, Benton and Russell note that most inquiries are reactive rather than proactive in policy terms and that they attempt to influence central government policy mainly through recommendations. They conclude that 'committee recommendations are in fact considerably influential, both in terms of initial government acceptance and eventual implementation. This applies not only to trivial or supportive recommendations but also proposals for substantive policy change.' (Benton and Russell 2012: 11).

They note a number of factors influencing the effectiveness of select committees:

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- the committee's style and reputation
- the nature and culture of the department that it shadows
- the personality and effectiveness of its Chair
- the drafting style of its Clerk
- the partisan affiliation of the Chair
- the nature of the policy area
- the nature of the wider policy community on the issue
- the point in the policy process at which the committee seeks to intervene, e.g. if agenda setting or contributing to a newly emerging policy area.

This essay is a reflective commentary on parliamentary committees and drug policy and is informed by: background reading on British politics and parliament; careful reading of documents in the parliamentary archive, in particular proceedings of select committees and public committees; Hansard reports of debates in the Houses of Commons and Lords; documents on websites of devolved governments, especially in Scotland; attendance at seminars organised by, amongst others, the Institute for Government and UKDPC, conducted under Chatham House rules; 16 responses to a questionnaire sent to a number of key informants who have contributed to Inquiries in a variety of roles, especially as witnesses, specialist advisors, or civil servants; and reading of contemporary diaries of government ministers and MPs. I have not given detailed reference to quotations from debates and deliberations to improve the readability of the text and to respect the sensitivities of those involved: quotations are offered as illustrations of more general themes rather than singling out a particular person or occasion for mention. What is presented is my interpretation of the wide range of information reviewed, grounded in a background of familiarity with the development of drug policy over a thirty year period, derived from participant observation and research.

Types of Parliamentary Committee and their Consideration of Drug-Related Issues

There are a number of types of parliamentary committee – departmental, cross-cutting, legislative, internal, ad hoc, joint, and intelligence and security, which operate in both the Commons and the Lords.

The establishment of Select Committees in the House of Commons in 1979 was a major reform aiming to strengthen Parliament vis-a-vis the executive. Select committees examine the expenditure, administration and policy of government departments and associated public bodies.

There are around 20 departmental select committees in the House of Commons (HoC), including the quasi-departmental Public Administration Committee, which are permanent, expert, and largely well-regarded. They hold 'inquiries' into aspects of executive policymaking and attract media attention. Under the 'modernising agenda', committees were given more resources and allocated core tasks. In 2008, they gained new powers to hold hearings with senior government appointees. Since 2010, Chairs and members have been elected, having previously been chosen

by party whips. These reforms have increased their power and prestige.

From the early 1970s, the House of Lords (HoL) also developed an array of select committees - legislative and domestic. Unlike the Commons, the Lords structure is thematic and cross-cutting rather than departmental. Influential committees in the drugs field have included the Science and Technology Committee and the European Union (EU) committee.

The committee stage of legislation is taken in non-specialist, temporary 'public bill committees' (formerly 'standing committees'). These consist of 15 to 45 Members reflecting the party balance in the House. Committees examine the text of a bill in detail. This work occupies a great deal of a Minister's or MP's time. Public bill committees may also take a limited amount of evidence. Issues relating to drugs appear across a wide range of public bills. For example, during New Labour administrations, there were around 10 Criminal Justice Bills and 3,000 new criminal offences, and many of these changes had implications for drug users.

Between 1999 and 2002, scrutiny was expanded through the establishment of: the devolved governments of Scotland, Wales and Northern Ireland; the London Assembly, as a counterbalance to the Mayor; Regional Chambers/Assemblies; and into local authorities. Implicit in many of these changes was a rejection of what was seen to be an outdated and inadequate Westminster model of government. One-party domination and adversarial politics were thought to have weakened the capacity of Parliament to scrutinise the executive and hold it to account. Arguments for a Scottish Parliament in particular referred to a desire for a more consensual, transparent and inclusive form of politics.

In addition, there are now over 300 All Party Parliamentary Groups (APPGs) to which parliamentarians may choose to belong and which concern themselves with single issues. They link the Lords and Commons but proliferation has diluted their impact. The APPG on drug misuse is one of the oldest, having been set up in 1984. More recently, an APPG on drug policy reform has vied with the drug misuse group for attention. These groups are supported administratively by outside organisations: for example, the secretariat to the APPG on drug misuse is provided by DrugScope. Scotland also has cross-party groups on alcohol and drugs: these are fairly informal committees, held within the Parliament, with the public in attendance and with representation from the four main parties.

Table 1 lists key inquiries and reports on drugs by select committees and shows the increased attention given to drugs over time as the problem has risen up the political agenda. Drugs has been considered by a number of key committees with the Home Affairs Select Committee (HASC) becoming especially prominent over time.

TABLE 1 KEY INQUIRIES AND REPORTS ON DRUGS

DATE	COMMITTEE	TITLE
1984-5	<i>Social Services Committee</i>	Misuse of Drugs with special reference to the treatment and rehabilitation of misusers of hard drugs
1985-6	<i>Home Affairs Committee</i>	Misuse of Hard Drugs
1997-8	<i>Select Committee on Science and Technology House of Lords</i>	Cannabis: the scientific and medical evidence
1999	<i>Home Affairs Committee</i>	Drugs and Prisons
2001	<i>Home Affairs Committee</i>	The Government's Drug Policy: is it working?
2005-06	<i>House of Commons Science and Technology Committee</i>	Drug classification: making a hash of it?
2010	<i>Home Affairs committee</i>	Report on The Cocaine Trade
2010	<i>Public Accounts Committee</i>	Tackling problem drug use
2011-12	<i>House of Lords Home Affairs EU Sub-Committee</i>	Inquiry into the EU Drugs Strategy
2012	<i>Home Affairs committee</i>	Drugs: Breaking the Cycle

A variety of topics relating to drugs arise during the scrutiny of public bills across a wide range of all government legislation, relating to welfare reform, children and young persons, border control, policing, immigration, coroners, mental health, Northern Ireland, offender management, criminal justice, immigration, counter terrorism, Crown employment and nationality, immigration, education and localism. Deliberations often involve detailed questioning of the Minister responsible.

MPs discussing drugs on these occasions have interests and expertise in topics which overlap with drugs. They may make connections between these, for example, by referring to similarities between prostitution and drug misuse, both being social and moral issues. MPs draw on representations made to them by constituents and pressure groups to inform such debate, indicating the influence of forms of evidence other than science and statistics. For example, in one session, reference was made to 'a recent television report on drug-taking in London' while another MP reported that he had gone out of his way to speak to drug dealers and to pupils in the secondary schools in his constituency.

The Scottish Parliament also scrutinises public bills emanating from Westminster. And in 2012, Holyrood debated families affected by problem drug use. During this debate, a number of MSPs attacked the proposal to link the award of benefits with mandatory treatment. The first stage of a

new Scottish law seeking to limit the impact of the 'draconian' Westminster reforms to the benefits system was later passed by the Scottish Parliament.

Table 2 shows the ubiquity of the drugs issue as it crosses a number of government departments. Over time there has been increased penetration of drugs into many areas of public life and policy. There has been however a rather surprising lack of attention to the health issues relating to drugs and a relatively small role has been played most recently by specific health committees.

TABLE 2 EXAMPLES OF NON-DRUG-SPECIFIC COMMITTEES WHERE DELIBERATIONS COVERED DRUG-RELATED ISSUES

DATE	COMMITTEE	TOPIC	NOTES
1999	<i>Committee of Public Accounts</i>	HM Customs and Excise: the prevention of drug smuggling	
2002-03	<i>Public Administration Committee</i>	Session inquiry into government targets and league tables	Prime Minister's Delivery Unit included attention to drugs targets across a number of departments
2002-03	<i>Committee of Public Accounts</i>	Modernising Procurement in the Prison Service	Included attention to procurement of drug programmes
2003	<i>House of Lords Select Committee on the European Union</i>	Europol's role in fighting crime	
2003	<i>Select Committee on Northern Ireland Affairs</i>	Took evidence on nature and extent of drug-related crime in Northern Ireland	Questions asked on young people's attitudes to drugs in Northern Ireland; approaches to tackling misuse; role of police in drugs education in schools
2004	<i>Select Committee on European Scrutiny</i>	Drug trafficking on the high seas	
2004-05	<i>Science and Technology Committee</i>	Forensic Science on Trial	
2008	<i>International Development Committee</i>	Inquiry into Afghanistan	Witness: Deputy Head of Afghan Drugs Inter-Departmental Unit (ADIDU), Foreign and Commonwealth Office
2009	<i>Innovation, Universities, Science and Skills Committee</i>	Inquiry into science and engineering policy in Government	Expressed concerns on sacking of Professor Nutt - stressed independence of scientific advisers

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DATE	COMMITTEE	TOPIC	NOTES
2009	<i>Science and Technology Committee</i>	Response to Government's review of the principles that should apply to the treatment of independent scientific advice provided to government	The Committee calls for the finalised principles to become part of the Ministerial Code as well as part of the Guidelines on Scientific Analysis in Policy Making used by Whitehall and the Code of Practice for Scientific Advisory Committees
2010	<i>Home Affairs Committee</i>	Inquiry examining the Government's approach to crime prevention	Reference to drugs and alcohol within discussions on evidence
2010	<i>House of Lords Science and Technology Committee</i>	Inquiry into Government behaviour change interventions	Some overlap with substance use and attempts to change such behaviours
2010	<i>Transport Committee</i>	Drink and drug driving law	
2011	<i>Lords ad hoc committee on HIV and Aids</i>	Investigating a wide range of aspects of the current situation on HIV and AIDS including monitoring, testing, treatment, prevention and stigma	Includes question 'have needle exchange programmes and other initiatives aimed at injecting drug users been successful?'
2011	<i>Justice Committee</i>	An inquiry on the draft sentencing guideline on drug offences (drugs and burglary)	Questions include: 'What is the likely impact of the proposed approach to sentences for 'drug mules'? 'What is the impact on re-offending of confiscation orders for drug offences?'
2011	<i>Health Select Committee</i>	Inquiry into public health	Final report silent on transfer of drug and alcohol spending to local authorities (which will represent up to half of the total ring-fenced public health budget). Report mentions risk of local authorities 'gaming' within the ring-fence. Importance of drugs and alcohol (and risk of disinvestment) not addressed.

Table 3 also illustrates the wide range of issues touched by drugs and its penetration into the activities of many departments.

TABLE 3 SCRUTINY OF PUBLIC BILLS AND ILLUSTRATIONS OF DRUGS ISSUES RAISED IN THE PROCESS.

DATE	BILL	ISSUES RAISED IN DEBATE
2003	<i>Criminal Justice Bill</i>	Classification of cannabis; government using the Bill not only to retain possession of cannabis as an arrestable offence but, for good measure, to add 117 other drugs to the arrestable list at the same time; increases the maximum sentence for dealing in cannabis from five years to 14 years; comments made that the policy appears confused
2004-5	<i>Drugs Bill</i>	Comment that seemed drafted to show Government being tough on crime and tough on the causes of crime; meaning of clauses such as 'in the vicinity of schools' questioned
2006-7	<i>Mental Health Bill</i>	How far addiction or substance and alcohol abuse falls within definition of a mental disorder? potential for compulsory detention
2007	<i>Criminal Justice and Immigration Bill</i>	Links between prostitution/sexual exploitation and drug dependence
2009	<i>Coroners and Justice Bill</i>	Drugs and gangs; sentencing to treatment for alcohol or drug dependence; how much attention was being given to investigation into the drugs the deceased had been taking prior to his or her death?
2009	<i>Policing and Crime Bill</i>	
2009	<i>Children and Young Persons Bill</i>	
2009	<i>Welfare Reform Bill</i>	Discussion of changes to require ESA claimants to undertake specific work-related activities; whether the proposals in the Bill which would introduce conditionality for benefits claimants who are, or may be, dependant on controlled drugs or alcohol, are compatible with the right to respect for private and family life, property rights and the right to enjoy those rights without discrimination
2010-12	<i>Armed Forces Act</i>	Introduces a bespoke military scheme for the testing of Service personnel for alcohol and drugs
2011	<i>Police Reform and Social Responsibility Bill</i>	Enables the Home Secretary to temporarily ban drugs for up to a year, and removes the statutory requirement for the Advisory Council on the Misuse of Drugs to include members with experience in specified activities

Private members bills also enjoy the attention of bill committees. Nigel Evans MP introduced the *Drugs (Sentencing and Commission of Inquiry) Bill* in the HoC on 12 January 2005. The Bill sought to introduce mandatory sentencing for persons guilty of repeat offences in connection with the supply or offer to supply of class A drugs. The Bill would also have established a Commission of Inquiry into the effects and classification of cannabis. Similarly Christopher Chope MP introduced a *Drugs (Reclassification) Bill* in 2007-08 as a Private Members' Bill. The Bill would have provided for the reclassification of cannabis as a Class B drug under the Misuse of Drugs Act 1971. Christopher Chope over a number of years introduced a Bill that would make provision for roadside testing for illegal drugs.

The Work of Committees

HOW THEY OPERATE

The 1984-5 Social Services Committee report on *Misuse of Drugs with special reference to the treatment and rehabilitation of misusers of hard drugs* was a response to what it saw as a growing problem. Evidence was collected and visits made and a specialist advisor – a consultant psychiatrist – was appointed. At about the same time, the 1985-6 Home Affairs Committee inquiry into *Misuse of Hard Drugs* produced an interim report followed by a final report. This committee heard from 26 witnesses and received 15 written submissions. It made visits overseas including to US cities and to the Netherlands. In 1997-8 the HoL Select Committee on Science and Technology conducted an inquiry into *Cannabis: the scientific and medical evidence* and appointed a distinguished pharmacologist as a specialist advisor. It heard from 20 oral witnesses and received 48 written submissions. (This was notably a committee of experts). The 2001 Home Affairs Select Committee in preparing its report on *The Government's Drug Policy: is it working?* invited experts from Sweden, Switzerland and the Netherlands, made visits to Manchester services, heard from 45 oral witnesses and received over 200 written submissions. It came to 24 key conclusions and recommendations. (There was in this case unusually some dissension among members with one minority vote). The report was followed up with considerable media coverage. The HoC Science and Technology Committee in 2005-6 wrote a report entitled *Drug classification: making a hash of it?* To reach its conclusions it held three evidence sessions, commissioned technical reports from RAND, received 14 written submissions and made a visit to the USA. Its appointed specialist advisor was a research addiction specialist. The committee included members with specialist expertise and was notable for its robust interrogation of witnesses. The 2010 HASC in reporting on *The Cocaine Trade* conducted seven oral evidence sessions and received 31 written submissions. It also made overseas visits to Portugal, Spain, and the Netherlands as well as fact finding visits within the UK. In 2010 the Public Accounts Committee gave attention to *Tackling problem drug use* for which it received evidence from the Home Office and the NTA. This inquiry was informed by a detailed National Audit Office report (2010) and robustly interrogated civil servants. In 2011-12, the HoL Home Affairs EU Sub-Committee *Inquiry into the EU Drugs Strategy* was composed of an expert and interested membership. Its specialist advisor was from the disciplines of social policy and criminology and it made a visit to Lisbon to meet staff of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The 2012 HASC carried out a *Comprehensive review of drugs policy* which received 193 submissions of written evidence. It heard from a large number and wide range of witnesses and used some innovative evidence-

gathering methods, including holding a public debate. It did not appoint a specialist advisor.

Committees thus share some characteristics in the way they approach an Inquiry but differ in other respects. The process involves a series of stages where a number of influences come to bear. These stages include:

- Choosing a topic
- Agreeing terms of reference
- Building an evidence base
- Interrogating the evidence
- Writing the report
- Publishing the report
- Receiving the government's response

THE CHOICE OF TOPIC

Select Committees respond to issues of the day and add weight to rising public concern. At times however the choice may reflect the particular interest of the Chair or an individual committee member.

Increasing attention to cannabis led to a series of investigations in the 1990s and around the turn of the 21st century – from the BMA, WHO, DH, ACMD, Police Foundation, the APPG on Drugs Misuse, and the *Independent on Sunday*. In this context, the House of Lords conducted its inquiry on Cannabis.

Wide-ranging reviews may be carried out where the government of the day at the highest level is not opposed to such an activity. Chris Mullin, Chair of the HASC in 2001, records that Tony Blair 'was relaxed about an inquiry into legalisation: "I have no clear view" he said "there could be some issues a select committee can explore which I never could"' (Mullin 2009: 208-9). In this case, an inquiry by a select committee was a useful way to test the water on public opinion as the new drugs strategy was being developed.

The 2012 HASC inquiry appears to have been instigated partly as a result of the activities of pressure groups – its initial announcement referred to 'the recent recommendation by the Global Commission on Drug Policy'. Drugs had also been an item on the Liberal Democrat Conference agenda the previous autumn. The choice here reflected effective lobbying activities and the conditions of Coalition government politics.

In their early years in the devolved assemblies, there was a strong tendency to focus on very large policy reviews. One of these was an Inquiry into *Drug Misuse and Deprived Communities* conducted by the Social Inclusion, Housing and Voluntary Sector Committee of the Scottish Assembly. Similarly an extended parliamentary process *Scotland's Futures Forum* published a report in June 2008 on what Scotland would look like in the year 2025 in relation to alcohol and drugs, which drew heavily on a collection of expert evidence.

TERMS OF REFERENCE

The terms of reference chosen are important in affecting the shape of an inquiry and its impact. The 1997-8 Lords committee on cannabis took a very specific topic to investigate – ‘whether there was a case for relaxing some of the current restrictions on the medical uses of cannabis’ - focusing on questions of science and technology. Wider issues, they said, were outside their remit - relating to law, sociology and philosophy. In this way they hoped to be able to accumulate evidence seen as more robust and scientific and thus less likely to be contentious. By contrast the 2012 HASC comprehensive review covers a long list of issues and ranges widely.

BUILDING THE EVIDENCE BASE

Civil servants are asked to provide background evidence to committees, provide data analysis and examples of interventions that work. This evidence may form a large part of a final report.

Select Committee inquiries are assisted by Clerks, employees of the House, who scope the issue and assist with questions and writing the report. Policy analysts may provide in-depth research and briefing and the permanent staff may be augmented by specialist advisers, often eminent people.

Observers comment that the real serious work of parliament is done in select committees. Committees mobilise a huge amount of information and generally work in a consensual manner with members co-operating across party boundaries.

The majority of contributions of written evidence come from stakeholder organisations - activist groups, think tanks, voluntary sector groups, employer representatives and others – which cluster round committees as a route to policy influence.

The devolved administrations have introduced innovative approaches to public consultation: the use of conferences and workshops, visits to community groups, focus groups and extension of the role of web-based consultations. These have extended the range of stakeholders included in policy deliberations.

INTERROGATING THE EVIDENCE

The evidence considered by select committees has increased in volume and complexity over time. The number of written submissions has increased, indicating the expansion of the policy community and growing public attention to the drugs issue.

Calling witnesses helps to link parliament to wider society: television or video coverage and the development of the parliamentary website have all helped to increase transparency.

Select committees can question Ministers and civil servants. Whether they can require government advisors to attend is unclear. Paul Flynn MP reports that Lord Birt was forbidden to give evidence to the Public Accounts Select Committee while working for the Strategy Unit (Flynn

2012: 126). The fear was that he might have been questioned on the Prime Minister's rejection of the unit's critical analysis of the costs and effects of drug policy.

The 'usual suspects' appear among those giving evidence: key influential individuals and groups. Disagreements between witnesses and sets of evidence mirror disagreements in the wider drugs community and society. Submissions also reflect the expertise of different lobby groups: some views are mobilised more effectively than others.

Inquiries have provided an opportunity for advocates to press for the inclusion of lay knowledge as evidence. In the late 1990s, organised groups of patient or user groups established links with the drug policy community: 'activists in giving evidence to the expert committees provided an effective conduit between grass roots advocacy, practical knowledge of using the drugs, and policymakers and lawmakers and helped to shape the form of the debate in a way that had not occurred in the closed expert discussions of the 1970s.' (Taylor 2010: 196).

Committees can be 'robust' in questioning witnesses. While this may be appropriate for Ministers, rogue bankers or newspaper magnates, it is less acceptable to treat others such as unpaid advisors – e.g. Chairs of scientific committees - with disrespect. Some also see too 'robust' questioning of civil servants as unacceptable¹. While the degree of courtesy extended to witnesses has varied by committee, the tone of questioning in some drugs inquiries might have the effect of limiting the range of people willing to provide evidence.

Leading questions may be put which experts find difficult to answer. MPs sometimes use questions not so much to elicit a response as to state their own position, for example asking 'You do not believe that full-time, one-to-one residential care for the really difficult young people is the best thing to do?'

What evidence seems most influential with committee members? First-hand contacts made on visits are thought to be invaluable. Scientific evidence appears less influential. One MP seemed most affected by his experience when he 'spent ten days in a council flat and it was quite horrifying . . . [people were] injecting themselves in the stairwells at night . . . leaving needles all over the place. It was quite horrible'.

The current 2012 HASC inquiry illustrates the role of the Inquiry as 'performance' - as political theatre. Inviting controversial high profile celebrities brings media coverage, as seen in the extensive reporting of Russell Brand's appearance at the Committee.

Some witnesses have concluded that MPs operate with pre-formed views and are not open-minded: they seem resistant to detailed explanations of evidence. One MP, questioning a

¹ In February 2012, it emerged [<http://www.telegraph.co.uk/news/politics/9054719/Gus-ODonnells-anger-reflects-a-growing-rift-between-mandarins-and-MPs.html>] that before he stepped down, O'Donnell had written to Labour's Margaret Hodge, Chair of the Commons Public Accounts Committee, to express dismay at her treatment of officials and her drive to make civil servants accountable directly to MPs, rather than to departmental ministers.

distinguished professor, asked 'Have there been any studies as to the health impact of long-term methadone use on the individual?' The Professor began his answer by referring to a review paper in the *Lancet* and to a multi-authored book about drug policy and the public good. But the MP was not interested and interrupted him with 'This is not a lecture'.

Public bill committees can also take evidence: for example, the opinions of the Advisory Council on the Misuse of Drugs (ACMD) and UKDPC were elicited in discussions on the temporary class drugs order. The way committee members conduct these discussions is often well informed, if opinionated, and in general questioning seems less hostile than in some select committee hearings. As with select committees, MPs take the opportunity to air their own opinions in a public forum while questioning witnesses, thus getting their views on the record. These views may then be taken up by the press or pressure groups and/or noted by civil servants, Ministers or other MPs. Here too opinions may be expressed in the form of a question: for example, one MP asked an expert witness 'Professor, do you accept that the criminal law can be an important way of directing patterns of behaviour?'

WRITING AND PUBLICATION OF THE REPORT

Select committee reports are generally well written and detailed and can become important historical documents. Unanimous reports are most influential. All reports receive a formal government reply. In 1998 'the cannabis report created a stir when it was published on 11th of November, heightened by the fact that the government rejected the report on the morning of its publication' (Taylor 2010: 222).

Publication of a report provides an opportunity for pressure groups to raise an issue or correct statements based on biased or inaccurate evidence. They may issue a press release and discuss the topic on radio.

The timing of a report is important. The 2010 report on the *Cocaine Trade* was followed by a change of government. The new government accepted only half its recommendations and stressed that it would be conducting a thorough review of all drugs policies. Less dramatically, a change of Minister, such as a Home Secretary, can affect the reception accorded to a committee's recommendations: for example his or her views on the classification of cannabis would affect perception of the value of a report.

It is also important to follow up on an inquiry report. Chris Mullin recorded that 'Our much leaked long awaited drugs report is published this morning and has attracted widespread attention. The BBC and several newspapers are leading with it.' Reaction to a report may not be what was hoped for, however, and a Chair has to be phlegmatic. Mullin comments that 'unfortunately Blunkett has muddied the waters by issuing a statement refusing to contemplate re-categorising Ecstasy and saying there are no plans for safe injecting houses. Silly man, having called for an "adult debate on drugs" he promptly closes it down.' (Mullin 2009: 289).

Another example of the importance of good timing for a report is that of the 2012 HoL EU drugs strategy inquiry report. Lord Hannay, Chair of committee, said 'we got our views in ahead of the game, which is what this House should aim to do whenever possible with its thematic reports.'

Commentators felt that this report had potential to be influential in relation to the drafting of the new EU drugs strategy later that year.

GOVERNMENT RESPONSE TO RECOMMENDATIONS

'Government responses to recommendations will normally be drafted by a civil servant who has been involved in briefing the Ministers who appeared at the enquiry. . . and are signed off at ministerial level. It is rare for responses to indicate a substantial rethink as a direct result of select committee criticism: rather, policy is tightened and ideas enabled to percolate through departments via committee reports.'(Maer and Sandford 2004: para 107).

Civil servants follow the progress of a committee and its evidence: they begin to think about the potential impact on aspects of policy and draft the Government's response.

Select committee reports in the 1980s had direct influence. The 1984-5 Social Services Committee report called for an increase in expenditure on treatment which did occur: whether this increase would have happened without the report is unknown but the report's conclusion gave legitimacy to executive decisions to expand services. The Government strategy *Tackling Drug Misuse* 1986 paralleled an interim report from the 1985-6 HASC and could be said to have been influenced by it.

Reports have had a strong influence on policy debate where they made a clear and authoritative statement. This was the case with the 1997-8 Lords Science and Technology report on the medicalisation of cannabis.

Where recommendations were internally inconsistent however, as was the case with a number of reports, the report as a whole was less likely to be influential. Where recommendations were immediately accepted, there is some evidence of collaboration between the Chair and a department Minister.

Recommendations which endorsed or embellished existing policy had influence: this was the case with many of the refinements to criminal justice practices which emerged from public bill scrutiny in the 1990s and 2000s. As such they seemed mainly to legitimise the stance of the executive. Recommendations requesting no change were generally gratefully accepted by government. However large changes were sometimes eventually accepted and implemented, as we have seen with regard to medical cannabis.

A shift in government policy could be supported by parliamentary discussions, both also responding to pressure group activity, as for example with calls for more spending on residential rehabilitation (Cocaine Trade report 2010, executive summary and para 193) or with criticisms of methadone treatment (comments made during the 2012 HASC Inquiry (27.2 2012)).

Similarly the HASC 2001 report came at an opportune time as government was beginning to think about relaxing the laws on cannabis. It had an influence on how people talked about the problem. The thinking of the committee accorded with the view emerging in government that policy could have a more significant impact on the harm caused by drug use if it focussed on 'problematic

drug users’.

The Commons Science and Technology report 2008 contained critical recommendations of ACMD which were acted upon as they accorded with government thinking. However this was not the case with its conclusion that there were significant anomalies in the classification of individual drugs and a regrettable lack of consistency in the rationale used to make classification decisions.

Key factors influencing the operation of committees

More focused committees may be more likely to pay attention to scientific evidence and have influence. When the Home Affairs Select Committee met in 2001 ‘one of the new Tories, David Cameron, a former special advisor to Michael Howard, helpfully pointed out that short, focused inquiries were more likely to be taken seriously than long unfocused ones.’ (Mullin, 2009: 215). The current HASC inquiry however lists 13 questions, arguably rather too many to produce a report likely to have immediate impact. But if the aim is mainly to draw attention to an issue, this may not matter.

A very specific remit for a committee can increase its impact: the HoC Science and Technology Committee 2005-6 inquiry into Drug classification was the second of three case studies under an over-arching inquiry into the Government’s handling of scientific advice, risk and evidence in policymaking. The committee looked at the role of the Advisory Council on the Misuse of Drugs (ACMD) and identified a number of flaws in the way the Council conducted its business. Key recommendations were acted upon.

Relations between committees and the executive arm of government are important influences on the impact of a committee. Government may use the platform of a committee’s inquiry to announce a change of policy while it is still underway: ‘at a Home Affairs Select Committee meeting, the Home Secretary David Blunkett announced that he favoured the reclassification of cannabis, and asked the ACMD to review the classification in the light of scientific evidence’ (Mullin 2009: 232).

A strong, independently minded Chair makes progress with Ministers outside the committee process. There is ongoing interaction between the committee Chair and the relevant departmental Ministers. A select committee and a Minister may work in partnership, as appears to have been the case with Chris Mullin and David Blunkett.

A committee Chair may raise issues as possible topics for investigation and the Minister may respond by encouraging them to avoid or redirect the issue, saying that the Government is already planning to review a policy, that the timing is wrong or that the government would not find such an inquiry ‘helpful’. MPs are pragmatic so extracting a Government promise to look again at a policy without a select committee review may be a better outcome than producing a critical report that Ministers reject out of hand.

The influence of individuals in the ‘messy’ processes of politics has to be recognised too. As Rhodes has argued, ‘analyses of governing structures need to be connected with the beliefs and

narratives of individuals.’(2000:86). Over time, influential figures can be said to have helped shape drug policy, such as Norman Fowler and Tony Newton in responses to the HIV/AIDS crisis.

Individuals on a committee affect the direction and strength of a report. HoL committees are often composed of people with specialist expertise – a contrast with those in the Commons where MPs deliberately place emphasis on their role as generalists. However in the Commons too, committee members may be experts, either scientists or having other experiences on which to judge the evidence presented to them. And, through involvement in inquiries, members of a committee add to their expertise.

The expertise of the Chair in particular can be brought to bear on discussions, for example where they have a background in law or financial administration. The very active and high profile HASC Chair in 2012 has helped to keep the issue of drug policy in the limelight.

When a Minister has lost office and becomes a backbencher then his or her expertise can be used in the scrutiny of legislation to great effect. As a backbencher, the MP now has the freedom to voice opinions different from those articulated in office. One felt able to comment in the form of a question to an expert witness: ‘do you think there is a need for a broader look at the whole area of drugs legislation? This proposal may be a welcome improvement, but it is a sticking plaster for one particular aspect of the problem. There is a broader issue about what the legislative framework should now be for drugs in our society’. Such a view would not have been open to the MP when a Minister.

The time allowed for deliberation is critical as well as the timing of the inquiry itself. The *Drugs Act 2005* was an occasion where public bill scrutiny was of particular relevance. Pressure groups, journalists and MPs have all raised concerns about the process of scrutiny prior to this Act. Some clauses in particular were identified as problematic in the way in which they were developed. Complaints were voiced that there was no formal external consultation nor was the ACMD consulted. The passing of the Bill in the ‘wash up week’ meant it failed to receive proper parliamentary scrutiny in the Lords.

The activities of pressure groups and their links to activists in parliament are also important factors influencing the outcome of scrutiny processes. During scrutiny of the *Welfare Reform Bill* the combined efforts of pressure groups and members of the House of Lords served (for a time) to limit the impact on drug dependent claimants. It was during the House of Lords Report Stage debate on the Welfare Reform Bill (22nd October 2009) that the government announced concessions, in response to amendments moved by Baroness Meacher.

How effective are committees?

Benton and Russell (2012) in their assessment of select committees in general noted a number of forms of influence:

- Direct government acceptance of committee recommendations
- Influencing policy debate

Essays on the governance of drug policy

- Spotlighting issues and altering policy priorities
- Brokering in policy disputes
- Providing expert evidence
- Holding government and outside bodies accountable
- Exposure
- Generating fear

(Benton and Russell 2012: 17).

These processes also appear at work regarding drug policy as Table 4 illustrates.

TABLE 4 EXAMPLES OF REPORT RECOMMENDATIONS AND RESPONSES BEFORE, IMMEDIATELY AND OVER TIME.

REPORT	RECOMMENDATIONS	GOVERNMENT REACTION	COMMENTS
1984-5 Social Services Committee	Call for immediate determined response from Government and society, for increased expenditure on services and for a strategy	Government acted on these	Chimed with mood of the time
1985-6 Home Affairs Committee	Action on drug trafficking offences	Accepted by government	Fitted with current of opinion in government and internationally
1997-8 Lords Select Committee on Science and Technology	Action on medical uses of cannabis	Government rejected report on morning of publication	A milestone in policy; raised public awareness; generated research into medical cannabis which in time changed policy (Taylor 2010)
1999 Home Affairs Committee	Drew attention to the needs of prisoners; argued need to strike a balance between cracking down on the supply of drugs and providing humane treatment for prisoners		Over time contributed to development of more coherent prisons drug policy (Duke 2003).
2001 Home Affairs committee	Recommended focusing attention on the Problem Drug User (PDU)	Home Secretary announced intention to reclassify cannabis at a committee session	Supported government policy to focus on harms caused by PDU
2005-6 HoC Science and Technology Committee	Called for scientifically based scale of harms; comments on role of ACMD	Classification system retained Change in relations between ACMD and government departments	Contributed to emerging debate on validity of existing classification system

REPORT	RECOMMENDATIONS	GOVERNMENT REACTION	COMMENTS
2010 Home Affairs committee	Drew attention to the increase in use of cocaine Recommended appointment of Independent Drugs Advisor to coordinate cross departmental work Drew attention to lack of rehabilitation places	Role of cross departmental coordinator rejected Government used opportunity of report's publication to set out its new approach to drug policy	Contributed to developing critique of shortage of residential rehabilitation places
2010 Public Accounts Committee	Called for better evaluation of drug policy Referred to value of residential rehabilitation	Following a recommendation made by the National Audit Office, government agreed to produce an overall framework to evaluate and report on the value for money achieved from the drugs strategy	Supported growing calls for economic evaluation of drugs strategy Supported concerns about lack of residential rehabilitation places
2011 Lords EU sub committee	Supported value of EU drugs strategy		Followed by serious debate in House of Lords; read by decision makers in EU.

The main contribution made by select committee reports seems to be their potential to impact on public debate and the public mood. But a key impact of inquiries is also on civil servants and similar responsible bodies who take seriously what is said in deliberations and feel a duty to respond to recommendations of reports. Parliamentary scrutiny influences paid public servants and shapes policy and implementation through prioritising certain actions, approaches and issues.

Participants' observations and evaluations of parliamentary committees

The observations in the section which follows are drawn largely from questionnaire responses received from a straw poll of key informants who had contributed to Inquiries in a variety of roles – as witnesses, specialist advisors, or civil servants. They are presented to illustrate some of the views held but do not pretend to be comprehensive nor representative. They are supplemented by comments taken from discussions at seminars organised by, amongst others, the Institute for Government and UKDPC, conducted under Chatham House rules, and directly from Hansard reports and other documents.

Ministers claim that they do take note of committee scrutiny: 'we listened in Committee, when I believe we had a constructive debate. We also listened to those outside—important views have been put to us'.

Chairs generally aim to 'make a difference'. They aim to track the Government's response to their committee's recommendations, and hold them accountable for lack of action or poor response. They are disappointed if follow up debates on their reports are not given attention or reported widely and if there is poor attendance. However phlegmatically they conclude that this is 'better than nothing' and at least the proceedings are in *Hansard*, along with their report and its evidence for people to consult.

Parliamentarians in general hold less sanguine views on the process. For some, discussion of drug policy is far from evidenced-based, being instead led largely by emotion and ignorance. Some thought attention to evidence was poor even when it came from authoritative and expert sources. MPs recognise that in politics, scientific evidence often plays a small part in decision making and can be trumped by moral, spiritual and economic concerns. MPs pride themselves on being in touch with the general public and sensitive to opinion. They can cast doubt on evidence coming from academics: 'academics are all very well in small doses but in reality they have little understanding of the practical world'.

MPs think that the drugs lobby needs to recognise that there are many other competing demands on parliamentarians' time and other topics are generally seen as more important than drugs. Even in the case of select committees, the list of topics they consider in any one year is very extensive. Parliamentarians are aware that governments follow proceedings closely and may respond while an inquiry is under way, as we have seen: they may issue a response immediately to close down discussion, clarify their position or challenge witnesses' evidence.

And, however well argued the parliamentarians' deliberations may be, they then have to get through the filter of media reporting, which is, they think, even more biased and partial and generally sensationalist.

So while facing one way to try to influence the executive to improve public policy, parliamentarians also face the other way outside to the wider society to influence public debate and connect to influential forces who may impact on their electoral chances and personal careers.

Pressure groups and practitioners' experience of giving evidence is that the quality of questions varies depending on the interest and knowledge of the person asking the question. For those who were engaged with the subject, their questions were thoughtful and it appeared that they really did want to find out more about the complex issues relating to drug policy. However, there were other members who seemed either clearly ideologically driven or speaking to the public gallery: their questions were thought to be shallow and to fail completely to understand the intricacies and interconnectedness of the issues.

Experiences vary across different committees. Overall they were left with little sense that there was much 'scrutiny' going on in terms of specific draft legislation. They were pleased however when evidence they submitted was quoted in a report.

Special advisors are able to bring to members' attention questions on the evidence given by witnesses if it seemed wrong or ill informed. Some observed that committee members sometimes

seemed to have particular axes to grind and that some committee members seemed particularly influenced by witnesses with practical experience.

Civil servants. Some thought that civil servants in general paid little attention to select committee reports and that they were much more likely to use think-tank reports. Others thought that reports had little direct influence on the work of departments, on its priorities and workload. One commented on one report that it stood as a stand-alone report and was quietly shelved. There seemed to be little follow-up to check whether the recommendations had been undertaken. The process seemed to be divorced from the day-to-day operation of delivering the Government's Drug Strategy - there was no clear system of follow-up or metrics to assess performance.

Perceptions of the impact of select committee reports may however reflect the role of a department. Those departments concerned with 'reform' and 'forward thinking' seemed less influenced than those civil servants in executive or delivery departments where a committee's recommendations had direct relevance to their work and were taken seriously.

Where civil servants were tasked with providing information to a committee, they could see flaws in the process. While civil servants and officials were generally highly regarded as sources of evidence by committees, some had to put up with tough questioning. One official's perspective was that the inquiry process was rather chaotic, it seemed rushed and there was little time to prepare for the submission. The quality of evidence presented was consequently rather limited as a result.

Scientific experts: internationally known experts consulted on overseas visits thought parliamentarians seemed more influenced by their visit to the country than academic assessments. Mainly they seemed to value evidence that confirmed what they already believed. And evidence that gives an (often illusory) picture of certainty, especially if it has numbers attached, seems also to be valued more than expert evidence. National experts felt their contributions were treated with respect and influenced conclusions. They recognised that to be influential, it was important to be aware of the constraints operating on committees and to provide succinctly written comments which could be actionable by a Committee: oral contributions should be short, including memorable sentences. The Clerks and their teams were invariably described as courteous and essential. Improvements to the whole process would come, they thought, from better general recognition of the contribution that science could make to policy development. Parliamentarians could be influenced by reasoned argument, where examples were backed up by scientific papers.

Experts believe it is important to make a contribution to these committees even though the way in which evidence is used and incorporated or not into a final report and recommendations is 'opaque to say the least'. One impression of inquiries in both Westminster and Scotland was that committees struggle to weigh the difference between the bold assertions made by influential and powerful individuals and the evidence provided by researchers. Statistical evidence seems to be valued less highly than narrative evidence.

Select Committees are seen by experts as an essential part of the parliamentary process but a

number found the process overall to be quite disappointing. They observe that Committee reports are quoted as authoritative but the process of constructing them is flawed. It might be better if they studied the evidence in advance of witness sessions. A better process would be to begin with a sound review of 'what do we know for certain' with regard to a particular question. Disconcertingly, MPs seem to have little understanding of or respect for the knowledge that has been accumulated over many years by addiction specialists with regard to treatment.

Committees and their Contribution to Good Governance

It is useful at this stage to remind ourselves of the key good governance principles outlined by UKDPC which cover:

- goals and objectives
- leadership
- co-ordination
- policy design
- development and use of an evidence base
- attention to implementation
- processes for accountability and scrutiny ; and finally
- processes for stakeholder engagement

Parliamentary committees can contribute to furthering all these principles but may have a particular role to play in regard to the setting of goals and objectives, development and use of evidence, scrutiny of policymakers and stakeholder engagement.

INFLUENCING POLICY DEBATE

Parliament acts as a barometer of opinion. The debate on drugs takes the form of a continuing process of deliberation and exchange between parliament, the executive and the wider society. The policy community, consisting of pressure groups, professionals, experts, researchers and others, is constantly on the alert, responding to events and engaging in discussions. Debates go backward and forward, there are shifts in decisions with a change of government or change of Minister, influenced partly by changes in the evidence and changes in press attention. This is not a simple linear process.

Committee reports constitute an ongoing dialogue about policy over time. Their inquiries reflect and build upon streams of advice presented to government, coming from ACMD, ad hoc departmental committees, commissioned research, submissions from professional organisations or voluntary groups, and advice from civil servants and medical and scientific advisors. Parliamentary scrutiny is different however in the sense of aiming not only to give advice but also to scrutinise and hold to account the government of the day and represent the views of the non-executive members of parliament. Parliament is most effective here if consensus can be achieved across parties.

A Select Committee report can encapsulate in one document a number of currents of activity, opinion and evidence that then contribute to a policy shift. This was the case with the 2001 HASC report. This report is often quoted, partly because it contains a mixed bag of evidence and recommendations which can be referred to by interested parties as suits their interests. This reflects a deliberate intention of the committee: 'we have also seen it as part of our function to give all sides of the argument a chance to set out their stall in the hope that their evidence will help to inform debate for some time to come'.

The Commons Select Committee on Science and Technology 2008 report expressed concern at the Government's proclivity for using the classification system as a means of 'sending out signals' to potential users and society at large. While their recommendations were initially rejected, their conclusion could be seen over time to play a role in the build-up of criticism of the scientific base of the classification system and contribute with other non-parliamentary activities to raising public awareness of the limits of the existing system.

PROVIDING EXPERT EVIDENCE

Taylor has concluded that science played an important role in the re-medicalisation of cannabis. Experts and specialist disciplines, operating through personal and professionalised scientific networks, pulled researchers together leading to a breakthrough in policy approaches encapsulated in the House of Lords inquiry (Taylor 2009). The transfer of science into policy was dependent partly on expert committees together with a desire to place policy on a stronger evidence base.

There is now an acceptance that parliament should be informed by reliable evidence and committees call for expert evidence during their deliberations. More than one committee has commissioned RAND to provide an objective assessment. (It may be seen as worrying that RAND is seen as objective while at the same time national scientists are sometimes distrusted). Science in general now plays a larger role in public policy and is increasingly influential at the heart of government in the executive: the Bird Report (n.d.) concluded that 'we could improve substantially and cost-efficiently the UK's quantitative understanding of, and effective interventions in, the many facets of epidemic and endemic drug use' and made a number of specific recommendations about how research should be conducted. The conclusion of scientists and of committee members looking at the relation of science to government is that science should be closer to the heart of government and that governments need to listen more closely to them. Perhaps a similar shift is needed more broadly within parliament.

HOLDING GOVERNMENT TO ACCOUNT

A role for select committees is to better link the wider public into the working of government – asking the questions they want answered. Inquiries have functioned to hold accountable members of the executive and those appointed to quangos: Ministers, senior civil servants, representatives of ACMD and NTA, police officers, prison officers, have all been called to account for their actions as witnesses. One method increasingly used by committees is that of 'exposure' with robust interrogation in public followed by publication of conclusions. For example, the 2005-6 Commons Science and Technology committee was critical of the way the ACMD conducted its

business: this was the catalyst for some changes in its procedures, for example, the ACMD now holds an open session at the beginning of its meetings.

An assessment of these governance processes

In general, it can be concluded that the select committee process and their reports are taken seriously by Ministers and civil servants. Backbenchers have given in-depth consideration to government policies and the operation of departments and the Government is required to give a detailed response to committee reports. But they are at best seen as part of a more gradual policy development process rather than representing a great turning point.

It is striking that it is the Home Affairs committee that is mainly active in the scrutiny of drug policy: this primarily emphasises the link between drugs and crime. This is a consequence of the Home Office having lead responsibility, which carries through into which select committee conducts most inquiries on drugs. This then influences which reporters cover the drugs issue, with crime journalists rather than health journalists following these committees, reinforcing in public debate the neglect of attention to health concerns.

To get more attention to evidence in policy and improve parliament's ability to distinguish between good and bad evidence would require broad cultural shifts, involving elected politicians and civil servants. Recruiting external (non-civil servant) experts with no vested interest to assess the evidence might be an improvement, as with the hiring of RAND in the *Cocaine Trade* inquiry. The recent broadening of the range of witnesses and sources of evidence has been valuable: input of evidence should not be restricted to scientists. However clarity is needed regarding which issues are genuinely scientific or technical and those which involve social or moral values. The nature of the Committee's approach could be improved by adopting a more inquisitive (rather than adversarial) method. A more deliberative style with some explicit comparison of the evidence of witnesses, coupled with a greater allocation of time to such sessions, could produce a deeper discussion and help public understanding where recordings were transmitted. Westminster could learn from Scotland here: for example, a Scottish Justice Committee investigation was said by one participant to be thorough and allowed time to question witnesses and explore issues with them. Improved governance would involve revisiting recommendations over time and establishing linkages between reports. Meaningful performance metrics could be developed building on the recommendations of the Public Accounts Committee (2009-10) but not restricting this to solely economic evaluations.

Conclusions

The essay has looked at the contribution of parliamentary committees to drug policy development and considered whether and how their recommendations have been acted upon, their role in holding government to account and scrutinising policy, how they have obtained and used evidence in their work and the factors that have influenced their effectiveness. A number of key conclusions stand out:

NOTABLE FEATURES OF CURRENT ARRANGEMENTS

- With the shift from 'government' to 'governance', parliamentary processes are now expected to link decision-makers to wider networks in a pluralistic and diverse civic society. In the drugs field, policy networks have expanded, presenting challenges for accountability mechanisms.
- The most effective form of parliamentary scrutiny lies with the Select Committees.
- The leadership shown by the Chair is important and Committees are now more powerful and respected since Chair and members are elected.
- Scrutiny by committee is most effective where terms of reference are clear and focused.
- The drugs issue is ubiquitous, appearing in a number of public bills: scrutiny of these draws in a wide range of parliamentarians who approach the issue from diverse points of view and with varying levels of expertise.
- The range of opinions and evidence accessed in the process of scrutiny has increased over time and parliamentary processes have become more transparent.
- Committee reports carry greater credibility where recommendations are consistent and where they are based on cross-party consensus.

PROBLEMS AND CHALLENGES

- Drugs is an issue which crosses many departments.
- The lead taken by the Commons Home Affairs Select Committee in reviewing drug policy is a consequence of lead responsibility being allocated to the Home Office in recent years. This has detrimental impact on attention to and understanding of health-related issues.
- The lack of scientific expertise among professional politicians limits their ability to evaluate the range of evidence relevant to drug policy. Clarity is needed on the distinction between scientific and technical questions and those which have to do with values and morals and the different forms of evidence appropriate to evaluate each.
- While recognising that parliamentarians, especially Ministers and MPs, work hard and have limited time, a system which allowed more time to discuss and evaluate evidence received from diverse sources and witnesses could improve decisions.

VALUABLE PROCEDURES

- The thematic rather than departmental approach to identifying topics for investigation which operates in the House of Lords and devolved administrations encourages better informed, in-depth and coordinated scrutiny of drugs-related issues.
- Scrutiny of drug policy has had some influence on executive decisions, especially where recommendations or amendments focus on technical questions, draw clearly on scientific evidence or where they fit with the direction of travel within executive thinking on policy.
- Over time, parliamentary discussions have contributed with other forces to changes in drug policy and practice. Committee consideration provides a platform for stakeholder involvement, and reports and other documents can encapsulate and place on the record contemporary information and opinion on a topic.

One interpretation of the way drug policy has developed over the past 30 years is to see a pattern of incremental 'progress by stealth'. This strategy works so long as drugs is kept 'below the radar' where practitioners and civil servants, operating in alliance, are able to offset some of the wilder ideas that emanate sporadically from government or parliament. Non-politicians use the opportunity provided by periodic parliamentary attention to drugs to increase the priority attached to this policy area, arguing for an increase in budgets then trying to shape implementation in a way informed by evidence to produce something that works better than it would do otherwise. These moments where parliamentary committees scrutinise legislation or a policy topic serve as a focus for lobbying and pressure group activity. Their deliberations and reports as official documents represent a high point of activity and capture opinion at one point in time.

This is to see the story of drug policy over the last 30 years as one of an incremental accumulation of specific policies and practices. However, while each may be individually appropriate, taken together these accretions have produced an elaborate architecture and paraphernalia of provision that is no longer efficient or fair and can trap unfortunates in its complex web. It could also be argued that piecemeal reform to processes will not in the end make much difference, since it is not parliamentary processes that are the main barrier to improving drug policies. Rather, some claim, it is the ideological purposes to which drug policy is put (inside and outside Parliament) which block reform. Incremental development does not lead to a change in the overall paradigm but works within it. Critical observers argue that there is a need for a wider-ranging open public debate if more fundamental change is to occur. However the outcome of such a debate might not be to the liking of radical reformers: the result could just as well produce reactionary policy.

Democratic societies do need good governance and some lessons emerge from this brief review of the role of parliamentary committees. It is evident that there have been more reports and attention given to drugs in the last decade or so, reflecting the increasing salience of the issue but also more activity in general from Select Committees.

The impact of deliberations within Parliament is mixed. Their discussions can have influence immediately, especially when specific technical issues are being addressed, where the view of parliamentarians accords with government thinking and is backed up by expertise, and where recommendations are unanimous. Conclusions of parliamentary scrutiny can also have influence when they work alongside the input of other forces over time as part of an incremental development of policy leading to gradual change. Where however there are no clear yes or no answers, the conflicting values and tensions in society are reflected in parliamentary discussions.

The simplest conclusion one can reach is that the work of parliamentary committees contributes to setting the context within which drug policy is formulated and implemented. With regard to parliamentary deliberations on drugs, the division between Health and Home Affairs has been fundamental to how the issue has been framed and reported. The ongoing tension in responsibility between health and social care and home affairs continues into committees and into media reporting, contributing to the relatively poor discussion of health related issues. This

problem of a deep bifurcation results from the continuing contest between law enforcement and supply side measures and health and social responses, demand side measures, which is played out in debates in parliament and represented in the division between social services or health committees and home affairs committees, with health being the poor relation subservient to the crime agenda.

Finally it is striking to observe from this brief review of parliamentary discussion of drugs over the years, that many of the issues identified in the 1980s are visible today. The problems mentioned in the Social Services Committee report of 1985 remain: inflexible opening hours; particular problems of homeless people; concentration on heroin to neglect of other substances; need for better attention to children; lack of variety in services not necessarily matching the needs of local clientele; stigmatisation and exclusion from mainstream services. In the 1980s, parliament expressed the fear that the 'nightmare of drug addiction as seen in America' would come to Britain and proclaimed 'everything possible should be done to try to avoid what has occurred in the USA.' Unfortunately they were not successful and these elements – especially the role of organised crime and the creation of an underclass - astutely identified by the Home Affairs Committee report of 1985-6 - did indeed appear in Britain and represent the major problems facing drug policy today.

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Appendix: Key characteristics of good governance that emerged from UKDPC expert consultation process.

The UKDPC principles are that:

- there should be *goals and objectives* that are clearly articulated, realistic but aspirational, and, if possible but not necessarily, consensual or with cross-party support;
- there should be *leadership* that is evidence-imbued, recognising the importance of evidence in policy development and the role of policy evaluation, and being willing to make changes based on feedback; leadership should also provide authority and resources and seek consensus and cross-party support and not seek to make political capital from the issue;
- there should be processes for *co-ordination* that begin at a high enough level to ensure commitment and resources, provide clarity of roles and responsibilities for those involved in policy development and delivery, and involve those responsible for implementation in agreeing objectives based upon an agreed policy framework;
- there should be a *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;
- there should be *development and use of an evidence base* that is supported by mechanisms that continually promote its development and expansion across all areas, is based around agreed upon standards for what 'counts' as evidence, including mechanisms to facilitate knowledge-building and sharing between researchers and policy makers, and is available in accessible ways for all stakeholders in order to improve accountability;
- there is attention to *implementation* that allows some flexibility for variation based on local needs and has sufficient financial resources and access to the evidence base;
- there should be processes for *accountability and scrutiny* that hold policy makers to account for their decision-making, including their decisions to use or not use evidence within 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; and finally
- there should be *stakeholder engagement* that include 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 policy makers, the media and the public

Eclipsing Science: The Magical Power of Language in Shaping Drug Policy

Dr Neil McKeganey, Centre for Drug Misuse Research

Introduction

In an ideal world drug policy and drug services would be based on the best available evidence, including the evidence of what works best. The notion of basing policy and provision on scientific evidence, as opposed to political supposition or personal preference, has an immediate and almost unquestionable appeal (Vienna Declaration 2010). And yet of course the reality is very different with both policy and provision in the drugs arena being shaped by many more factors than the available evidence and even, on occasion, in opposition to the available evidence.

To an extent the disconnection between evidence and policy is inevitable. There are simply too many gaps within the available evidence to base policy and provision solely on the contribution of science. Similarly, the multiple problems that drug abuse presents cannot always wait to be tackled until the necessary evidence is painstakingly collected, analysed, and the policy implications distilled and set out. There can be no better example of the need, on occasion, to develop policy and services in advance of the available evidence than the shift in policy and service provision that occurred in the 1990s as a result of fears of an imminent epidemic of HIV infection amongst injecting drug users.

Within the context of those fears the UK saw the rapid and widespread development of needle and syringe exchange schemes and other harm reduction services, including the provision of advice and information on safer injecting techniques and the sterilisation of injecting equipment. Those services were developed not on the basis of a robust body of evidence of effectiveness but largely in advance of that evidence because of the need to reduce drug injectors HIV-related risk behaviour (Stimson, 1995). To have delayed the development of needle and syringe exchange services, and other harm reduction services until a substantial body of evidence had been built up would have been a dangerous and costly folly.

There are other reasons however for the disconnection between evidence, policy and service development. Research is often a long-term activity that can take place over many years. By contrast policy change can occur within a matter of days, weeks or months driven sometimes by high-profile single cases that attract widespread media attention or a shift in the balance of power between political parties. Equally, even where research evidence is abundant there will still be occasions when policymakers and others raise new questions that can shift policy and provision even if the data in support of those questions is thin on the ground or non-existent.

In contrast to the idealised vision of a world of evidence based-drug policy the reality is one in which the policy process can seem volatile, unpredictable, sometimes urgent, sometimes painfully slow, endlessly fascinating and by no means guaranteed to deliver success. It is a process that is often characterised more by turbulent and contested change than incremental progression and within which language and rhetoric can be a good deal more influential than the slow onward progression of science.

Within this essay I look at one of the most contested areas of UK drug policy and provision to do with the place of methadone in the treatment of dependent drug use. The most significant change to have occurred in the perception of methadone within UK drug policy and provision has come about not on the basis of the steady accumulation of knowledge but the almost magical power of (in this case) politically charged language.

The Evidence Base

In the period since the mid-1960s when Drs Vincent Dole and Marie Nyswander undertook ground-breaking clinical and research work identifying the positive impact of methadone maintenance in the treatment of opiate dependency, methadone has become the mainstay of addictions treatment in countries across the globe (Dole and Nyswander 1965,1966, Dole Nyswander and Kreek 1966). The therapeutic benefits of methadone, prescribed on a maintenance basis, have been identified on the basis of extensive research and clinical observation. In terms of the research evidence we know that opiate dependent individuals prescribed methadone are at reduced risk of overdose (Clausen et al 2008); reduced risk of needle and syringe sharing (Kwiakowski and Booth 2001); reduced risk of becoming HIV and HCV positive (Ball et al 1988, Serpelloni et al 1994, Abdul-Quader et al 1987); they commit fewer crimes (Lind et al 2005, Dolan 2003); remain in contact with drug treatment services longer (Sees et al 2000); and they have a more stable lifestyle (Gunne and Grondbach 1981).

Alongside the various demonstrable benefits, methadone has remained a controversial treatment. It has been shown that drug users are at increased risk of death on both the inception and the termination of methadone maintenance treatment (Cornish et al 2010), and that prescription of the drug may lengthen rather than shorten the period over which individuals remain drug dependent (Kimber et al 2010). Research has shown that a significant proportion of individuals prescribed methadone are topping up their medication with illicit opiates, placing themselves at very high risk of a fatal drug overdose (Bloor et al 2008). Within many countries there has been evidence of a steady increase in the proportion of drug-related deaths connected in some way to methadone. In Scotland the latest figures from the Scottish government have revealed that 47% of addict deaths in 2011 were linked in some way to methadone (National Statistics 2012)

In view of the extensive body of evidence on the benefits of prescribing methadone to dependent opiate users it is hardly surprising that the treatment has become so widely used within the UK and elsewhere. The overall prevalence of problem drug misuse in Scotland has been estimated as 59,600; and it has been estimated that 22,224 of those problematic drug users are being prescribed methadone on a maintenance basis. On the assumption that it would be unusual for

much more than half of the total number of problematic drug users to be in contact with drug treatment services this suggests that in excess of 80% of the drug users in contact with drug treatment services in Scotland are being prescribed methadone on a maintenance basis (Information Services Division 2011, EMCDDA 2012). It has been reported that there are approaching 150,000 drug users in England receiving opiate substitution treatment of which the largest proportion are being prescribed methadone (EMCDDA 2012). That figure represents around 73% of the total number of drug users in contact with drug treatment services in England.

Since the early nineteen nineties drug policy within the UK has been centrally influenced by the belief that "treatment works" with one of the key challenges being to ensure that increasing numbers of drug users have access to drug treatment and prescribing services:

All problematic users must have access to treatment and harm minimisation services both within the community and through the criminal justice system. The availability of treatment is growing and waiting times are coming down. However I share the frustration of those users and their families who have been waiting too long for urgently needed treatment. Provision of treatment is still far too patchy and variable and accessing rehabilitation supported after treatment a lengthy and difficult process. Services will be expanded so those chaotic drug users seeking help do not have to wait (Updated Drug Strategy 2002:3)

The positive view of drug treatment in general, and methadone maintenance in particular, shifted markedly in 2005 in the face of concerted criticism of the way methadone was being prescribed within the UK. Key in that wave of criticism was a talk given in Scotland in 2005 by the leader of the Scottish Conservative Party Annabel Goldie.

The Methadone Car Park: A Changed Narrative and a Changed Policy

In 2005 Goldie launched a stinging attack on the Scottish government when she accused ministers of leaving some 19,000 Scottish drug users parked on methadone at an annual cost to the tax payer of some £11m. Whilst there were no statistics available in 2005 (or indeed subsequently) on the actual length of time individuals were remaining on methadone in Scotland, Goldie's use of the term "parked" conveyed an image where large numbers of individuals were somehow stuck on their prescribed medication and failing to make any significant progress in their journey towards becoming drug free. From being regarded as a highly effective treatment, that needed to be extended to increasing numbers of drug users, methadone was now being characterised as failing treatment which locked addicts into life of continuing dependency and costing the tax payer dearly. In the wake of Goldie's criticism other organisations were producing critical assessments of the way in which methadone was being prescribed within the UK. The Centre for Social Justice, for example, accused those working within the drugs treatment industry of prescribing methadone far too widely, driven, it was suggested, more by government performance targets than the needs of patients:

Our analysis is not that methadone does not and cannot have a useful and positive role in the treatment of addiction. Its routine and mass prescription is hard to justify on either clinical or ethical grounds and is entrenching rather than solving addiction. The rapid expansion of its prescription appears to be as much an outcome of political pressure and target driven policy as of a dispassionate clinical response to the treatment needs of a particularly vulnerable population. We have found the current mass prescription of methadone to be the cause of deep disquiet amongst drugs workers and addicts alike (Centre for Social Justice, 2007:25).

Whilst there has been a continuing debate within the UK addictions field as to the appropriate balance between substitute prescribing services and other forms of treatment there can be little doubt that it is the characterisation of drug users being parked on methadone that has somehow captured the professional, political, and media discourse on drug treatment policy. In 2010 Mark Easton, the BBC Home Editor, commented that for many years UK drug policy had been underpinned by:

A philosophy of harm-reduction (that) has seen tens of thousands of heroin addicts effectively parked on methadone for years (Easton 2010)

Peter Dawson, a pharmacist, writing in the Guardian similarly noted that:

The National Treatment Agency for Substance Misuse recognises that addicts have been parked on methadone for too long and now promotes abstinence as the new treatment goal with time limits on the duration of methadone maintenance (Dawson 2012)

Chris Ford, a London-based general practitioner expressed her irritation at the characterisation of drug users being parked on methadone, and what she saw as the unwelcome interference of politicians in what were seen to be clinical matter of determining what kinds of treatments needed to be prescribed to drug using patients and for how long:

Most sensible clinicians see abstinence as one end of a spectrum and see no conflict whatsoever with substitute prescribing. In my experience most people working in the field want the best for their patients. I am deeply offended by language such as "people indefinitely parked on methadone" "routinely writing off full potential etc". If any of my patients wants to try and come off all drugs- they have my full support. (Ford 2010)

As a doctor I use methadone and buprenorphine with many patients alongside a variety of psychosocial and other healthcare interventions. Prescribing can last for one week or it can last for 30 years-it is and should be completely patient-driven and dependent on them as individuals. An arbitrary time frame imposed on any patient's medication regime is unacceptable and I for one will not accept such political interference. It is essential that this new governments drug policy is based on sound evidence and we the clinicians must

strongly resist a potentially lethal change to policy (Ford 2010)

Despite the annoyance that some health service providers clearly felt about the language of drug users being parked on methadone the image has had a powerful influence on drug treatment policy. The 2010 UK drug strategy "Reducing Demand Restricting Supply Building Recovery: Supporting People to Live a Drug Free Life" (Home Office 2010) set out a commitment to ensure that drug users were not remaining indefinitely on prescribed methadone but were moving forward in the journey of their recovery to abstinence:

Substitute prescribing continues to have a role to play in the treatment of heroin dependence, both in stabilising drug use and supporting detoxification. Medically-assisted recovery can, and does, happen. There are many thousands of people in receipt of such prescriptions in our communities today who have jobs, positive family lives and are no longer taking illegal drugs or committing crime... However, for too many people currently on a substitute prescription, what should be the first step on the journey to recovery risks ending there. This must change. We will ensure that all those on a substitute prescription engage in recovery activities and build upon the 15,000 heroin and crack cocaine users who successfully leave treatment every year free of their drug(s) of dependence (HM Government 2010:18)

More recently the "Putting Full Recovery First" report, which all of the main departments of the UK Government signed up to, further emphasised the commitment to move away from a policy in which drug users were seen as being parked on methadone:

Whilst we recognise that substitute prescribing can play a part in the treatment of heroin dependence, both in stabilising drug use and supporting detoxification, it will not be the final outcome paid for in PBR (Payment By Results). There may be people in receipt of such prescriptions who have jobs, positive family lives and are no longer taking illegal drugs or committing crime. But it is important to utilise such interventions as a bridge to full recovery, not as an end in itself or indefinite replacement of one dependency with another.

No longer, therefore, will addicts be "parked" on methadone or similar opiate substitutes without an expectation of their lives changing. We must ensure all those on a substitute prescription engage in recovery-driven support to maximise their chances of being free from any dependency as soon as is practicable and safe. (Department of Health 2010:10)

In the light of the shift in the perception of methadone the Department of Health issued new guidance to drug treatment services working within prisons which emphasised the importance of ensuring that methadone was indeed being used as a tool for recovery rather than a substitute medication prescribed to dependent drug users on a permanent basis:

Where longer term prescribing is offered to those whose sentence exceeds 26 weeks, it should be explained that at an appropriate time there will be an expectation that the

prisoner works towards reducing their dose of opiate substitute medication, and that abstinence remains the ultimate goal.

At a later stage if there is some exceptional reason why abstinence cannot be considered, then the reasons for this must be clearly documented in the clinical record, at each three-month review. Maintaining a prisoner on a long-term opioid prescription should be an active decision agreed between the clinician and the patient informed by the multidisciplinary reviews. (Department of Health 2010)

Finally, in 2011 the UK National Treatment Agency's convened an expert group to advise on the place of substitute medication in optimising drug users opportunities for recovery. The report of this group sought to distinguish between the situation in which drug users are being parked on methadone and the importance of ensuring that individuals are able to receive the medication they require for as long as they require it:

It is important to differentiate standard maintenance on OST (opiate substitution treatment) in a recovery-orientated system of care from the criticism that some people have been 'parked' on methadone. Regular recovery care plan reviews and the recovery-orientated culture, enhanced visibility and facilitated access to mutual aid, and a more overt collaborative approach to care planning should ensure nobody stays on OST for any longer than appropriate. (National Treatment Agency for Substance Misuse 2012:16)

Within these extracts it is easy to see how the characterisation of drug users being "parked on methadone" proved to be so influential in shaping the policy debate around methadone and influencing the way in which methadone is used within UK drug treatment. But why did the notion of drug users being parked on methadone prove to be so influential in the face of the lack of data on the actual length of time individuals were being prescribed the drug or that their recovery was indeed being impeded as a result of the duration of their prescribed medication? To answer that question it is necessary to look at the power of language within political discourse.

The Power of Language

In an interesting paper on the nature of persuasion in political discourse Frank Mols has focussed on how some political figures are able to articulate views that somehow mould the popular and professional discourse around a particular issue. One reason that has been offered as to why people are amenable to being influenced by opinion leaders has been provided by cognitive psychologists namely the notion that people are in general "cognitive misers":

That is, humans are conceived as inefficient information processors, who possess limited capacity to store and retrieve information, and these limitations are assumed to lead to a propensity to take cognitive shortcuts (Mols 2012:330)

However, according to Mols, the capacity of political figures to influence opinion has to do with more than the limited capacity of individuals to internalise complex messages. Rather, according

to Mols, there are some individuals who have the ability to function as “identity entrepreneurs” creating in their discourse a master frame that influences the very terms of the popular and professional debates in their area:

In the frames in communication literature, the prevailing idea, it seems is that influential leaders are good at reading public sentiments, and good at packaging their message in a way that is consistent with these sentiments...what is not taken into account, in this reading, is the possibility that opinion leaders...can do things to create a public opinion ‘wave’. (Mols 2012,331)

Mols’ interest here is in the way in which political commentators use language to create a sense of shared identity and in doing so influence the debates round the issues of immigration and religious tolerance. Interestingly as Mols points out it is not necessary for the “identity entrepreneurs” to draw upon an evidential base in making their case - indeed it seems as if language can be even more influential in the absence of evidence to support or contest the master frame:

Those who insist on sound evidence will not only become regarded as not fully committed to the group, but also risk being likened to Chamberlain, and accused of naivety and an inability to recognise an imminent threat. (Mols 2012:338)

The characterisation of drug users being parked on methadone is illustrative of the same narrative power that Mols identifies in his analysis of political language around immigration and religious tolerance. In both cases what one sees is the capacity of political leader and opinion formers to create a master discourse around a topic that proves hugely influential even in the absence of confirming or disconfirming evidence.

Persuasion and the Methadone Car Park

There are a number of reasons why the language of drug users being parked on methadone has proven to be so influential within the UK. First, the term itself is immediately accessible requiring no specialist knowledge as to its meaning. The term powerfully conveys an immediate, physical image rather than a complex abstract idea. In this respect there is a similarity here with the term “hooked” that is often used to describe addiction with both of terms conjuring powerful images that in themselves convey meaning in a functional rather than a factual discourse. Second, the language of drug users being parked on methadone was hugely influential in spite of the lack of empirical data. Unable to cite conflicting evidence, those who were inclined to criticise the language of drug users being parked on methadone were left objecting to the term on philosophical grounds (arguing, for example, that methadone rather like insulin should be able to be prescribed on a lifelong basis), or on the basis that their own personal experience was at odds with the characterisation (Ford 2010).

The lack of data on the actual length of time individuals were being prescribed the drug meant that the characterisation of drug users being parked on methadone gained much greater

momentum than it might otherwise have done had the contrary evidence been available. Third, the criticism that tens of thousands of drug users were being parked on methadone was made at a time where the balance between the main political parties in the UK was shifting. The Conservative party were seen as being increasingly likely to win the 2010 general election and were seen as likely to usher in a radically changed drug policy in which the emphasis on harm reduction, which had underpinned the expansion in the numbers of drug users prescribed methadone, would reduce and greater emphasis would be given to recovery (McKeganey 2011). The language of drug users being parked on methadone resonated with the notion of impending change in the world of drug treatment and in doing so provided a ready hook for political commentators and others to characterise the changed policy around methadone.

Discussion and Conclusions

The characterisation of drug users being parked on methadone, which was used in Scotland in 2005, rapidly created a master frame influencing political, media and professional discourse around methadone and attaining an almost unchallenged authority. Interestingly even those who might have objected to the term found themselves still using the language of drug users being parked on methadone to discuss the role of substitute prescribing in drug user recovery. Setting aside the issue of whether drug users were in fact being parked on methadone, and whether this is a good thing or a bad thing, what this shows above all else is the capacity of language to influence policy and provision within the drugs field.

There is a degree to which the current discourse to do with emphasising the importance of "recovery" is exerting a similar powerful influence on the drugs treatment field. It is now virtually impossible to talk about drug treatment without making explicit reference to the notion of recovery so powerful has the notion become as a master frame. As was the case with the notion of drug users being parked on methadone, the notion of recovery has taken hold even in the face of a lack of information as to the nature of recovery, the expertise involved in fostering recovery, the proportion of individuals who might be expected to recover or the length of time that it might take for them to recover. The lack of detailed understanding in each of these areas, rather like the lack of data on the actual length of time drug users were remaining on methadone, does not in any way impede the power of the language of recovery to shape drug treatment policy and provision.

The fact that drug policy and provision can be radically altered by the power of language says something important about drug policy within the UK, (and perhaps elsewhere) namely that it is vulnerable to being profoundly influenced by the political process even where it expresses an adherence to evidence-based policy. Whilst it is certainly desirable to base drug policy and drugs provision on the best available evidence, it is unrealistic to suppose that political, media, and professional commentary on drug treatment and drug policy will ever be entirely circumscribed by the available evidence. What this means in practice is that even within a data rich environment, where evidence is abundant, there may still be a degree to which drug policy will be disproportionately influenced by changes in language.

The answer to the problem which this essay has drawn attention to cannot lie in seeking to constrain political discourse around drug policy: to attempt to do that would be tantamount to calling time on political discourse itself. Rather, what is needed is the capacity for a strong counterweight to political discourse where that discourse departs from the available evidence in pursuing a particular line. The need then is for some kind of respected, independent body to be able to act as a brake on the excesses of political language. Within the UK in recent years the use of statistical data in ministerial announcements has been subjected to independent scrutiny following the inauguration in 2008 of the UK Statistics Authority set up with a budget in excess of £5m a year. The capacity of language to shape policy and provision is no less than that of the power of statistics to influence policy and provision and there is no less a need for an assessment of linguistic rigour in the case of political discourse than there was for the assessment of statistical rigour in political announcements and characterisations.

The danger here, in the absence of the capacity to provide independent authoritative assessment on the use of language is that it is the simplified messages that stand the greatest chance of influencing policy with the result that, in time, the policy process becomes increasingly dysfunctional, influenced more by the simplicity of the message than the accuracy of the language.

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Cannabis Classification and Drug Policy Governance

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Summary

This essay considers what the cannabis episode can tell us about UK drug policy governance. In the UK over recent years the efficacy of the 1971 Misuse of Drugs Act (MDA) has been one of the most widely discussed and debated areas of UK drug policy. Since inception, the MDA 1971 has remained relatively stable with very few drugs moving up or down the scale and until recently, and with very few exceptions, there has been little public debate on the nature of the system. This changed in the run up to the cannabis reclassification in 2004 from class B to class C in 2004 and the reverse of this decision in 2009. Contemporaneous to changes in the drug classification system have been broader debates in policy circles over the nature of evidence-based policymaking seen to be a key aspect of good governance.

Drug policy is made in a politically charged atmosphere often not seen to be conducive to the ideals of evidence-based policymaking. Where evidence-based policymaking is concerned, the characteristics of good governance suggest that good policy development should make use of evidence in a manner that creates a mechanism for agreeing what counts as evidence in any given policy area and how this should be reconciled. There should be an even-handed approach to evidence by decision-makers and key accountability mechanisms. The cannabis episode demonstrates how in UK drug policy there is still much to do if these aspirations are to be realised in practice.

Introduction

In the UK over recent years the issue of drug classification within the 1971 Misuse of Drugs Act (MDA) has been widely debated. Much of the focus has concentrated on the legal status of cannabis. The issue of cannabis classification has been described in a variety of ways. Lloyd (2008) suggests that the debate was 'full of sound and fury', but yielded very little. Turnbull (2009) writes of the cannabis 'debacle', whilst Stevens (2011) refers to the 'cannabis kerfuffle'. Part of the reason why it has been described in such a manner has been that changes to the classification system amount to tinkering at the edges of drug policy. The issue of cannabis classification gained prominence, however, because it was linked to an increasing preoccupation amongst academics, policymakers and the public over the way that evidence is used, misused or unused in policymaking. These discussions have been consolidated under the umbrella term evidence-based policymaking. Policymaking that draws on and uses a broad evidence-base has seen to be a key component of good governance. Yet this has to be tempered so as to not interfere with the principles of democratic decision-making, as suggested by the principles guiding the way scientific advice relates to government decision-making. Here the roles and

responsibilities state that:

- Government should respect and value the academic freedom, professional status and expertise of its independent scientific advisers.
- Scientific advisers should respect the democratic mandate of the Government to take decisions based on a wide range of factors and recognise that science is only part of the evidence that Government must consider in developing policy.
- Government and its scientific advisers should not act to undermine mutual trust.
- Chairs of Scientific Advisory Committees and Councils have a particular responsibility to maintain open lines of communication with their sponsor department and its Ministers.

(Department for Business Innovation and Skills, no date)

These guidelines were developed in part as a response to the fallout from changes in the legislation surrounding cannabis, which ultimately, resulted in the dismissal of Professor Nutt from his role as chair of the Government's Advisory Council on the Misuse of Drugs (Monaghan, 2011). This short essay considers what the cannabis episode can tell us about UK drug policy governance. In doing so, it takes the following format. The first section offers a brief overview of the 1971 MDA. This is followed by a look at more recent events relating to proposed changes to the drug classification system. Next discussion turns to the link between the disputes over drug classification and how these relate to some of the principles of good governance. The final section turns towards some potential solutions and seeks to learn lessons from the area of policymaking in crime and criminal justice to overcome some of these problems. Finally some concluding remarks are made.

The 1971 MDA Drug Classification System

The efficacy of the 1971 MDA has for a while been one of the most widely discussed and debated areas of UK drug policy.² In this brief overview, there are three main points to note about this key piece of legislation. These are: a) its origins in international debates over how best to regulate the global drug problem; b) its scope and coverage and; c) the creation of the ACMD. A fourth issue concerning the controversial classification of substances for legal purposes is reserved for later in the piece.

The international origins of the 1971 MDA lie in discussions that took place in Geneva in the run up to the 1961 United Nations Single Convention on Narcotic Drugs. The Single Convention proffered a robust approach to drug use. It aimed to standardise the control of narcotics across nations so that certain drugs could be used only for scientific, medical, and in some cases, industrial purposes. This was achieved by arranging drugs into schedules and applying appropriate controls based on their harm and toxicity. Any article in contravention of the convention was a punishable offence, with a custodial term for serious breaches (Fortson 2005). This provided the structure for domestic legislation meaning that drug possession (along with production and supply) almost invariably became a criminal offence within the signatory states,

² The history of its formulation has also become a point of interest. For a detailed account of its implementation readers are advised to consult Macgregor (2012).

but the severity of the punishments were contingent on the perceived harms of the substances and the classes or schedules to which they were assigned by each individual country's legislature. Ultimately, then, the system did leave signatory states some room for manoeuvre (Boister, 2001; Dorn and Jamieson, 2001).

Drug possession is only one feature of the legislation. In reality – and as is often the case with the English legal system – its passing served to amend other pieces of legislation on the statute book at the time including the Dangerous Drugs Acts of 1965 and 1967. As Fortson (2005:327) demonstrates, the MDA had at its base a preoccupation with the regulation of opium, but it also included restrictions on the importation and exportation of drugs specified by the statute and included the scope for authorities to punish the performance of acts in this country that resulted in the commission of an offence contrary to a 'corresponding law' abroad. A defining feature of the MDA, and one that has generated a lot of recent heat, is its instigation of a strict classification system for scheduling drugs. As of 1971, drugs are placed in one of three categories, A, B or C determined by the extent of relative harm their misuse is perceived to inflict on the individual and society. Indeed, as Levitt, et al. (2006:15) note Section 1.2 of the MDA states that drugs are divided between classes based on: (a) whether the drug is being misused; (b) whether it is likely to be misused and (c) whether the misuse in either case is having or could have harmful effects sufficient to constitute a social problem.

The MDA also utilises a set of schedules to indicate the severity of the controls to be applied with respect to legal use of the drugs. The most restricted drugs – placed in Schedule 1 - can only be supplied, administered or possessed for research or other special purposes under license from Home Office. Schedule 1 substances include ecstasy, coca leaf, LSD and raw opium. These are not seen to have any official medical value. The drugs in the remaining four schedules are available for normal medical uses mainly by prescription from a doctor and supplied via a pharmacy. These substances reside anywhere between Schedules 2-4, for example methadone, heroin and opium in its medicinal form are all located in Schedule 2. Rohypnol and Temazepam are in Schedule 3. Schedule 4 is divided into 2 parts. Substances listed in Part 1 require a prescription to make possession legal. Most minor tranquilisers are located here. Substances in Part 2 can be legally possessed without a prescription, but drugs that have a very low chance of being misused are available over the counter without the requirement of a prescription. Part 2 contains anabolic steroids. These include cough remedies and some mild painkillers. Schedule 5 consists mainly of drugs considered to pose minimal risk of abuse. Some of these include dilute, small-dose, non-injectable preparations including mild pain killers that are allowed to be sold over-the-counter at a pharmacy without a prescription, and all may be possessed by anyone with impunity. There are some restrictions in that once they are purchased they cannot legally be supplied to another person, but in reality this is almost rarely enforced, (DrugScope, no date).

A further key component of the legislation was that it established Britain's first statutory expert advisory body on illicit drugs, the ACMD, which has come to assume a central role in reviewing British drug policy. Since its inception, the it has played a decisive role in UK drug debates and controversies. Indeed, the ACMD have been pivotal in terms of developing an evidence-base for drug policy, thus embedding science, research and expertise into the decision-making process in this domain. It has, furthermore, been common practice that the government responds to the

recommendations made by the ACMD. A report by the House of Commons Science and Technology Committee (2006:13) highlights how the statute states that it is the purpose of the council:

...to keep under review the situation in the UK with respect to drugs which are being or appear to them likely to be misused and of which the misuse is having or appears to them capable of having harmful effects sufficient to constitute a social problem, and to give to any one or more of the Ministers, where either Council consider it expedient to do so or they are consulted by the Minister or Ministers in question, advice on measures (whether or not involving alteration of the law) which in the opinion of the Council ought to be taken for preventing the misuse of such drugs or dealing with social problems connected with their misuse, and in particular on measures which in the opinion of the Council, ought to be taken.

The Science and Technology Committee report also demonstrates how, amongst their many functions, the ACMD continuously review the UK drug situation, paying particular attention to the misuse (or the potential thereof) of drugs by the public to the extent that they might be considered a 'social problem'. This is mainly achieved through the production of detailed and rigorous evidence reviews. Their membership is made up from across the scientific, industrial and professional sectors, but most of their work concentrates on the pharmacological evidence-base for existing and emerging substances. For most of its existence it was common practice for the government to accept and act upon the recommendations of the council, although in a very high-profile way this relationship has been tumultuous over recent years, highlighted in recent public debates about the classification of ecstasy, magic mushrooms³ and, primarily, cannabis within the MDA.

Cannabis Classification: A Policy Cycle⁴

Since inception, the MDA 1971 has remained relatively stable with very few drugs moving up or down the scale and until recently, and with very few exceptions, there has been little public debate on the nature of the system. This changed in the run up to the cannabis classification in 2004. In the preceding years a groundswell of evidence from a number of high-profile reports into the operation of the MDA had concluded that the current system had created some anomalies and that cannabis, in particular, was classified and scheduled too high (Police Foundation, 2000; Home Affairs Committee, 2002; ACMD, 2002).

The Police Foundation Report (2000) had particular significance suggesting that cannabis reclassification alongside more discretionary use of police cautions for cannabis possession offences could significantly help improve relations between the police and certain communities.

³ In the 2005 Drugs Act, against the evidence and the opinion of various practitioners, magic mushrooms were placed into class A on the grounds that their active components - psilocin and psilocybin - were of equivalent harm as other class A substances. This has had consequences for use of psilocybins, in particular, in treatment for mental health conditions.

⁴ This section borrows heavily from Monaghan (2008; 2010a; 2011)

Indeed, at this time the Brixton experiment of cannabis policing was taking place. This effectively replaced the threat of arrest with informal disposal and a formal on-the-spot warning for those caught in possession. This would not form part of a national record. Its implementation was, however shrouded in some mystery and there is much speculation about the issue. Critics of the project accusing the officer in charge, Brian Paddick, of acting unilaterally and shielding his intentions from the Metropolitan Police hierarchy. Whatever its origins and subsequent demise, the project was evaluated, and judged to work by both the Metropolitan Police Authority (Metropolitan Police Authority 2002) and the local community (MORI 2002). Against this backdrop, the then Home Secretary David Blunkett, told the Home Affairs Committee in October 2001 that he was 'minded' to downgrade cannabis and would seek advice from the ACMD on the possibility of reclassification. The ACMD reported back in early 2002, that cannabis should be reclassified. In July 2003, it was announced that on Parliamentary approval cannabis would be reclassified to a class C drug, coming into force in January 2004⁵.

In a broader discussion over the evidence-base for the reclassification, Monaghan (2008; 2010a) demonstrates how the reform of the UK cannabis laws was contingent on two main factors: (a) that reclassification would help free up police time as the assumption would be against the police using the powers of arrest for most cannabis possession offences. This provision would enable the police to concentrate on the problems associated with so-called 'harder' drugs such as heroin and crack cocaine (May, et al, 2002)⁶; (b) in terms of its toxicity or harmfulness, cannabis was not comparable with other class A or B drugs. However, a significant development, following reclassification, was the (re)discovery by various charities and academics of the link between cannabis use and mental illness. A study in New Zealand suggested that smoking, particular potent strains of cannabis - 'skunk' - virtually doubled the risk of developing certain mental illnesses such as schizophrenia (Fergusson, et al. 2005). This was particularly where there was a family history of the illness although the risk was increased where this was absent also. Research from the Netherlands (Henquet, et al. 2004) and the UK (Arseneault, et al. 2004) around the same time reported similar findings.

In March 2005, in response to significant media attention directed to this research and other similar findings, the then Home Secretary Charles Clarke announced that the reclassification of cannabis implemented the previous year would be reviewed. In January 2006, the ACMD (2005) published a second review, stating that class C was appropriate, a decision accepted by Clarke. Despite the fact that according to the British Crime Survey (e.g. Hoare and Flatley, 2008), drug use amongst young people – in particular cannabis – had been on the decline for a number of years, drug classification returned to the media headlines in 2008. The new Prime Minister, Gordon Brown announced that, in light of continuing interest in the link between cannabis use and mental health, the classification of cannabis would once again be referred back to the ACMD.

⁵ The 1984 Police and Criminal Evidence Act was also altered so that cannabis assumed a unique status as a class C drug as the police maintained the power of arrest for those caught in possession (Warburton, et al, 2005, p. 116). Additionally, the 2003 Criminal Justice Act introduced more draconian punishments for supply of class C substances from five years to fourteen years, on a par with those of class B

⁶ This was unless there were 'aggravating' factors such as smoking cannabis in the vicinity of legal minors, for instance, near a school.

The ACMD (2008) reported back that although there was a consistent, but 'weak' association between cannabis use and the development of psychotic illness, they remained resolute that cannabis was correctly classified as a class C substance. However, unlike in 2005, in May 2008, the government acted against this advice and placed cannabis back into to class B.

Some informed observers argue this was done to demonstrate difference with the previous policies and to curry favour with certain parts of the press (see Lezard, 2012). Whatever the underlying reasons, this was the origin of the dispute between Professor Nutt and the New Labour government, which was to later escalate when in March 2009 the advisory council considered the legal status of ecstasy, reporting shortly after and recommending a downgrading of its classification (ACMD, 2009). The government's decision seemingly to ignore outright this advice led to a heated exchange between the chair of the council Professor David Nutt and the then Home Secretary, Jacqui Smith. Later in 2009, relations between members of the ACMD and the government further deteriorated. Alan Johnson, who by this time had replaced Smith as Home Secretary, accused Nutt of overstepping his remit and of 'campaigning against' government policy. In a lecture delivered in July 2009 Nutt claimed that based on the existing science both cannabis and ecstasy are less harmful than legal drugs such as alcohol and should, therefore, be downgraded, thus reducing the criminal penalties for offences relating to mainly the possession and supply of these substances.

Part of the evidence-base cited for this claim was research co-authored by Nutt (Nutt, et al, 2007;⁷), outlining an alternative ranking system based on a reworked spectrum of drug harms where alcohol and tobacco were ranked alongside the main illicit substances of abuse. This research was based on a 'delphic' approach with a range of experts (psychiatrists, pharmacologists and experts in addiction) who were notified which drugs would be discussed beforehand to allow them to 'update their knowledge' (Nutt et al, 2007:1050). The research focused on nine classifications of harm, three each for physical harms, social harms and harms relating to drug dependence. Of the 20 substances listed, ecstasy was ranked eighteenth in terms of harm, with cannabis eleventh and alcohol fifth. It is worth pointing out, that the methodology employed in the article was the subject of much critique – not least that the results were contingent on the experts asked. Such criticisms were addressed to some extent in a later paper, (Nutt et al, 2010) where a broader range of experts from more diverse fields were involved⁸. The results were also different with alcohol ranking as the most harmful substance based on the new criteria of harms, followed by heroin and crack cocaine. However, several other such assessments done employing different criteria all arrive at essentially the same conclusion, which is that

⁷ This research was carried out prior to Nutt becoming Chair of the ACMD. He was a committee member and oversaw the work of the ACMD technical committee. The findings of the research were discussed in Oral evidence sessions of the Science and Technology Committee and should, therefore, have been known to the government

⁸ The 2010 paper was conducted with 16 experts from a range of backgrounds including addictions, issues relating to young people, chemistry, psychology, mental health issues and criminology and criminal justice. Some were more heavily represented than others. 16 different types of harms were also discussed split into 2 categories 9 'harms to users' and 7 'harms to others'. Multi-Criteria Decision Analysis was used to provide a weighting to those harms deemed more serious than others. For a fuller account of the types of harms discussed and the make-up of the expert panel see Nutt, 2012 chapter 3).

alcohol is more harmful than many illicit drugs and that the current ordering within the classification system does not correspond to the level of harms as was intended on implementation.

Some of the travails of scientists and experts working with the government on issues of drug policy and vice versa have been charted. In their analysis of recent welfare policy changes in the UK, Deacon and Patrick (2011) suggest that the '*Sturm-und-Drang*' of electioneering is not conducive to measured debate on policy. Much the same can be said of drug policy formulation, with the additional proviso that this takes place in the context of almost permanent electioneering as the issue has in the words of Loader and Sparks (2011) 'heated up' over the last 30 years. The following section considers some of the implications of this for drug policy formulation.

The Politicisation of Drug policy and the Implications for Good Governance

Public debates over the nature of drug policy sit alongside those of crime and criminal justice and are underpinned by a non-trivial degree of politicisation. According to Loader and Sparks (2011:60-1):

The allegation appears to carry at least the following implications. It suggests that there has been a change, a watershed, a before and an after, a time when these issues were less overtly contentious and less divisive than they are now... It tends to follow that crime and punishment, security and control, can sometimes become games played for higher stakes. The authority, or legitimacy, or credibility of governments and institutions may come to stand or fall...on questions of competence, or promise keeping, or demonstrations of concern for citizens' security, or the ability to deliver adequate penalties to satisfy an assumed demand. Moreover the notion of politicization includes the claim that in many, if by no means all, contemporary democracies crime has become a prominent token of electoral competition between parties and that for this reason political responses to it are heavily swayed by calculation and expediency. It is, on this view, generally more convenient under such conditions for political actors to avoid the risk of contamination by evincing sympathy for or exercising leniency towards despised and censured minorities (Loader and Sparks, 2011: 60-1)

Heavily politicised issues such as drugs and crime carry all the hallmarks of what Rittel and Webber (1974) refer to as 'wicked issues'. These are areas of policy that defy neat solutions as there is little agreement on the nature of the problem in the first instance. More often than not this is a result of complexity. Drug classification issues are a prime example. We have witnessed in debates over the evidence-base for classification decisions, how it is unclear whether the matter in hand is one of public health, law and order or morality, or indeed, all three. As drugs research and policy span disciplinary boundaries, policymaking in this area shares similar traits with other areas of controversy such as climate change (Wynne, 1996), BSE (van Zwanenberg and Millstone, 2005) and tobacco control including the issue of second-hand smoke (Pawson, et al, 2011). These debates take us right into the heart of the difficult issue of the role of science, expertise and politics in the policy process and how the legitimacy of each is threatened as

solutions to problems are sought after. Weingart (1999) considers such debates in terms of the scientification of democracy and/or the democratisation of science. For our purposes, in policy areas where science and politics mesh, there are clear implications for good governance.

The cannabis episode is particularly revealing in this context for a number of interrelated reasons including a) illuminating the political leadership's attitude to evidence; b) illustrating the influence of different stakeholders in the policymaking process including the role of the statutory advisory committee and the accountability mechanisms and; c) highlighting how different types of evidence are reconciled in the decision-making process. These issues overlap with the characteristics of good governance, uncovered in the earlier stages of the UKDPC work, particularly those that relate to the use of evidence.

It would be easy to dismiss the political leadership of the New Labour era as having, what Weiss (1986) refers to as a 'political' and 'tactical' attitude towards the use of evidence. This is where evidence is carefully selected to support a pre-aligned policy position and where evidence can become subservient to the political realities of the day. We have seen how the political winds changed under Gordon Brown's premiership and that Home Secretaries Jacqui Smith and Alan Johnson were keen to act on cannabis, by assigning causation rather than correlation to the long-standing but no less controversial issue of cannabis use and mental illness. This was in spite of the ACMD (2008) having already offered advice on this topic, urging the maintenance of the status quo. Blackman (2010) suggests that the government was attempting to take the initiative here; to reassert its commitment to prohibitionist policies, via the construction of a 'popular preventive'. Here it is argued that the cannabis reclassification to class B was less about evidence and more about the new leadership establishing its authority.

Yet such claims are somewhat misleading. In a previous section, the title 'policy cycle' was deliberately chosen. According to Sabatier and Jenkins-Smith (1993), it takes roughly a decade or more for a policy cycle to undergo a full revolution. If we apply this timeframe to the cannabis classification changes focusing on the period from 2000 to 2010, then we see that evidence was both used and ignored in the decision-making process. In the run-up to 2004, David Blunkett was heavily influenced by the evidence building up which pointed at the misclassification of cannabis as a class B substance. He was particularly swayed by the evidence of potential police efficiency savings and the toxicological evidence suggesting that cannabis was not as dangerous as other class B substances. Although citing a different evidence-base as the grounds for his review of the initial reclassification, Charles Clarke, likewise, allowed himself to be guided by the advice of the experts in the area, his focus was primarily on the potency of contemporary cannabis strains in relation to those of bygone eras. What the episode does indicate is that if politicians and decision-makers wish to be guided by evidence, particularly in complex policy areas, then there is some semblance that they will have to act as an adjudicator between different evidence bases. This will inevitably lead to accusations of political expediency when the evidence favoured does not chime with that favoured by particular groups.

Policy decisions emerge, in part, out of the way a range of stakeholders coalesce around a particular position. Various groups arrive at their own interpretation of the evidence balance in order to propel decisions one way or another. Previous research has suggested that the evidence

produced via expertise that fits in with the preconceived ideas of policymakers stands the best chance of being utilised in the decision-making process (e.g. Stevens, 2007). To elaborate, this requires consistency between experts and decision-makers in relation to a set of pre-existing social and cultural values. Ministers, governments and parliamentarians interpret or alight on evidence to align with pre-existing belief systems and it is also the case that scientists and experts likewise arrive and interpret evidence according to their underlying value systems. The cannabis episode, however, demonstrated that whilst evidence selection often follows this trajectory it is not a foregone conclusion that when the interests and beliefs of experts and policymakers are aligned, that this will translate into policy. As Monaghan (2011) has noted, where drug classification is concerned, the ACMD and government shared a similar perspective that the current system was broadly fit for purpose, but could be improved or 'rationalised' by minor tweaks to the legislation, which generally involved switching the classification of certain substances. It was only from 2009 onwards that this system started to visibly malfunction⁹ as on repeated occasions the government chose to ignore the advice of its experts.

For the purposes of illustration, a quick review of the debate over ecstasy classification also demonstrates how well placed evidence producers and the evidence they supply can be sidelined in the decision-making process. In the ecstasy scenario, the ACMD's (2009) scientific evidence stated that ecstasy is harmful, but that its relative harms were not akin to drugs such as heroin and crack cocaine. Indeed, they are significantly different if one considers the evidence base on toxicology, mortality rates, morbidity rates, and associated social harms (Nutt, et al., 2007; 2010). In the ecstasy case, a significant scientific stakeholder lobby advocated policy change. Although their arguments were presented in a concerted and largely united front, the scientific evidence was side-stepped by a government playing the card of precaution (Monaghan, et al, 2012). And on this basis, an opposing coalition advocating maintenance of the status quo came to the fore. Indeed, noteworthy support came from the Police and Superintendents Association who were quick to point out that classification should not be simply an academic or scientific exercise because 'it is dealing with people's lives'; a point sympathetically received by the Brown Government.

For Blackman (2010), the fallout over the cannabis issue and the dismissal of Professor Nutt ultimately signifies a 'legitimation crisis' in the government's drug policy (Habermas, 1975). Although this concept is multifaceted it can be said to describe a state of affairs where 'institutions are out of step with social and cultural values and government faces a loss of public confidence' (Blackman, 2010:348). For Blackman, this legitimation crisis stemmed from the government's commitment to the war on drugs, despite the fact that some success appeared to be forthcoming with the more pragmatic policies also being employed. In effect, they were hamstrung and resorted to 'the personalisation of substantive issues' (ibid.) where, as we have seen, the work of Nutt and colleagues was called into question to give the government a means of seeming to be addressing the drugs problem

Reconciling different types of evidence is a common theme in debates over the role of expertise

⁹ In reality, the dissonance probably started much earlier from around 2003/4 when advice on Ecstasy was rejected as were many of the findings from influential reports such as the Police Foundation Inquiry (2000).

in policymaking. Elsewhere, the notion of professional equipoise is discussed in the literature on clinical medicine and health to refer to a situation whereby clinical practice is often divided over which treatment is the most effective to any given condition (e.g. Elwyn et al, 2000). Likewise, critics have pointed out that one of the true stumbling blocks to the realisation of evidence-based policy is the fact that the 'evidence' is rarely definitive. Indeed, one of the paradoxes of research in any given area is that the more heavily something is researched, the less there is convergence on points of agreement (e.g. Head, 2010).

The cannabis debates were no different. The evidence base for the link between cannabis use and mental health is characterised by inconclusive data and throughout the classification debates different perceptions and interpretations of the evidence competed for influence in the decision-making process. A central aspect of evidence cited by David Blunkett for his reclassification decision was that in respect of toxicity, cannabis was less harmful than other class B drugs such as amphetamines. This computation related to the purity of the substance and the levels of Tetrahydrocannabinol (THC) - the main psychoactive ingredient - found in cannabis. This rationale was the subject of much debate. For supporters of the policy change, evidence was referenced (e.g. ECMDDA, 2004) pointing to the fact that the purity and potency of cannabis obtained on the street had not altered significantly over the previous two decades. For the critics, this was something of a fallacy and claims were made, mainly in the media, suggesting that levels of THC in contemporary genetically modified and hydroponic cannabis were anywhere between four and 20 times higher than the strains previously used. A third significant voice in the debate claimed that this 'evidence' was actually 'non-evidence', on the grounds that data on the effects of drugs on humans is woefully inadequate with gaps in the evidence-base on ingestion techniques as well as on new routes of drug supply.

Whatever the true reading, this example demonstrates that a mechanism for agreeing what counts as evidence in such debates was absent here. Although it would be difficult to produce, it could be a welcome development in the future. Moreover, when it comes to decisions over drug classification, evidence tends to be canvassed from various channels including the Police and law enforcement agencies, the scientific and expert communities, healthcare professionals and those with expertise on youth issues. Indeed, all the above are represented on the ACMD. What has been unclear, however, are the grounds on which some evidence is given primacy whilst other evidence is relegated to the periphery or ignored, leading to questions of transparency in the decision-making process. Such examples of policymaking have become commonplace in what elsewhere have been termed adversarial policy domains (Monaghan, 2010b). The key issue, therefore, is how to circumnavigate this.

Potential Solutions for Governance of Drug Policy

Debates over the nature of policymaking in areas of crime and punishment resonate with those in drug policy. For Loader and Sparks (2011), in the former, the relationship between science and politics has heated up over the past few decades and is inherently combustible. Under such conditions, numerous attempts have been made to try and add 'coolant' to the debate. These include: a) creating a heightened role for the use of scientific expertise in policy under the aegis of evidence-based policymaking and searching for 'what works in a given area and extolling the

virtues of 'crime science'; b) creating a heightened awareness for academic work in policy circles by academics becoming policy advisors; c) creating a heightened value for academic input into the policy process via academics taking positions within government as an observer-turned-player and '(re)insulating penal policy'.

There is not the space for a detailed discussion of each here. The final method is, however, worthy of elaboration. Loader and Sparks (2011:110-113), by drawing on the work of Pettit (2001), demonstrate how much contemporary penal policymaking, because it is subject to democratic pressures, has the outcome of being 'excessive and illiberal'. Political deliberations over the length of time a terror suspect could be remanded in custody without trial are indicative. For Pettit, this is consistent with an 'outrage dynamic' whereby political decision-makers need to position themselves as tough on issues. Lacey (2008) maintains that this is an undesirable state of affairs and points to the lack of space within governance frameworks to discuss these 'wicked issues' in an even-handed way. Pettit's solution is to develop 'arms-length' institutions or bodies that can 'entrench professional' expertise in the decision-making process (Loader and Sparks, 2011:112). Loader and Sparks (ibid.) go onto state how Lacey, Pettit and others 'each draw an analogy between penal policy and the delegation of monetary policy to independent central banks. They argue that, like the setting of interest rates, sentencing and penal policy are better taken out of the hands of elected politicians, as the temptation to take (wrong) decisions for short-term political advantage is simply too strong'; a charge that was brought against Jacqui Smith and Alan Johnson in their dispute with Professor Nutt.

The insulation solution itself, though, carries significant potential for critique. By devolving the decision to experts or even encouraging a space for the rational application of expertise to a policy problem could be seen as an abrogation of the principles of democracy and a step along the way to technocratic decision-making (Clarence, 2002). Weingert, (1999:154) suggests that under the conditions of technocracy, 'the politician becomes fully dependent on the expert. Politics is replaced by a scientifically rationalised administration' precisely because they have the requisite knowledge at their disposal and are thus in a more privileged position than their political counterparts. For Van Zwanenberg and Millstone (2005:14) the model for technocratic governance can be found in the enthusiastic reception given to enlightenment ideals by various, nineteenth century French scholars including Saint-Simon and Comte, who have become associated with positivism. These thinkers placed significant emphasis on the production and use of instrumental, or technically useful knowledge, which was flourishing as 'science' as a discipline emerged. In this tradition, the pre-cursor to technocratic administrations, science should not only play an active role in decision making, but should be its main driver.

Although the promotion of technocratic decision-making was *a la mode* in the nineteenth century, in contemporary times it is rendered problematic and the widespread critique of positivism serves as a reminder as to why technocratic decision-making in its purest sense has key limitations. Popper (1959) has demonstrated how technocracy underscores a very utopian view of what science can and cannot do and operates with an inductive account of its nature. By contrast for Popper, the scientific method is inevitably fallible as science can never arrive at the definitive solution to any given problem. Scientific explanations or theories become stronger through rigorous testing, but they are always falsifiable. Recall here the enduring paradox that more

research often leads to less clarity in pointers to action and that the principles of scientific advice show, scientific findings have to be balanced against political feasibility.

Despite this, encouraging the insulation of rational debate within policy is strategy that attempts to bridge the gap between the research and policy communities in the name of good governance. The dismissal of Professor Nutt and debates over cannabis governance more generally demonstrate how particularly in heavily politicised areas, this is furiously difficult. It is suggested here that a way forward may lie in giving due recognition to what Sanderson (2009;) has termed 'intelligent government'. Drawing on the ideas of Majone (1989) and Toulmin (2001) and writing from the perspective of Dewean pragmatism, Sanderson suggests that this requires a movement away from evidence-based policymaking underpinned by instrumental rational action towards evidence-based policy as practical rational action. Underpinning this is the acceptance that policymaking in contemporary society must deal with the complexity and uncertainty. Sanderson (2009:713) notes:

We must recognise that policy making is not just a technical exercise of harnessing evidence and expertise, but a broader exercise in 'practical rationality', a communicative or deliberative process within which ethical and moral concerns are addressed and all legitimate voices can be heard in coming to 'reasonable decisions'

The Government's response to the Science and Technology Committee (2006) report into the classification system is remarkable similar. Here, they stated that:

Decisions are based on 2 broad criteria – (1) scientific knowledge (medical, social scientific, economic, risk assessment) and (2) political and public knowledge (social values, political vision, historical precedent, cultural preference). Decisions must take account of scientific knowledge of medical harms and social and economic evidence, as well as the insight provided by public consultation, and the knowledge and understanding provided by public bodies and Government departments (UKDPC, undated).

The headline event from the cannabis episode – the dismissal of Professor Nutt – suggests, however, that on balance in the area of drug policy and with particular reference to the classification of substances, recent government decision-making is driven more by reactions to public opinion than being proactively inspired by scientific and other expertise. That said, when a longer view is taken covering whole policy cycles, there may be some grounds for optimism.

Conclusion

This commentary on cannabis and governance points to one of the most enduring dilemmas in political science and elsewhere; that is, how to bridge the gap between what Latour (2004) has referred to as the 'Two Houses of Science and Politics' or what Caplan (1979) refers to as the 'two communities' of social scientists and policymakers. As we have witnessed, such issues have taken on added resonance recently with the dismissal of Professor Nutt from his role of chair of the ACMD. As mentioned at the outset this is one of the most enduring issues in political science and policymaking. Looking back at the record of the New Labour government (1997-2010) and

bearing in mind the difficulties of treating this as a homogenous entity, it would be misleading to dismiss outright their efforts in developing drug classification policy with recourse to the evidence. This, however, is not to endorse their policymaking as a gold standard from which the current and future government and government's elsewhere should learn. New Labour displayed an acute awareness of the benefits of evidence-imbued policy as well as a clear desire to ignore these principles for the sake of gaining political capital when it was deemed necessary. History will probably judge that the balance was skewed in favour of the latter

Where evidence-based policymaking is concerned, the characteristics of good governance suggest that good policy development should make use of evidence in a manner that creates a mechanism for agreeing what counts as evidence in any given policy area and how this should be reconciled. There should be an even-handed approach to evidence by decision-makers and key accountability mechanisms. The cannabis episode is particularly revealing when analysed through this lens. It demonstrates how there is still much to do if these aspirations are to be realised in practice. UK drug policy making is fraught with political challenges. It represents a state of affairs when politicians make policy in an almost permanent state of electioneering, but evidence can and does play a role and so, whilst this is probably not a case study in effective governance nor is it one of total disregard for the principles of good governance outlined by UKDPC. The true picture lies somewhere in the middle of this continuum. Quite where will depend on one's wider appreciation of the issue and whether one desires policies to be developed with more and better recourse to the evidence-base.

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Consultation processes and good governance: From 'unproductive process' to 'real engagement'?

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The UK Drug Policy Commission's governance project is raising important questions about the appropriate governance mechanisms for drug policy. As in other policy areas, our focus as a field is often on substantive policy issues (for example, investment in drug treatment or review of drug laws) and less on the processes through which decisions about them are made. Clearly, however, the quality of the policy that we get depends on the robustness and quality of the processes through which it is developed. It is perhaps above all our experience of recent consultation and engagement processes (such as those around the Drug Strategy 2010, the NTA's Building Recovery in Communities consultation, development of the drug and alcohol 'payment by results' pilots and the Sentencing Council's consultation on drug offences) that has prompted recent debate and discussion about governance issues in the drug sector. Are our voices really being listened to? If so, whose voices and on what basis? What sort of evidence and testimony should we be providing to government and how is it assessed and evaluated? How impactful have recent consultations been, and how much resource has been devoted to them?

The answers to these questions are not straightforward. Indeed, an interesting feature of the literature on consultation processes is that it raises issues about the relationship between some of the 'key characteristics of good governance' identified by the UK Drug Policy Commission through its Delphi research and St George's House consultation event. Specifically, UKDPC's research highlights relevant issues, respectively, around 'the development and use of the evidence base', 'accountability and scrutiny' and 'stakeholder engagement'. Consultation processes have a key role to play in all these areas, but the discussion about them also highlights some important questions about how these governance functions relate to one another. For example, there is a distinction between the role consultation exercises play in *informing* policy decisions by contributing to the *evidence base* ('use of the evidence base') and their role in providing *representation* for different stakeholder *views, perspectives and interests* ('stakeholder engagement').

This, in turn, highlights distinctions between different forms of evidence – for example, statistics and research findings, evidence from the direct experience of implementing policy on the ground and evidence from service user experience. For example, is there a distinction between positive 'narrative' evidence (which is prominent within the recovery movement and literature) and merely 'anecdotal' evidence, and how is that made? And how do consultation processes weigh, say, the experiences of a particular local drug service with evidence drawn from an international research literature? All these forms of evidence (and others) may be sought through consultation exercises, but how are they best balanced and evaluated? The current 'mood music' suggests that

the Government is keen to reach beyond the 'usual suspects' in its consultation work and to engage directly with those affected by policy and services in communities – this raises questions of how we design processes where abstract evidence is influential, but not imperious, and the voices of those who are affected by policy but not necessarily expert are engaged with appropriate care and attention.

I hope the discussion of consultation processes in this essay will also help to raise some wider questions about governance that are relevant to the UKDPC work, with three general points standing out in particular. First, much of the discussion of effective consultation process is not specific to drug policy, but applicable across a range of policy areas. This raises some questions about what the particular issues are around drug policy governance (for example, in view of its emotiveness and political divisiveness – which are not unique to drug policy of course). Secondly, effective consultation can be a significant drain on scarce time and resources (both for consulters and consultees) during a period when we are experiencing public spending cuts and a corresponding squeeze on resources, and adjusting to profound policy and structural changes. This raises issues about the cost-benefit of 'good governance', particularly as there are opportunity costs in diverting resources away from other activities (such as service provision). Third, we are experiencing a transformation in the way drug and alcohol services are planned, commissioned and delivered, and particularly a transfer of decision-making power and accountability from national to local government. Potentially, this will mean a corresponding shift in the locus of consultation and engagement activity to local level, with profound implication for governance issues.

The central argument of this essay can be summarised as follows: consultation is essential for effective governance, it is a process and not an event, it can take a variety of forms, with different approaches often serving different purposes, and there is an acute lack of evidence about or evaluation of different types of consultation process. Specifically, we know very little about how responses to recent drug sector consultations were analysed and evaluated, what impact they had on policy processes or what their costs were in terms of the resources of both the sector and government. But what we do know is sufficient to raise the question of whether the game is always worth the candle.

The Government also has concerns about consultation process. It introduced new guidance on consultations from September 2012 to replace the previous administration's Code of Practice 2008. Announcing this change, the Cabinet Office Minister Oliver Letwin explained that 'the aim is to replace potentially unproductive process with real engagement with those affected' (Third Sector, 18 July 2012). This provides an opportunity for dialogue on effective and constructive consultation and engagement processes. At the same time, there are risks of disinvestment in and disengagement from consultative processes at a time of resource constraints, and with evidence of doubts about the value of some processes on both sides. There is a risk of a vicious circle developing in which disengagement reduces the value of consultation processes, compounding disengagement. We would then be in danger of a relationship developing between government and stakeholders that is perhaps best captured by the old Soviet joke aimed by workers at Khrushchev's nomenklatura: 'they pretend to pay us and we pretend to work'.

This essay begins with a discussion of the 'good practice principles' codified by New Labour and the approach that is being developed by the coalition government. It then examines the variety of consultation mechanisms and their potential role in consultation processes with reference to the research literature. It stresses the need for clarity about the *variety* of consultative mechanisms available, the *range* of purposes that they can serve for both decision-makers and stakeholders, and the potential for *integrating* different approaches as part of a broader vision for public engagement in policy development, with particularly important applications to drug and alcohol policy. It then considers the conduct of some recent consultations in the drugs field and argues in support of new and innovative approaches (for example, as a component of the Government's 'localism' agenda), with the conclusion highlighting some key issues around consultation and engagement as a governance issue for drug policy going forward at a time of significant policy and structural change for our sector.

Background and Context

The 2008 Code of Practice published by the previous New Labour administration set out seven 'good practice' criteria for formal consultations conducted by HM Government; to paraphrase:

- formal consultation should take place at a stage when there is scope to influence the policy outcome;
- consultations should normally last for at least 12 weeks;
- there should be clarity on process, proposals, scope for influence and the costs and benefits of the proposals;
- consultation processes should be accessible and targeted at those they are intended to reach;
- the burden of consultation should be kept to a minimum;
- responses should be carefully analysed and feedback provided; and
- officials should seek guidance on how to run an effective consultation and share what they learn from their experience (HM Government 2008).

It recognised that 'formal, written, public consultation' was not always the best or most appropriate way of seeking input from 'interested parties' (for example, where views were sought at an early stage in policy formation or where the issue under consideration was narrow or specialised). In such cases, a formal exercise governed by the Code would not be appropriate (*ibid*, p. 5). Indeed, the Code expressly stated that it was expected and accepted that Government departments would deviate from its principles on occasion (*ibid*, p. 6).

Three (apparent) changes from the 2008 Code are discernible in the 2012 document from the Cabinet Office setting out the Coalition Government's new consultation principles, which are presumably intended to supersede the Code. First, it is a very different *type* of document: much shorter, more discursive and less codified (it is only three pages long and does not attempt – for example – to set out good practice principles or provide a taxonomy of different kinds of consultation mechanism). Second, it advocates a more flexible approach depending on the nature of the proposals under consideration, with less emphasis on formal, written consultations, and more on a range of other approaches, including e-mail, web-based forums, working groups,

public meetings, focus groups and surveys. Thirdly, and perhaps most controversially, it reflects the Cabinet Office's view that the principle that formal consultations should be held over a 12-week period has been unnecessarily restrictive, and permits variation in the duration of consultations of between two and 12 weeks, depending on the nature of the proposals under consideration (Cabinet Office 2012, p. 2).¹⁰

This document also states that any new approach to consultation practice will respect 'The Compact' between Government and Community Sector Organisations (CSOs), which was revised and re-launched by the Coalition Government in 2010 (*ibid*, p. 1). The Compact commits the Government to involving CSOs in policy and service design from the 'earliest possible stage', and to facilitating the engagement of those likely to have a view or perspective (HM Government 2010, p. 9). It states that Government will 'where it is appropriate, and enables meaningful engagement, conduct 12-week formal written consultations, with clear explanations and rationale for shorter time-frames or a more informal approach' (*ibid*). It says that Government will 'consider providing feedback (for example through an overall government response) to explain how respondents have influenced the design and development of policies, programmes and public services, including where respondents' views have not been acted upon' (*ibid*).

The Compact sets out corresponding responsibilities for CSOs, including an expectation that they will 'promote and respond to government consultations where appropriate'; seek views of 'service users, clients, beneficiaries, members, volunteers, and trustees when making representation to government' and focus on evidence-based solutions 'with clear proposals for positive outcomes' (*ibid*). If CSOs are to ensure their submissions are based both on evidence and the views of service users, beneficiaries and/or members, then they require time and resource to enable them to participate in a meaningful way.

From this perspective, a 12-week default for formal consultation processes does not appear unreasonable. Indeed, in some circumstances – for example, where the proposals raise particularly fundamental and complex issues – a period *longer* than 12 weeks may be required to inform and engage an appropriate range of stakeholders effectively. From a participants perspective, a key concern is that setting of time frames should take account of the *overall* burden of consultation and other demands on a particular sector or agency in a particular time period (including 'consultation overload'). The current interest in the potential range of consultation mechanisms is welcome, but it should not exclude consideration of circumstances in which there could be a case for more intensive and/or longer duration mechanisms.

The production of new Cabinet Office principles appears to reflect a general sense of

¹⁰ To be precise the 2012 Consultation Principles state: 'Timeframes for consultation should be proportionate and realistic to allow stakeholders sufficient time to provide a considered response. The amount of time required will depend on the nature and impact of the proposal (for example, the diversity of interested parties or the complexity of the issue, or even external events), and might typically vary between two and 12 weeks. In some cases there will be no requirement for consultation at all and that may depend on the issue and whether interested groups have already been engaged in the policy making process. For a new and contentious policy, such as a new policy on nuclear energy, the full 12 weeks may still be appropriate. The capacity of the groups being consulted to respond should be taken into consideration.'

dissatisfaction and frustration within Government with existing consultation practice, and particularly a view that 'following bureaucratic process' is not necessarily achieving the kind of 'real engagement' that policymakers would value, and is making disproportionate demands on time, energy and resources. There is also a sense that theory is catching up with practice – recent Government consultations have taken a variety of forms, and many have not been held over a 12 week period.

This would explain the shift of emphasis away from 'formal' models governed by the sorts of principles set out in the 2008 Code, in favour of other approaches, governed by an overarching 'principle of proportionality' fitting 'the type and scale of consultation' to 'the potential impacts of the proposal or decision being taken'. What is perhaps most striking in trying to determine the drivers for the Government's approach, however, is how little information is available about its experience of consultation processes (including how it manages them and the resources this requires) and the absence of any real public discussion in which Government has expressed a clear view on the value, representativeness or impact of particular consultation exercises, including on drug policy.

In summary, there is a cross-party commitment that consultation mechanisms should continue to play a role in governance processes, and that a range of approaches should be considered. The role of the 12-week formal consultation process has recently come under scrutiny, although the Government seems to be committed to this continuing as a 'default position' by its endorsement of the Compact. While the Government favours a more flexible approach, this is supported as yet by little analysis or evaluation of the respective merits of different mechanisms, and there is no guidance (for example, a set of criteria) to help public bodies to determine the circumstances in which a formal consultation over 12 weeks (or more) is or is not appropriate, or to guide them in determining the most appropriate and effective consultation mechanisms and processes for specific issues and purposes.

Issues and Themes for a Positive Approach to Consultation Practice

The development by the Cabinet Office of new principles that highlight the potential role of alternatives to formal consultations provides an opportunity for dialogue between government and stakeholders to develop a vision of consultation in drug policy governance going forward, including options for innovative practice. This would be timely in the light of two further developments: (1) issues of austerity, and the pressures this places on the resources of both public bodies and services and their representatives, and (2) the development of localism and the challenge of developing effective consultative mechanisms at local level. Both of these trends are discussed in the UKDPC report 'Charting New Waters', and have significant implication for issues of good governance.

This section identifies some key issues that would need to be considered in developing such a model.

What are we talking about when we talk about consultation?

Consultation is best viewed as an on-going process conducted through a range of consultation and engagement mechanisms. Different approaches to consultation have different objectives, strengths and limitations. We currently lack detailed maps of different consultation mechanisms, or guidance to inform decisions about the most effective approaches to achieve specific engagement objectives and to ensure appropriate forms of participation.

The Direct Government website describes the practice of consultation as 'involving the public in the work of government', commenting that this has become an integral part of the policymaking process and that 'every year hundreds of consultations are launched at all levels by government'.¹¹ The literature on public participation and stakeholder engagement covers a wide range of activities from opinion polling and focus groups to citizens' juries and formal public consultations. The Cabinet Office's new consultation principles (Cabinet Office 2012) identify a range of consultation processes other than 'written consultation', including e-mail or web-based forums, public meetings, working groups, focus groups and surveys.

Mark Baetz and Brian Tanguay note that 'there are manifold forms and gradations of consultation' (1998, p. 396) and Dee Cook describes it as 'a crucial, yet deeply problematic process' (2002, p. 516). Public and stakeholder engagement is conducted through a wide variety of mechanisms that differ in the information that they provide, the purposes they serve, their relevance for policy development and decision-making and their strengths and limitations. It would be extremely useful, therefore, to map out the various different forms of engagement activity (including their respective strengths and limits) to inform current debate about consultation practice. This could build on the 'consultation matrix' devised by Catt and Murphy (2003, p. 417). It is, for example, important to distinguish between approaches that seek to ascertain the *views* or *opinions* of the public or some section of it (for example, opinion polling) and those that draw on the *experiences* and *expertise* of people who are directly involved with or affected by an issue (including service providers and service users). Equally important are related questions about how different kinds and forms of consultation response are evaluated and synthesised by the body that is conducting a consultation – for example, both personal experiences and research findings may be relevant, but they are also distinct, and should not be assessed or weighed with reference to the same sets of criteria.

The Cabinet Office principles emphasise that consultation is a 'process not an event', and that there is a need to 'engage in different ways at different stages' (Cabinet Office, 2012). Similarly, Dee Cook observes that 'consultation, participation and empowerment are processes which are problematic and challenging for researchers, practitioners and policymakers alike', and that 'developing appropriate tools and recognising that consultation is a *process* not an event, are essential starting points' (p. 530). A piece of work mapping out different consultation and engagement mechanisms could inform guidance for government departments and other public bodies on the constituents of effective consultation *processes*, as well as the approaches that will

¹¹ See 'The government's consultation process explained' at http://www.direct.gov.uk/en/Governmentcitizensandrights/UKgovernment/PublicConsultations/DG_4003113

be most suitable for particular purposes. Currently, while the new guidance urges public bodies to consider alternatives to written consultation there is little information on how these should be assessed, with the risk that decisions will be driven by the convenience (or resource constraints) of the government department or other public body (nor is there a clear statement of the strengths of written consultations or guidance and where they *will* be the most appropriate engagement mechanism).

Where does consultation happen?

Consultation can take a variety of forms; it can also be conducted at different points in decision-making and implementation processes – for example, by national government on broad principles of policy, at local government level on matters of implementation, and at organisational level to ensure responsiveness to service users and beneficiaries. Different approaches may be required at different levels and stages, and all these mechanisms may contribute to the on-going consultation and engagement work that informs a specific policy initiative.

The literature on the development of consultative processes includes a consultation in the City of Saint John in Canada that invited public input on how it should address a budget deficit (Culver and Howe, 2004), the establishment of advisory groups to consider alternative policies for containing the spread of contaminants associated with a chemical plant owned by Uniroyal Chemical Ltd in Elmire, Canada (Baetz and Tanguay, 1998), the development of deliberative polling in the UK on issues including crime, Europe, the monarchy, economic issues and the future of the NHS (Fishkin et al, 2000) and the requirement for the police in Britain to consult with local communities in implementing and evaluating community policing (Cook, 2002). Clearly, these consultations have different objectives to the kinds of formal, written consultations that are conducted by national government and other public bodies, as well as from each other.

This raises the question of how the on-going review of consultation principles engages with the localism agenda. What kinds of consultative mechanisms will inform the work of Health and Wellbeing Boards or Police and Crime Commissioners? Will the development - for example - of Police and Crime Plans, local Joint Strategic Needs Assessments and joint Health and Wellbeing Strategies be informed by consultation? If so, will there be a *requirement* to consult, what *form* will consultations take and how will local involvement in consultation processes be *supported* and *resourced*? Assuming there is a commitment to consultative approaches to local decision-making, there is also potential to develop innovative consultation and engagement strategies at local level - for example, citizens' juries and deliberative polling (this is further discussed below).

There is a research literature that can help inform discussion about the development of consultation as an element in the localism agenda. Dee Cook discusses the burden that was placed on local authorities and health authorities by the New Labour administration to 'consult service users, carers, local communities and voluntary and community sector groups in the planning, evaluation and review of their services', for example, in developing National Service Frameworks and Community Safety Strategies (2002, p. 516-7). Julia Abelson and colleagues highlight the development of local consultative mechanisms in the National Health Service, which they describe as 'the principal laboratory for exploration of deliberative approaches to decision-

making and priority setting' (Abelson *at al*, 2003). In the NHS and elsewhere there has also been a growing commitment to involving service users not only in decisions about their care, but also in the design, delivery and management of services. This is obviously a very different form of consultative practice than, say, the consultation on the 2010 Drug Strategy, underlining the fact that 'consultation' is not a single, homogenous activity or process.

Consultation, democracy and decision-making

A general issue of drug policy governance is the relationship between the collection and analysis of evidence on the one hand, and the authority to make policy decisions on the other. In a representative democracy, the ultimate authority to make decisions will often sit with elected politicians (nationally and locally). The evidence and messages emerging from consultation processes will tend to be balanced by decision makers against other sources of information and advice, including direct briefings by officials and the findings of opinion surveys, as well as by political commitments and ideologies (as set out, for example, in party policy). A key question – which is often neglected – therefore concerns the appropriate role and influence of stakeholder consultation within democratic political structures, and particularly the *limits* on its role and legitimacy.

In an article on 'Consultation and Contest', John Kane and Patrick Bishop consider the dangers of 'talk[ing] up consultation as a populist democratic device' (2002, p. 89). They argue that this is inconsistent with representative democracy for which 'a policy is legitimate if it has been made by the appropriate authority after due consideration of the various interests and opinions that exist amongst the public'. They conclude that 'a representative government should *never* (save in a referenda) allow citizens to believe that their input in policy questions will be determinant of final decisions' (*ibid*). This is rarely possible anyhow as policy problems are 'freighted with diverse and sometimes incompatible opinions and interests, and consensus among them may in the end prove impossible' (*ibid*).

Helena Catt and Michael Murphy also note that 'consultation, by definition, is not decision-making' (2003, p. 415), but rather a process that can inform it. There is a need, they argue, to distinguish between 'the range of situations where the government gives the group a voice in making decisions while on the other side *are all the instances where the group is involved in advising or providing information for the decision-makers*. It is the second set of procedures that are commonly referred to as consultative processes' (*ibid* – my emphasis). It is entirely legitimate, for example, for a pressure group to argue in a consultation response that drug law reform will contribute to achieving policy objectives that are identified by government. But to criticise a public body for failing to consult on a particular issue or option, such as drug law reform, is arguably to misunderstand the legitimate role of consultation in decision-making in a representative democracy (see discussion of the Drug Strategy 2010 consultation below). This highlights the importance of ensuring that there are realistic expectations of consultation processes (on both sides): of what consultation is *not* for, as well as what it is for.

It should be added that there will be genuine issues about control of the agenda in local consultations with communities and service users, where the principles of representative

democracy do not have the same relevance. In particular, it will be a problem if a service is rigidly controlling the content and agenda where the purpose of the consultation mechanism is to increase its responsiveness to the priorities of local communities or service users. Dee Cook assesses the effectiveness of community consultation by police forces, commenting that the police tend to frame the discussion within their own 'terms and operational priorities' (2002, p. 524). By contrast, 'the community perspective seeks a proactive role for consultation, which derives from an engagement with an agenda not of the police's making: for example, encouraging awareness of culture and diversity and encouraging police action on community-defined problems' (*ibid*). Again, this highlights the different principles that should apply to different types of consultation and engagement exercise, and the need to unpick this detail in order to develop a broader vision of the potential role for consultation.

Competence and fairness

It is important that consultation processes take account of the quality of evidence. At the same time, those most directly affected by policy may lack the competence or resources to respond in a detailed and evidence-based way, and a fair and inclusive processes should not exclude their voices.

If consultation mechanisms are to contribute to evidence-based policy development, then it will not be sufficient to sample opinion and aggregate preferences. It has been observed that analysing consultation responses is primarily a *qualitative* rather than a *quantitative* process, with a focus on the quality of the evidence and argument in support of proposals advocated by consultees. Is there a risk, however, that this will prioritise the perspectives and agendas of those organisations and interests that have the resources, capacity and expertise to develop responses of a particular type and quality, with the consequence that other legitimate points of view are excluded?

It is possible to distinguish between two principles that should be considered in development of consultation processes:

- Fairness in the distribution of opportunities for meaningful participation; and
- Competence based on access to appropriate knowledge and understanding of the issue.

This presents a dilemma in so far as only a restricted group of individuals and agencies will have relevant knowledge and expertise. This group may not be representative of the full range of legitimate perspectives, or include those most directly affected by the policy.

In a paper published in 2001 Nick Tilley considered the potential for 'the discourse of user empowerment' to collide 'with the other key driver of contemporary health and social policy - evidence-based policy' (discussed in Cook 2002, pp. 526-7).¹²

¹² The paper referenced is Tilley, N. (2001) Evaluation and evidence-led crime reduction policy. In R. Matthews and J. Pitts (eds), *Crime, Disorder and Community Safety*, London: Routledge. Also see Pawson, R. and Tilley, N. (1997), *Realistic Evaluation*, London: Sage.

He concludes that evidence is critical to inform policy formation and implementation, but that what he calls the 'evidence-led agenda' promises 'too strong a role for evidence' (*ibid*). Critically, he emphasises the importance of theorising based on experience of contexts, mechanisms and outcomes, as opposed to the generalisable evidence that is exemplified by Randomised Controlled Trials. The focus should be on achieving 'an improved grasp on what worked, how and with whom within the process' (*ibid*).

There is a legitimate role for independent specialists and organisations to contest the account and interpretation of the evidence-base provided by policy developers. Such challenges will enhance policy processes and improve outputs and implementation. However, there is a lot to be said in favour of a view of consultation that has a strong focus on the appreciation of service providers, service users, communities and others of the impact of applying a general policy proposal given complex local structures, cultures, interests and so on. This is a form of 'expertise by experience'. This is consistent with the emphasis in the new Cabinet Office principles on the importance of consultation for understanding unintended consequences and getting views on implementation.

The importance of distinguishing between different modes and levels of consultative practice is again evident here. The balance between what might loosely be described as evidence-based and experience-based input - and their respective roles within a consultation process - will vary depending, for example, on whether it is a formal consultation on a broad policy agenda, a citizens' jury, deliberative poll or a tool for service user engagement in service management. In so far as there is a problem in reconciling the demands of competence and fairness this may be resolvable through the careful design of consultation processes – for example, enabling those most directly affected by a policy to have a more informed discussion by involving them in a citizens' jury where they can hear and consider evidence from different specialists and interest groups (and to make it worth their while maybe introducing some kind of 'citizens' jury service' with arrangements for time off work and payment of expenses too!).

A note on legitimacy and participation

The way that an individual or organisation responds to a policy and its implementation will depend to some degree on their perception of and attitude to the process by which it was developed, including whether they feel they have had opportunities to participate in decision-making processes and that their evidence was properly considered. It seems a reasonable assumption that where there is a perception of procedural fairness in policy development, there will tend to be better compliance with a policy even among those for whom it was not their preferred option. Conversely, where stakeholders feel their voices have not been heard this may have impact on the success with which a policy is implemented. Perceptions of consultation processes may influence, for example, the commitment with which an organisation approaches its role in implementation. In some circumstances, it may even result in failures to comply with policy. This should be another key consideration in the design and development of consultation processes.

It is helpful to consider the three 'domains' of engagement identified by John Kane and Patrick

Bishop, which they call 'technical', 'transactional' and 'political' (2002, p. 92). Technical consultation would include many of the sorts of issues concerning implementation and unintended consequences discussed above. By contrast, they argue that the 'political' is properly understood as a domain of 'contestation' and not 'consultation' - for example, this domain would include the management of opposition to a policy decision or initiative (*ibid*).

The 'transactional' level is the domain 'in which various stakeholders are identified and their interests and opinions taken into account'. They explain that this mode 'is transactional because consulting here implies (if it is serious) bargaining with relevant groups or individuals, compromising where necessary and possible, appeasing potentially competing interests and conciliating potentially opposing opinion' (*ibid*).

Critically, the transactional domain is critical for the *legitimacy* of decision-making processes, and therefore ensuring 'buy in' from consultees who will often have the subsequent responsibility for 'selling' the policy outcome to their constituents and for implementation.

It is hoped that participants in fair processes will recognise the legitimacy of policy decisions based on inclusive procedures even where they do not reflect their own preferences or interests, because they will recognise the need for compromises and accommodations between different viewpoints and interests.

Kane and Bishop stress that 'the benign presumption underpinning this theory is, of course, that the consulters are sincere in their endeavours, that they really do listen and are genuinely prepared to take on board objections and conflicting claims (2002, p. 88). Conversely, they conclude, 'if ... consultation is mere tokenism, and decisions are already in place that will not be altered whatever input is obtained, then the consulted are liable to view the whole process with a cynical eye and refuse to recognise the legitimacy of its outputs' (*ibid*). As well as diminishing the robustness of the discussions - and therefore the quality of policy outputs - a failure to engage stakeholders in meaningful and transparent consultation processes can have practical costs when these same stakeholders assume responsibility for implementation.

A particular challenge is to secure the meaningful participation of marginalised and minority groups, who will often be the most impacted by policy developments in fields like drugs and alcohol. Dee Cook argues, for example, 'that while government does indeed "talk the talk" on consultation, it has yet to persuade many that it will "walk the walk". If the objects of social policy - service users, the poor, powerless and disaffected - were to find their voice, the talk itself may become unpalatable' (2002, p. 529).

This again points to potential tensions between evidence-based and user-led engagement and policy. On the one hand, it is important that the protocols, culture, language, mode and means of participation are not set up in a way that may be alien and intimidating for many of those most affected by policy. On the other hand, these groups will often need support to enable them to participate in an effective and meaningful way. Crucially, there is a real risk of tokenism, with any 'unpalatable talk' being simply disregarded.

New models of participatory democracy

It is useful to distinguish between consultation mechanisms that are concerned with collecting evidence and those that provide forums and structures for deliberation informed by evidence, such as citizens' juries. These should not be viewed as an alternative to information and evidence *gathering* mechanisms, but as providing a mechanism for the *assessment* and *evaluation* of evidence, which could involve a representative group of people from a community directly affected by the policy issues under consideration. As such, these kinds of mechanisms could also help to address the problem of balancing informed and expert input with involvement of a range of voices and interests, including those who may not have relevant policy expertise.

In recent years a number of approaches to public engagement have been developed where the role of participants is not to provide evidence or expertise to inform decision-makers, but themselves to engage in deliberative processes where they reflect on evidence and make policy or practice recommendations. These include citizens juries (which were developed in Britain by the Institute for Public Policy Research (IPPR)), planning cells (pioneered in Germany), consensus conferences (which have been hosted by the Science Museum in the UK) and deliberative polling (developed by James Fishkin and colleagues and - amongst others - by Channel 4 television). (These models are identified and described in Fishkin *et al*, 2000, pp. 659-660.)

James Fishkin and colleagues observe that these kinds of mechanisms can 'represent what public opinion would be like if everyone had an opportunity to become informed by experts on all sides and to reflect on issues by discussing them with people of diverse views' (2000, p. 660). Discussing deliberative polling they add that 'the aim is for each participant to become better informed and refine their individual views, whether in opposition to or in support of preponderant opinion' (2000, p. 661).

This can be contrasted with mechanisms that simply aggregate existing views or preferences. So Fishkin and colleagues comment that 'although it is axiomatic that snap judgements generally make for poor policy, that is precisely what opinion polls are designed to measure' (2000, p. 664).

While other forms of consultation approach participants as 'clients' or 'customers' (to which it could be added 'experts' or 'interest groups'), the common denominator for these kinds of exercise is that they involve people as *public citizens* not *private individuals* (Kane and Bishop, 2002). They comment that 'consultation exercises which provide information about the nature of a policy problem and provide alternatives for its solution invite people to engage and think *as public citizens* rather than, or as well as, private affected interests' (2002, p. 94). Relatedly, to persuade other participants of the merits of their proposals, they will have to appeal to publically justifiable arguments, as their own private preferences or sectional interests will carry little – if any weight - with others.

It is sometimes suggested that participatory processes such as citizens juries and deliberative polling could provide a progressive alternative to established mechanisms such as formal, written consultations. It is important therefore to recognise that they are intended to serve a different purpose, and would naturally assume a different place in an overall vision of effective consultation

processes. These mechanisms do not exist (at least, not primarily) to provide decision-makers with additional evidence or a view from practitioners or service users. Rather they are about empowering citizens to develop their own proposals following deliberation on the evidence that is placed before them (which might include expert testimony, including evidence from service providers and users).

Viewed in this way they might be viewed primarily as a way of addressing the 'democratic deficit', rather, for example, than highlighting challenges for implementation, such as unintended consequences. Thus Fishkin and colleagues observe that 'deliberative polls are intended to complement the familiar institutions of representative democracy rather than supplant them ... The real issue is not to deflect policymakers from being influenced in their deliberations by what the public thinks but to expose them to what a more informed state of public opinion would be like' (2000, p. 664).

This raises the possibility of developing these kinds of engagement mechanisms as a key component of the localism agenda, which is about empowering local communities. Mechanisms like citizens juries can increase the legitimacy of decision-making and the willingness of stakeholders to implement decisions that they have contributed to. This could be particularly valuable at a time when local policymakers are managing substantial budget cuts and facing difficult decisions between competing priorities.

It is important, again, that public bodies have some accountability to public participants for their participation. Julia Abelson and colleagues comment that 'at minimum, they want the resulting decision communicated to the public with some demonstration of how the public's input was used or considered in the decision-making process' (2003, p. 247). They conclude that, to date, deliberative processes 'appear to offer more promise than reality' and that 'the limited experience with deliberative methods to date, have demonstrated that the outcomes of deliberations are rarely, if ever, binding and are often heavily "managed" by the sponsoring organisation, typically the health authority' (*ibid*).

Keeping it real

Governance processes - including consultation mechanisms – have significant financial and opportunity costs in terms of time, energy and resources for both public bodies and organisations and individuals who engage with them. At a time of public spending cuts and the challenge of managing a major process of public sector and health service reform it is important to have realistic ambitions for and expectations of consultation processes. Further evidence on the impact and effectiveness of various forms of consultation process would help to ensure a more cost-effective approach to consultation practice, as will resourcing second tier organisations to support service providers and others to respond effectively and efficiently. Consideration should be given to the appropriate balance between the quantity and quality of consultation activity.

It is one thing to develop a vision of the perfect consultation process, another to ensure that it is realistic – not least, given the other factors that will influence decision-making and the resource costs of consultations. While mechanisms like citizens juries and deliberative polling can provide

important insights into what informed public opinion might look like, and may give policymakers the confidence to reframe public discussion and 'lead the debate', those holding (or aspiring to) elected office will inevitably be swayed by evidence from standard opinion polls. There also needs to be clarity about how these kinds of deliberative activities relate to decision-making by elected representatives (and others), through national and local democratic process.

Consultative mechanisms involve significant resource costs – for example, Fishkin and colleagues observe that organising a deliberative poll 'costs a substantial sum of money', while suggesting that 'the mistakes of government cost even more' (2000, p. 665). Equally, processing hundreds or thousands of written consultation responses properly, and providing feedback to stakeholders is demanding on the time of officials, and preparing them makes heavy demands on the scarce resources of those individuals and organisations that respond. As John Kane and Patrick Bishop observe 'no doubt tokenism is sometimes the resort of public servants who must be *seen* (and may be legislatively required) to consult even when faced with oppressive constraints on time, cost and patience', adding that 'genuine consultation ... can be lengthy and expensive, fraught with difficulty and danger, especially if a policy has wide-ranging impact on a plethora of groups and individuals' (2002 pp. 88-9).

The new consultation principles state that 'the governing principle' should be 'proportionality of the type and scale of consultation to the potential impacts of the proposal or decision being taken, and thought should be given to achieving real engagement rather than following bureaucratic process'. Adherence to this principle will help to prevent tokenism, ensure that consultation processes are cost-effective for both decision-makers and those participating and that they have legitimacy with stakeholders and those who are affected by policy. Consultation practice with a focus on 'real engagement' will require greater transparency about what the opportunities for influence really are, which might provoke a wider debate on both the cost-benefits of consultation and its role in democratic processes – nationally, locally and within the life of particular institutions.

In this context, the lack of robust evidence on the impact and efficacy of consultation processes is striking. Catt and Murphy comment that 'the connection between particular institutionalised forms of public consultation and the specific ends they are supposed to achieve is one question that needs to be confronted in a more rigorous and systematic fashion' (2003, p. 408). Abelson and colleagues comment that 'while a useful set of practice recommendations for employing different deliberative methods is beginning to emerge ... there is a paucity of rigorous studies of these approaches to determine their efficiency' (2003, p. 243).

A word of caution on virtual consultation mechanisms

The new consultation principles highlight the potential for developing 'email' and 'web-based forums'. These kinds of virtual approaches can add significant value to consultation processes – not least by creating opportunities for people to respond who might lack the time or resources to prepare a standard written response. However, it is worth noting that the development of virtual *mediums* for engagement is not necessarily the same thing as the development of innovative *methods* and *modes* of engagement. The strengths of these mediums in drawing in a wider range

of respondents should be balanced against the costs of processing and qualitatively assessing a potentially much higher volume of responses, some of which may be based on limited expertise, experience or reflection. For example, while 'virtual' consultation processes may encourage people to respond who might not otherwise have done so, this could be partly because they do not require views and opinions to be supported by detailed evidence and argument. That is not to discount the value of these kinds of engagement mechanisms, but they are clearly not an alternative to more formal consultation processes, even where they can provide another helpful source of information.

Keith Culver and Paul Howe discuss a consultation by the City of Saint John in Canada to inform budgetary decisions, which they comment was 'among the first to go beyond ... limited use of information and communications technologies to involve mature, easily available technologies such as web discussion fora to enhance citizens' access to two-way discussion with one another and with government officials' (2004, p. 54). However, they conclude that the impact of this process on the budget-making process was 'slight', particularly given the 'reservations expressed by officials about the number of consultation participants, the degree to which they faithfully reflect the larger community, and the quality of their contributions' (2004, p. 65).

Drug Policy

So, what forms of consultation have informed recent drug policy and what has been the experience of consultation processes in our sector? Anecdotally, my impression is that while there is much positive engagement practice there has been dissatisfaction with some recent consultation processes in our field on both sides.

Consider, for example, the Home Office consultation on the Drug Strategy 2010 and the National Treatment Agency's consultation on Building Recovery in Communities.

Drug Strategy Consultation 2010

From DrugScope's point of view, the wider processes of engagement that helped to shape the Drug Strategy 2010 were positive and fruitful. In particular, they provided the sector with a genuine opportunity to shape the vision of 'recovery' that informs the section of the strategy on 'Building Recovery in Communities'. The influence of the sector voice is evident, for example, in the description of recovery as an 'individual person-centred journey', the recognition of the role of 'medically-assisted recovery', and the emphasis on social (re)integration (for example, on access to housing, employment and meaningful activity).

However, the formal consultation process for the Drug Strategy 2010 did not adhere to the Code of Practice 2008, and was widely regarded as unsatisfactory. The consultation began on 20 August 2010 and closed on 30 September 2010, a six-week period, and covering a holiday time, which might ordinarily be grounds for an extension beyond the 12 week norm. No explanation was provided for the shorter time frame.

It was announced as 'a targeted consultation ... to provide an early opportunity for drug sector organisations and other key partners to influence the development of the new drug strategy'. Yet the Drug Strategy was published on 8 December 2010, so there was in reality only limited further opportunity for influence (although DrugScope was subsequently involved, with other stakeholders, in a meeting with officials at the Home Office to discuss a draft strategy document).

There is little public information on the process for the analysis of the consultation responses or their impact on the final strategy, but the facts and figures that are available would suggest that the Home Office had neither the time nor capacity to consider all these responses in detail. There was a 10-week period between the close of the consultation and publication of the Drug Strategy, which would have included sign-off across several Government departments, as well as editorial and communications work. The Home Office received a total of 1,850 responses, including submissions from drug and alcohol treatment providers, young people's services, family services, representative groups, pressure groups, statutory bodies including the Advisory Council on the Misuse of Drugs, police forces, the Association of Chief Police Officers, Local Authorities, Primary Care Trusts, Drug Action Teams, Community Safety Partnerships, local strategic partnerships and UK embassies and commissions (see HM Government 2010b). DrugScope's submission alone was over 70 pages long, and based on consultation events with our membership in London, Birmingham and Newcastle, as well as an online survey with over 230 responses. It is not credible to suggest that this volume and variety of response was considered in any detail within a two-month period.

The Home Office did produce an official 'summary of the consultation responses', but this was notably short on detail – the original consultation document was 19 pages long, there were 1,850 responses and the Home Office summary of responses was 17 pages. It did not include precise information on the numbers or proportion of respondents who raised specific issues or expressed preferences for particular policy options. Instead, it relied on general statements of the form 'many respondents thought that' and 'in general, respondents thought that', generally supported by one or two quotations, which were often not attributed to particular respondents. Nor is there discussion or explanation of the process or evaluative criteria that were used to assess the responses.

A note on the scope of the Drug Strategy consultation

Release's response to the Drug Strategy consultation provides a particularly clear and detailed discussion of its departure from key aspects of the Code of Practice 2008. As well as the lack of any explanation for the departure from the 12 week time-scale, Release argued that the consultation document lacked sufficient clarity and detail on the policy options under consideration, and noted the failure to publish an impact assessment considering potential costs and benefits, or a race equality impact assessment (Release 2010).

Similar issues were raised by Transform, which went so far as to recommend that 'the consultation process be reviewed by the Cabinet Office pending a relaunch', and that 'a new consultation process should address the identified shortcomings by adhering to the government Code of Practice, including evidential support and impact assessments for all proposals and

covering all aspects of UK drug policy of concern to stakeholders' (Transform 2010, p. 2). Specifically, Transform argued that the consultation was remiss for its failure to address the issues of harm reduction, sentencing and decriminalisation, supply side enforcement, classification, the role of the Advisory Council on the Misuse of Drugs, international drug policy, the evaluative framework for policy and tobacco. The exclusion of issues of law reform was also picked up by Release which began its response by declaring that it would 'not be limited to the questions detailed in the consultation paper' (Release 2010, p. 1).

Subsequently, critics of the Drug Strategy consultation with an interest in law reform issues pointed to the Home Secretary's dismissal of 'liberalisation and legalisation' in the Foreword to the Strategy, despite an acknowledgement that law reform had been advocated by 'some respondents' to the consultation process.

This all raises legitimate issues about the scope of the debate about drug policy in the UK, as well as highlighting a number of departures from the Code of Practice. It is important to stress, however, that the absence of specific issues and questions from the drug strategy consultation is consistent with the Code of Practice 2008. It is stated that the Code 'is not intended to create a commitment to consult on anything, to give rise to a duty to consult, or to be relied on as creating expectations that the Government will consult in any particular case'. Criterion 3 of the Code expressly states that 'consultation exercises should be clear about the scope of the exercise, setting out where there is room to influence policy development and what has already been decided, and so is not in the scope of the consultation'. This raises broader questions about the role and limits of consultation exercises within democratic processes of governance that were discussed earlier.

Building recovery in communities

In February 2011, the National Treatment Agency (NTA) launched a consultation on 'Building Recovery in Communities' (BRIC), which it stated would create a 'new national framework for recovery' to replace Models of Care for Treatment of Adult Drug Misusers (and elements of Models of Care for Alcohol Misusers). The consultation document comprised 48 questions, ranging widely over all aspects of treatment provision and recovery (NTA 2011). The time frame for the BRIC consultation was compliant with the 2008 Code, stretching for a 13-week period from 2 February 2011 to 4 May 2011 (although this did include the Easter holiday). The NTA received responses from 280 individuals and organisations, including service providers, membership organisations and centres of expertise (for example, DrugScope, Royal College of Psychiatry and the UK Drug Policy Commission), Drug Action Teams, local councils and London boroughs, prisons, Primary Care Trusts and NHS trusts (see NTA 2012).

Nor was the NTA's response rushed; on the contrary, it would finally appear a full year after the close of the consultation exercise in May 2012. It does not, however, provide much in the way of detailed evaluation of the responses. The NTA response to the consultation was 12 pages long: 13 pages shorter than the original question paper. It does not provide quantitative or qualitative evaluation of the responses, although the format of some of the questions would have provided some data (for example, on responses to yes/no questions). The NTA response comprised

general statements of the form 'respondents thought that' or 'many respondents thought that', followed by unattributed quotations on the relevant topics. Nor is description of the process of managing the consultation provided, or an explanation of the methods that had been applied in the evaluation (see NTA 2012).

Perhaps most striking of all, however, was what did not materialise from the BRIC consultation. No document has subsequently been produced to replace Models of Care for Treatment of Adult Drug Misusers. While the NTA's Action Plan for 2012-13 (published on 4 May 2012, two weeks before the NTA released its response to the BRIC consultation) was entitled 'Building recovery in Communities: the transition to the new public health system', it made no reference to the consultation exercise, and there is no evidence that it had been shaped or influenced by it (NTA 2012b).

Those who submitted responses were largely reliant on rumours during the 12 months of silence that followed the close of the consultation exercise. It was, for example, widely believed that the Department of Work and Pensions (DWP) had taken ownership of the recovery agenda, and that key figures in the DWP were resistant to production of guidance led by the NTA and based on the BRIC consultation. If the BRIC exercise – at least as originally envisaged - was effectively dead in the water, this would explain the NTA's approach in its analysis and response to the consultation.

In March 2012, the Government published 'Putting full recovery first' which was described as 'the Government's roadmap for building a new treatment system based on recovery' (Department of Work and Pensions, 2012). Apparently produced by the DWP, but with a Foreword from the Home Office Minister Lord Henley, and bearing the logos of eight Government departments, the status and provenance of this document were somewhat unclear. It clearly was not, however, significantly shaped by the BRIC consultation; indeed it caused widespread anxiety in the sector by equating 'full recovery' with abstinence. It did, however, make direct reference to the BRIC consultation, reiterating the commitment that some kind of BRIC 'guidance' would replace Models of Care, but explaining that it was now intended that the NTA would write to local areas outlining its response to the consultation and drawing attention to a 'suite of documents to support all those involved in increasing the recovery orientation of local systems' (ibid, p. 9). Whatever the value of this approach and these documents, it is fair to say that this did not deliver on the original terms of engagement for the BRIC consultation, or meet with legitimate expectations in terms of impact and output of those who responded.

Some concluding remarks on recent experience

Neither the Drug Strategy nor BRIC consultations were fully compliant with either the letter or the spirit of the 2008 Code of Practice, with evidence of growing frustration and disaffection with formal consultation processes on both sides. From a Government perspective, it can be inferred that there is a growing sense that the volume of responses to consultations have been difficult to manage within available time and resources and disproportionate to the real, practical opportunities to exert influence or add value. Formal consultations have come to be seen as too often involving 'bureaucratic processes' that fail to deliver 'real engagement with those affected' that is meaningful and helpful to policymakers.

From the perspective of the drug field, there is, I believe, a growing scepticism about the potential to influence Government (or other) policy through these processes, and therefore about the value of participation – particularly at a time when resources are stretched. (Although, it should be stressed that there are wider processes of consultation that are highly valued by the sector, and there continue to be well-conducted formal consultations – for example, the Sentencing Council’s consultation on Drug Offences, which ran from March to June 2011, was in many respects an exemplar of good practice.) The Compact states that organisations should be involving ‘service users, clients, beneficiaries, members, volunteers, and trustees when making representation to government’. But how are community sector organisations to continue to justify the skill and resource needed for detailed responses of sufficient quality – and the demands this makes on the time and energy of service users, clients, beneficiaries, etc – unless there is evidence of impact (or, at least, that their responses have been properly considered)? Is the game really worth the candle?

Currently, Government departments appear to be experimenting with a range of consultative approaches with a lack of overall clarity of purpose or approach. For example, the Department for Education’s consultation on ‘Positive for Youth’, which ran from June to September 2011, was not widely publicised beyond a relatively small body of children and young people’s organisations, and took the form of a series of ‘discussion papers’ with no consultation questions as such, or clarity on process, specific proposals or intended outputs. The DWP’s ‘consultation’ on the social justice strategy 2012 was particularly curious. This ‘consultation’ was conducted on-line, with the principal dissemination route apparently provided by a link in the DWP’s stakeholder newsletter for February 2012. There were no details about the proposals, only a general invitation to provide ‘thoughts and opinions on what social justice means to you’. The survey closed on 22 February 2012 and the Social Justice strategy was published on 13 March 2012, only three weeks later. It is difficult to see how this ‘consultation’ could have influenced the strategy at this late stage, or what value would be added by a general trawl of ‘thoughts and opinions’ on the meaning of ‘social justice’. It is not clear how long the ‘consultation’ was open for, but it appears to have been no more than five to 10 days.

Conclusion

The foregoing discussion suggests that consultation is best conceived as an on-going process, that should involve a range of mechanisms and activities, operating at different levels in the formulation, design, development and delivery of policy. While the new Cabinet Office consultation principles include promising pointers and commitments from Government, there would be merit in a wider debate about consultation processes, facilitating a proper dialogue about frustrations as well as benefits, constraints as well as opportunities. It would be particularly helpful to map out the full range of consultation processes and their distinctive characteristics, strengths, limitations, costs and benefits. There is also a lack of research, impact and evaluation addressing the experiences of those involved in consultation processes and their efficacy.

There are a number of resources that set out the principles of effective consultation and there are on-going initiatives that will continue to inform the development of effective consultation

processes. The Organisation for Economic Co-operation and Development (OECD) published *Citizens and partners: information, consultation and public participation in policy making* in 2001, which includes a list of general principles. Compact Voice (the independent voice of the voluntary sector on The Compact) published *Ensuring meaningful engagement and consulting* in March 2012, which provides a 'benchmark of the minimum expected in order for engagement in consultations to be considered meaningful, in particular when the public body is unavoidably restricted to less than a twelve week consultation period'.¹³ This guidance was endorsed by the Civil Society Minister, Nick Hurd.

Many of the principal issues will be broadly invariant across a range of policy domains – so are there any specific points relating to the current governance of drug policy in the UK? I would make four observations in conclusion.

First, while there is a need for a *general* review and discussion of consultation practice (which could involve, for example, organisations like the National Council for Voluntary Organisations, the Association of Chief Executives of Voluntary Agencies and the Institute for Government), there would also be merit in a sector specific review, bringing together relevant government departments (for example, the Department of Health and Home Office) and independent organisations to discuss current practice and map out an agenda for effective consultation on drug policy. Since 2010, there has been experimentation with some innovative engagement processes in our sector, from which lessons could be learned and potentially generalised – for example, the Department of Health sponsored 'co-design' process for Drug and Alcohol Recovery Payment by Results, which has involved a range of consultation mechanisms at different point in the processes, working nationally and locally and employing a variety of methods.

Second, there are concerns about the impact and effectiveness of some recent consultations in the drugs field. This raises a wider issue of the accountability of decision-makers, for example, where participants do not feel there has been an adequate level of feedback and response. This is complicated by the fact that consultations are often organised by public bodies that have a direct role in commissioning and providing funding for organisations that are affected by, and will be implementing, the proposed policy. I believe that second-tier organisations like DrugScope must continue to play a role by providing a 'buffer' between service providers and public bodies, and feeding back on the outcomes of more frank discussions with and between stakeholders than might be possible in meetings facilitated by the relevant public bodies (or simply where they are 'in the room'). Without this form of second tier support, it is likely that the voice of small and medium sized voluntary and community sector organisations will be lost. (Additionally, incidentally, a case could be made for an independent 'ombudsman' role to consider concerns or complaints about consultation processes on the basis of principles like those identified by Compact Voice.)

Third, the drug and alcohol sector will be profoundly affected by the 'localism' agenda. With the abolition of the National Treatment Agency in April 2013, responsibility for commissioning drug and alcohol services will shift to Directors of Public Health employed by local authorities. From

¹³ At www.compactvoice.org.uk/resources/publications/ensuring-meaningful-engagement-when-consulting

November 2012, elected Police and Crime Commissioners are likely to have a keen interest in substance misuse issues. It will be challenging to ensure that the 'voice' of the drug field is heard within new local structures such as Health and Wellbeing Boards, which will be responsible for a broad policy remit, as they begin to develop their own public engagement mechanisms. This raises a general issue: there are consultations concerned with drug and alcohol policy directly, but there are also a range of consultations on other policy issues that have a profound impact on providers, users and other beneficiaries of drug and alcohol services which our sector needs to engage in, from health reform, to criminal justice, to welfare to education. Currently, the sector is not always being included in these broader consultations. Conversely, this raises issues about the sector's capacity for engagement and the problem of 'consultation overload'.

Fourth, there is a lot of misinformation about drug issues, and drug services are working with a highly marginalised and stigmatised section of the population, which may not be naturally sympathetic for local decision-makers. There is an opportunity for our sector to support the development of innovative mechanisms like citizens juries and deliberative polling to educate a wider public, and to give politicians and other decision-makers a sense of the opportunities to provide leadership to public opinion on drug policy issues.

As James Fishkin and colleagues observe, politicians 'come up with decisions that they hope are ... consistent with the views of their constituents, but which may fail to reflect what these constituents would want if they had a modicum of information and the time to make considered judgements' (2000, p. 665). This sort of approach, for example, might help to open up a wider public discussion of options for drug law reform. Equally, communities are not genuinely empowered at local level if they are making decisions about service provision that will have serious future impact without sufficient information and opportunities for deliberation. Real empowerment will require mechanisms that support and enable the local community to make informed decisions based on proper deliberation.

There are grounds for concern about some recent consultation exercises in our sector. There are also possibilities for developing innovative engagement mechanisms as part of the localism and 'Big Society' agendas, with the potential to raise community awareness of drug and alcohol issues, and of the ability of our sector to contribute to a range of local policies and priorities.

The development of new consultation principles highlighting the variety of engagement mechanisms could have a positive impact on practice. It should also be recognised that public bodies – nationally and locally - have limited resources for consultation work and there are significant constraints on the policy options that they can realistically consider (notably, political and fiscal ones). There may even be an argument for putting quality before quantity in developing consultation practice, along with greater mindfulness in ensuring that consultations focus on areas where there is genuine opportunity for influence, even if that restricts discussion to a narrower spectrum of proposals.

To finish where we started, we need to be clear that forms of consultation like citizens juries, surveys and web fora, whatever their merits, are not *alternatives* to formal written consultations: they are not intended or designed to do the same job. Similarly, while 'engagement with *those*

affected is vital for robust consultation it is not its only function. The anxiety is that we could see not a rise in innovative consultation practice, but more 'quick and dirty' consultation (for example, using web fora and e-mail), with a corresponding reduction in opportunities to participate in consultation processes governed by established principles, even where this *is* appropriate¹⁴

The bottom line is that organisations like DrugScope generally do need at least 12 weeks to develop responses to detailed policy proposals on the basis of proper engagement with their memberships and other stakeholders, who have the experience of delivery that public bodies want to tap into. We also need to be able to demonstrate to our members that their views are being properly considered and can have an impact in order to justify the demands that consultation processes make on their time and resources – particularly where these are increasingly tight.

In terms of developing work on consultation practice as an element of good governance, a number of key issues and activities have emerged from the discussion in this essay, including:

1. The need for further mapping and guidance on the different kinds of consultation mechanisms, their strengths and weaknesses and their specific contributions to wider consultation and engagement mechanisms;
2. The value of understanding consultation and engagement as on-going processes to which different activities can contribute in different ways and the need for further work on the nature and constituents of effective consultation practice (this could include, for example, more clarity on the role for 'second tier' organisations and support);
3. The need for research on the impact and effectiveness, costs and benefits of consultation processes including the role, if any, for independent monitoring (including the potential for some kind of Ombudsman function);
4. Specific work on effective consultation mechanisms where public bodies are concerned with widely misunderstood and/or politically contested issues like drug policy, and where the consultation concerns service provision for sections of the community who are negatively perceived or stigmatised (including drug and alcohol service users);
5. Specific work on the potential role of deliberative mechanisms such as citizens juries to provide forums for consideration of politically sensitive issues, such as drug law reform;
6. The development of consultation processes in the transition to localism and under conditions of financial austerity, including guidance on consultation mechanisms to support Joint Strategic Needs Assessments, Joint Health and Wellbeing Strategies and Police and Crime Plans.

¹⁴ It is notable that this is the two comments posted (at the time of writing) in response to the Third Sector article announcing the new principles. The first comments: 'I would suggest that any reduction on the 12 week minimum timescale is going to reduce the capacity of most organisations to respond, particularly as resources within the sector are in most case already stretched to their absolute limit'. The second says 'If ... there are few/no responses from the smaller voluntary sector organisations is the consultation process still valid? ... the government insists that it wants to put local people first, and needs their views!'

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