Policy forum: The UK drug strategy

Addressing the lack of knowledge underpinning the 2008 drug strategy

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Following consultation with members of the academic and drug research community, the UK Drug Policy Commission (UKDPC) has identified key gaps in the knowledge base underpinning the drug strategy and the 'top 10' are highlighted. Many of the gaps in knowledge identified at the start of the 1998 strategy have endured, and suggestions are made for some of the causes of this faltering progress. The conclusion is that an overall research strategy and new structures and systems are needed to address the inadequate knowledge base.

Key words
drug strategy, evidence, research, evaluation

Introduction

The UK government's 2008 drug strategy is due to be published in January and will be active from April, when the current 10-year strategy ends. However, despite receiving over 1,100 responses to a recent consultation exercise (HM Government, 2007), the current drafting of the strategy will be hampered by a woeful lack of robust scientific research demonstrating 'what works'. After spending billions of pounds on drug interventions over the past decade, it is very concerning that the results of this investment are not clear. A lack of evidence means that resources may not be fully optimised, and has contributed to doubts about the efficacy of components of the strategy, and ill-informed debate. It is therefore vital that measures are put in place within the new strategy to ensure that gaps in our knowledge are addressed.

Much ignorance has endured

This summer, in consultation with 27 members from the academic and drug research community, the UK Drug Policy Commission (UKDPC) reviewed the evidence underpinning the proposals for the next strategy and identified key gaps that require addressing. It is notable that many of the gaps we have identified can also be found in the 1998 strategy paper *Tackling Drugs to Build a Better Britain.*

Table 1, overleaf, shows today's 'top 10' knowledge gaps coupled with some of the 19 'priority areas for additional research' identified in 1998 to demonstrate the overlap.

Despite the initial commitment to commissioning new research in the 1998 strategy paper, and subsequent additional investment in research and new data sources, this table demonstrates that many of the key knowledge gaps remain. Furthermore, our 'top 10' is hardly an exhaustive list. We must accept that we know little more today than in 1998 about the extent and nature of the drug problem, which interventions are most effective and how they can be effectively delivered.

Reasons for faltering knowledge development

We believe that there are several reasons why the knowledge base around drugs failed to develop significantly under the last strategy:
(i) Serious under-investment in research,

Table 1 2008 'top 10' knowledge gaps and equivalent 1998 gaps

2008 'top 10' knowledge gaps	1998 equivalent gaps, identified in *Tackling Drugs to Build a Better Britain.*
1. Longitudinal research and analysis to understand the causes and developmental pathways (relating to initiation and desistance) of problematic drug use. 2. Use of statistical modelling to predict trends in problem drug use and identify the likely impact of different interventions.	■ Qualitative and long-term assessment of impact on of problematic drug use of wider social factors. ■ Qualitative studies of patterns of misuse of regular young users. ■ Comprehensive surveys of young people (age five upwards) and drugs misuse.
3. Evaluations of targeted generic and drug prevention initiatives.	■ Long-term evaluations of effectiveness of prevention and education programmes.
4. Understanding the needs of diverse communities (eg. ethnic minorities, eastern European communities).	
5. Interventions involving families of drug users within the treatment system.	
6. Evaluation of interventions in prisons and ways of maintaining services on transfer and release. 7. Long-term follow-up of drug using offenders to evaluate the impact of interventions.	■ Practices that have led to sustained reductions in drug-related crime and community fear. ■ Further assessment of cost-effective treatment in the criminal justice system.
8. Understanding how to deliver effective care packages for promoting recovery.	■ The cost-effectiveness of current treatment and care options.
9. Evidence for the effectiveness of new or less well-evaluated treatment and harm reduction options, for example: ■ interventions for stimulant users ■ treatment for young people (under 18) ■ contingency management ■ new technologies such as vaccines.	■ The effectiveness of treatment interventions for young people. ■ The treatment of stimulant drug dependency.
10. Drug supply and enforcement: impact, effectiveness and value for money; and a clearer conceptualisation of market disruption and measurements for this.	■ Establish the quantity, quality and type of drugs reaching our streets, its place of origin, distribution network and means of transport; and the most effective methods of intervention at each stage of the process. ■ Establish the relationship between street level prices, availability and demand. ■ Long-term evaluations of community safety programmes within high-risk communities.

information and analysis. The rush to deliver interventions was not matched by relevant investment in research and development.

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

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

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

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

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

Knowledge development in the drugs field has been historically under-resourced. From the best calculations we can make (from available and inadequate UK governmental data) the UK spends less than one per cent of the total drug strategy resources on research. Compare this, for example, with the federal US treatment and prevention budget, which alone devotes over 20% to research (ONDC, 2007).

However, the problem is not just about investment, essential as this is. Even when considerable resources have been spent on research, evaluation and monitoring over the past decade, the benefits are often not maximised. Research projects are funded to answer very specific questions without considering how they might be used to develop the wider knowledge base or link-up with other studies. Systematic reviews frequently find that comparisons between evaluations are not possible due to differences in methodology and outcome measures. New data sources such as the National Drug Treatment Monitoring System, Arrestee Survey and the Drug Interventions Management Information System and further investment in the British Crime Survey have been welcome, but are also lost opportunities. Further analyses over and above the standard reports would help us to understand questions such as the 'natural history' of drug use. This isn't necessarily just about increasing government investment, but looking at structures and systems too. For instance, if datasets were more readily available to the wider research community it would be able to play a greater role in providing analyses.

Given the generally accepted importance of evidence-based policy and the serious deficiencies in this area, it is clearly a cause for concern that there was nothing specific in the consultation document relating to developing the knowledge base.

The drug strategy needs a research strategy

To address the current deficiencies in the approach to knowledge development, a dedicated 'knowledge pillar' needs to be created within the drug strategy providing a coherent and co-ordinated programme of research and analysis, with appropriate funding. This should encompass:

- basic research into the extent, nature and causes of drug use and problem drug use
- evaluation of the effectiveness of interventions and programme delivery and factors that impact on this
- monitoring and evaluation of the strategy as a whole.

To deliver this, new structures and systems are required. For instance, consideration could be given to establishing an independent body or group to lead this work, and the UK research councils and other relevant agencies could develop a combined funding programme, as has already happened for infectious diseases. Whatever system is adopted, it will need to have the following qualities to maximise its value and ensure credibility:

- sufficiently independent and transparent – with clear time-frames
- co-ordinated and planned so that links are made between different projects and a coherent picture is developed; there should be clarity about the purpose of the research and how it will assist in the drug strategy delivery process.
- robust – using a wide range of methods as appropriate to the aims of the research and conducted to professional standards
- Delivery-focused with data fully analysed and findings disseminated in a way that will be understood by all stakeholders and is linked to future policy development.

The government, the research councils and other relevant agencies must now work together to ensure that such a system is put in place.

Further information

For more information on the issues raised in this paper including the 'top 10' knowledge gaps please refer to the UK Drug Policy Commission's response to the UK government's drug strategy consultation at www.ukdpc.org.uk/reports.shtml.

Contact details

To contact the UK Drug Policy Commission please email info@ukdpc.org.uk or telephone +44 (0)20 7297 4750.

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