# How Can Research Improve Drug Policy?

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This is the first instance I can think of in which a non-governmental organisation with a policy enthusiasm seems to think that analysis is actually central to the issue. As a researcher, I will try to suggest ways in which research can improve drug policy. I will focus primarily on the US, and to justify this parochialism I will explain that the US hangs over the rest of the world in terms of influence on policy and dominance of the research effort in this area.

The story is a depressing one for the US. Research is very little used in policy-making. At the macro- level, we rely predominantly on punishment, and in a sense that exempts policy from research because punishment is more of a moral than a management issue. There exists a drugs strategy, which year after year talks about the centrality of science rather than ideology, but only follows science if research produces attractive answers. In reality, science plays no role in the national drugs strategy.

This phenomenon does not simply happen at the gross level of the emphasis on punishment; research is also marginalized at a programmatic level. For a long time, Drug Abuse Resistance Education (DARE) has been the most widely-used programme, even though there is a compelling research base that suggests that it is at best ineffective, and possibly even counterproductive. Equally, within the medical profession, there exist regulations about methadone prescription, which push sub-optimal methadone dosing, and have done so for over 20 years now.

The drug problem is viewed essentially moralistically in the US and much of the Western world, which imposes constraints on the policies allowed, and also on what kind of research can be done.

## Treatment

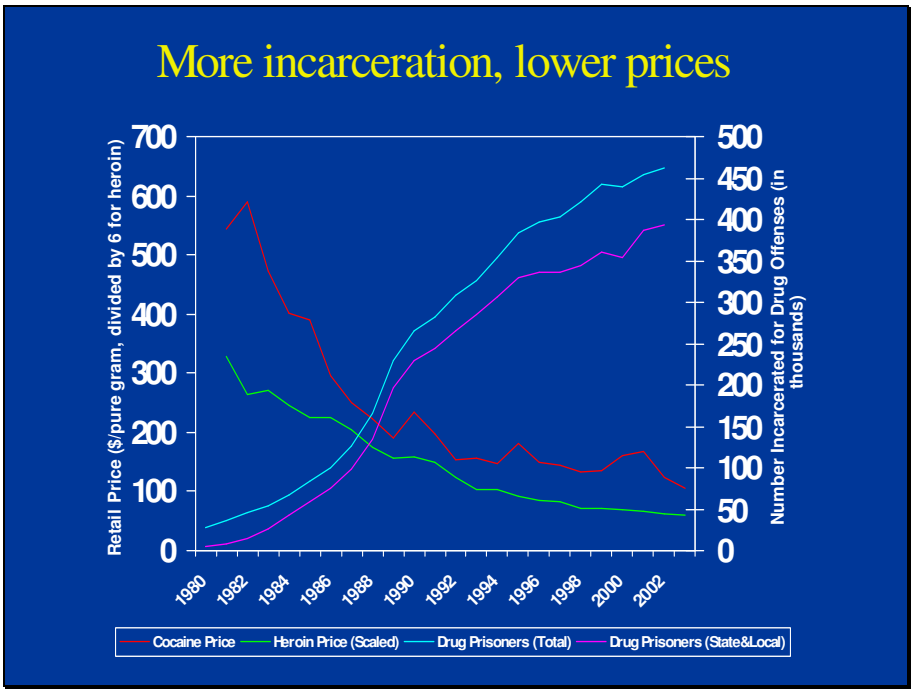
Treatment is clearly the best-researched of the policy areas in this field, if you take the standard classification of treatment, prevention and enforcement. There is a substantial body of work to suggest that treatment can and mostly does work. The evidence is adequate to make the broad case that treatment can result in the reduction of drug problems, and one can even make cost-benefit calculations. The research is no longer dominated by the US, *vide* the NTORS study in the UK, and similar efficacy and effectiveness studies elsewhere. Some treatment results are really quite dramatic, e.g. reductions in crime and HIV risk behaviours with methadone treatment are very substantial, often more than 70%. The problem is keeping patients in treatment. Even not very good treatment, which is what is mostly available, is good enough to generate quite high benefit/cost ratios.

## PREVENTION

Prevention arguably remains a mystery. Everyone is in favour of prevention; there is no downside to it, but research here is dominated by the US. It is very hard to point to prevention-effectiveness studies outside the US. It is a very weak research field. There are considerable structural problems in doing these evaluations with a relatively rare behaviour like drug abuse. Many programmes have turned out to be ineffective. In the end, DARE itself was finally downed by such evaluation and is presently being redesigned by researchers. There are a few programmes which look promising, such as 'life skills' training by Gilbert Botvin. This approach performs very well in evaluations carried out by him and his colleagues, but it is troubling that the developers of the technique are carrying out the evaluation. There is a growing literature about implementing life skills training-type programmes. At the moment, prevention is more a slogan than a policy, but looking at some European budgets, it is not even a slogan that any country puts much money into. There may be effective prevention programmes, but we have yet to develop a base on which to measure them.

## ENFORCEMENT

Enforcement is by no means a slogan, but it is even more of a mystery than prevention. There is very little money being invested in research here, so the resulting research base is extraordinarily small. There is no evidence that tougher enforcement raises prices, reduces availability or reduces prevalence. It may do so but there is no evidence that it does. The figures on the effect of tougher punishment on prices show the *prima facie* implausibility of enforcement policies. There has been a ten-fold increase in the number of prisoners for violation of drug offences in a 20-year period.



It is quite impressive that the US imprisons half a million people for violation of drug offences; it provides the rhetorically nice comparison that Europe does not lock up that many people for all criminal offences. In the last 20 years there has been a decrease of almost 90% in the price of heroin and cocaine. A causal link between these figures is not suggested, but there is no evidence that increased enforcement leads to an increase in drug prices.

## EPIDEMICS

Some good work has been done by Jonathan Caulkins, with the help of researchers at Vienna University, to develop new models of epidemics that have real policy value. The work has the simple underlying notion that drug use is learnt behaviour, with current users 'infecting' non-users in a metaphorical sense. The extent and spread of drug use is a function of attitudes, and prices are a fairly minor part of the epidemic phenomenon. Epidemics burn out when the drug gets a bad reputation. Heavy users, especially of drugs like heroin, cocaine and methamphetamine are the ones that spread this bad reputation. The good news is that bad reputation seems to be a very long-lived phenomenon. There have recently been dramatic declines in cocaine and heroin prices but there has been no reignition of the epidemic, and the bad reputation is maintained. At some stage, in the beginning of an epidemic, there are a lot of new users, which suggests one set of policies may be particularly appropriate then. Later in the epidemic, when we are dealing with endemic use and we are no longer so worried about the spread of drug use, you may go to a lower level of drug enforcement and greater focus on treatment.

## SUCCESS STORIES

Can research make a policy difference? It is useful to think about areas in which values and prejudices are comparably important and in which researchers have had some success, providing us with some source of comfort. Alcohol control provides a very large amount of policy relevant research and has had real policy consequences. Ten years ago, Griffith Edwards edited '*Alcohol Policy and the Public Good'.* He summarised what is known about the effectiveness of different interventions, and generated a rich base of analysis about the effects of constraints on availability, the effects of taxation and promotion. The simplest case in which we see policy having an effect on use is in regards to the legal drinking age. Repeated and well-designed research studies measured the effects of raising the drinking age from 18 to 21. Research indicated reduced numbers of road mortalities, particularly among 18 to 20 year olds. The findings had the signal effect of raising the legal drinking age as a matter of federal policy implemented through the states.

The recent UK government policy document on alcohol, which I take to be fairly scandalous scientifically, does not reflect this well. However, you can see throughout the world that taxation and availability controls are increasingly influenced by a growing body of good quality research. This research is much easier in the alcohol control area, as you have many policy levers, and the legality of research makes it much easier. This is not an argument for legalisation, but it is certainly a consequence of prohibition that research becomes very difficult.

In the drugs field there are also a limited number of success stories. For example, at a time when a large share of the federal drug budget in the US was going into interdiction, the Department of Defence commissioned RAND to see what would

happen if it became even more involved in drug interdiction. The research group did some simulation modelling which showed it would be very difficult, even with much more effective interdiction, in terms of increasing the probability of drugs being seized and of drug smugglers being captured, to increase the price of drugs by more than 5%. The results of this research came out when Congress was considering expanding the interdiction programme, and partly as a result federal expenditures on interdiction were cut from 28% down to about 10%.

Although the study was not particularly strong empirically, it looked scientific, was published by a highly respected analytical organisation and, at the time, the Defence Department was fairly neutral on the issue. Congress was being pushed into adopting a policy, which involved passing implausible legislation that would effectively require the Defence Department to seal borders to the smuggling of drugs within 90 days. This research had an impact because it was released at the right time, under the right auspices, it had the right look to it, and people wanted to hear the message, so they took it. About ten years later, another scientific-looking study with a similar number of equations (but the wrong equations and wrong data) was released at a time when the mood had changed, it was pro-interdiction, and policy moved in the other direction. Even though the mood eventually changed, RAND's initial research was the basis of a 10-year victory for rational policy-making, which seems something to celebrate in this area.

Some research has reconceptualised the nature of the drug problem. Early research in the *Drug Use Forecasting Programme* involved a lot of modelling work, and led to the monitoring of drug use among arrestees in the US, UK and Australia. It focused attention on the fact that the bulk of consumption of heroin and cocaine, was accounted for by a narrowly-defined population confined to those that came into contact with the criminal justice system. This gave drug policy an importantly different focus, and pushed policy makers to see the centrality of crime and the importance of treatment, which is increasingly a theme of UK policy. So there certainly are instances when specific research has influenced the way drug policy is conceptualised and, in some instances, it has even made changes in the characteristics of the drug policy itself.

## HOW CAN THIS BASE BE BUILT ON?

We need to be realistic about the limitations of what research can do with a moralistically defined problem.

There is a huge research and policy mismatch between how money gets spent programmatically in the US and where the research money goes. It would be a fair estimate that the annual national drug control expenditure by federal, state and local governments is in the region of $35 – $40 billion. Considering just the federal budget, about two thirds goes on enforcement. This increases to three quarters if you include state and local budgets. In terms of research dollars, the National Institute of Justice have less than $50m, and the National Institute of Drug Abuse approximately $1bn dollars. In terms of policy-relevant research, NIDA only does treatment and prevention research. Almost nothing is spent on enforcement-focused federal research, and foundations do not like crime as it raises difficult values issues, and drug enforcement is caught up in that. Hence the mismatch between policy and evaluation.

Treatment programmes are required politically to show that they meet cost-benefit criteria but there is no such requirement with enforcement. Evaluation on the treatment side acts as a constraint, while enforcement has to meet no standards whatsoever. It is assumed that enforcement serves the public good and professionals should be left to do their jobs with no assessment: the government is acting as a moral agent. Lawyers, let alone the police, have no research tradition, and even the FBI has no analytical capacity.

## INCREASING THE INFLUENCE OF RESEARCH ON POLICY

Research should start with relevant policy questions:
*Who should be imprisoned for how long?* There should be some evidence concerning what imprisoning drug users and dealers accomplishes.
*Who should have access to treatment resources?* Currently there are circumstances in which a dependent user has to commit a crime in order to get into a treatment programme. If we are always going to have grossly inadequate resources for treatment, we should have sound criteria to direct spending.
*Are there effective interventions in producing countries?*
*Do we need to consider different policy options for substances which seem to be of little concern?* There are whole lines of drugs, which are illegal but nobody thinks about, and which are just put in the prohibited category because they always have been, e.g. psychedelics.
*Where might the results of research be accepted?* A research agenda needs to identify areas which might be accepted, e.g. avoid 'legalisation', and exploit active debates.

## IMPROVING POLICY WITH CURRENT RESEARCH

We must accept the frailty of the existing research base, but try to show the relative strength of the case for expanding treatment. We must also emphasise that harsh policies are without a good empirical base; are expensive and often inhumane; and are contradicted by such little evidence as is available.

## CONCLUSIONS

Modest victories for research should be scored highly, and we must remember that drug policy research is still very young. Reframing drugs as a health problem helps research, and research can in turn help us to achieve that reframing.