THE BECKLEY FOUNDATION
DRUG POLICY PROGRAMME

A DRUGSCOPE REPORT

ASSESSING DRUG POLICY
PRINCIPLES & PRACTICE

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REPORT TWO

DrugScope

Assessing drug policy principles and practice

INTRODUCTION

The first Beckley report, *Towards a review of global policies on controlled drugs,* put forward the case for an objective and independent review of existing global frameworks for the control of illicit drugs. The overarching objective of current UN strategy is 'a drug free world' by 2008. After decades of strong political commitment and financial investment throughout the world, there are still no signs of a significant reduction in the size of the illicit markets for drugs such as heroin, cocaine and cannabis. Increased availability of these drugs has corresponded with a massive escalation in drug-related harms: crime and public nuisance, drug-related deaths, damage to health and mental health, social costs and damage to the environment. The human costs of drug abuse are immense, the search for effective responses is urgent.

The first Beckley report expressed concern about the lack of progress so far, and the reluctance of the relevant international bodies to respond with a serious review. The history of the development and pursuit of drug policies has often owed more to ideological and political considerations than to measured considerations of evidence and experience. Things are beginning to change however. Both the UNODC and the European Union are committed to evaluating the impact of drug policies and reviewing their drug strategies in the light of the results. This is also true of national governments throughout the world. This trend is extremely positive. But the effective development of a comprehensive, evidence-based drug strategy is not straightforward, and there is still a lot to learn.

Against this background, this report considers good practice in objective-setting and evaluation; argues that drug policies should be evaluated against their successes and failures in reducing drug-related harm; and assesses the strengths and weaknesses of some existing evaluation frameworks. Once again, it is emphasised that there is no single correct approach to drug misuse, as this policy area has significant political and ethical dimensions, but it is argued that it is nonetheless possible to identify the basic constituents of *any* effective strategy.

PART ONE: TOWARDS AN EVALUATION METHODOLOGY FOR DRUG POLICY

CONSTITUENTS OF GOOD EVALUATION

Debates about evaluation may appear abstract and technical. The reality is that poor objective-setting and evaluation mechanisms will have a devastating impact on real lives. For example, if a drug strategy does not have the objective of reducing drug-related crime, then local communities that live with the day-to-day realities of open drug markets, burglary and street robbery are rendered invisible to the relevant policy community. Similarly, if there is no mechanism for assessing the effectiveness of particular policy initiatives, then huge sums of money are likely to be wasted on failed policies while effective interventions are starved of investment. Methods of evaluation matter on a practical, day-to-day level.

There are six basic constituents of an objective, evidence-based approach to drug policy.

1 Policy-makers should articulate clear, achievable and realistic policy objectives at the outset (ideally on the basis of debate amongst, and approval by, the relevant professionals and the general public).

2 Policy-makers should set a clear time frame, with dates at which progress will be reviewed.

3 Policy-makers should establish independent mechanisms for evaluating and reporting on progress against these objectives.

4 Policy-makers should ensure that independent reviews are conducted to the highest professional standards.

5 Policy-makers should be committed to communicating the results of reviews to professionals and the general public

effectively, and to promoting and encouraging open debate on their implications.

6 Policy-makers should be willing to review and, where necessary, revise drug policy in the light of the emerging evidence on effectiveness.

Overall, and as a matter of basic principle, the proposals for evaluation developed in this report assume that the way forward on drug policy is not the subject of an existing political consensus (nationally or internationally), and that, in part, this is because the evidence is not pointing clearly in any particular direction. In such circumstances, there is a clear need for on-going research, data-collection, experimentation and evaluation, and for an open consideration of options that is informed by the best available evidence from across the world. At present, too much of the policy debate is characterised by suspicion, misinformation, poor reasoning and entrenched and polarised views. More effective policy responses will inevitably emerge from a greater willingness on all sides to review successes and failures openly.

SETTING OBJECTIVES: ISSUES OF PRINCIPLE

No approach to drug policy is value-free. Even the formal principles of good evaluation practice will appeal, implicitly, to some basic ethical principles. Informed policy is vital. Reliable evidence should be acted upon, not ignored. It is a bad thing to persist with policies that are clearly failing and to fail to support policies that are clearly succeeding. Drug policy should be the subject of free and open debate.

Few would dissent from these broad commitments.

But the principles of good evaluation – important as they are – can provide no ultimate *direction* for policy in the absence of objectives against which the successes and failures of policy initiatives can be assessed.

To date, most strategies have concentrated on the simple objective of reducing the supply and consumption of illegal drugs. The evaluation of those strategies has relied on indicators of the total amount of drugs produced and consumed as estimated using proxies like street prices and drug seizures. This approach has two obvious limitations.

1 There are a range of consequential harms resulting from the production, distribution and use of illegal drugs that have a profound impact on the quality of life of individuals and communities, but are obscured by an exclusive focus on availability or prevalence.

2 There is no guarantee that these consequential harms will increase and decrease in direct proportion to trends in consumption and availability. It is possible for a decrease in drug use to coincide with a rise in drug-related harm and vice versa. For example, the level of HIV transmission associated with drug injection is only partly a function of the number of people injecting drugs (and still less of the availability of drugs in general). It also depends on whether they inject safely and with clean equipment. All else being equal, a fall in use and availability will correspond with a fall in drug-related harm. But this is not invariably or inevitably the case.

The ultimate aim of drug policy should be to reduce harm. The first Beckley report set out six harm-reduction objectives. These are expanded upon below to form the basis for a comprehensive set of key indicators that should be at the core of any mechanism for the evaluation of drug policy.
This approach does not involve 'giving up' on reducing prevalence. In many situations, reducing the overall level of drug use (or of a particular pattern of use) will be the most effective way of achieving the objectives of the policy. However, the weight of evidence of the last four decades is that it is very difficult for government initiatives to achieve sustained reductions in prevalence and these achievements are not necessarily linked to a fall in harm. (Our next report will examine the small number of historical examples where prevalence has been reduced, and attempt to draw out the policy lessons.) For the Beckley programme, as our first report stated, 'reducing prevalence is reconceived as an important means of reducing drug-related harm, and not as an end in itself'.

In this context, we are acutely conscious of the exhortation by MacCoun and Reuter that drug policy proposals should meet a 'political standard'; that is, that they should not offend the fundamental cultural or political values of a society (MacCoun R and Reuter P, 2001, pp. 12-13). Reducing the size of the illicit market, and the level of use of illegal drugs, has long been the headline aim of most drug policies. While we do not advocate abandoning these efforts, we do shift the emphasis. It could be argued that the general public in many countries would not accept the change of direction that we suggest. This may be true, and is for policy-makers to judge in their own circumstances. We are sure, however, that the shift is intellectually consistent, and that there is a growing public recognition in many parts of the world that drug control is more complex than simply a straight fight against the traffickers.

We also accept that the search for a methodologically pure and ideologically neutral evaluation tool in this field is likely to be long and ultimately fruitless. In particular, the approach to drug policy advocated here arguably has a Western and secular bias. Some religious communities will view intoxication as *intrinsically* harmful, regardless of the wider consequences, while, for others, the use of certain widely prohibited psychoactive substances has a positive cultural and religious significance.

But, within these limitations, it is entirely feasible to gradually develop a practical evaluation methodology that gives policy makers some clear evidentiary 'sign posts' to help them make good decisions. In the past, the development of highly complex methods of analysis – accompanied by lamentations about the incompleteness of existing knowledge – has too often served as a *barrier* to better policy, by providing policy-makers with a convenient excuse for ignoring the evidence on effectiveness that *is* available to them and acting on it. Policy-makers do not need vast statistical tomes. What they do need are concisely presented reviews of the emerging evidence that focus on the high-level policy issues that they are responsible for deciding upon.

WHAT OBJECTIVES SHOULD WE BE MEASURING?

So, what are the harms that should determine the ultimate objectives of drug policy? This question is addressed below with reference to the six objectives identified in the first Beckley report. It is explained why these objectives should be a focus for drug policy and some of the more specific harms that should be monitored and evaluated within each broad category are identified.

OBJECTIVE 1
To reduce the levels of crime and public nuisance associated with the production, supply, purchase and use of drugs.

Drug-related crime is generally subdivided into three separate phenomena:

1 ***The illegal trade in drugs.*** Tackling the crime associated with the illegal supply of controlled drugs has been at the forefront of drug policies for many years. Police, customs authorities, the military, and even the secret services in some countries have been engaged for decades in battles with organised crime groups in an attempt to control this trade. While there is at present no reliable way of measuring the level of violence and corruption associated with drug trafficking, it is clear, for example, that many thousands of people are killed each year around the world, either because of their involvement in the drugs trade, through fighting against it, or as innocent bystanders.

2 ***Drug-related crime.*** In most countries, a small minority of problem drug users – usually those with heavy or addictive patterns of use – raise the money to buy drugs, to a greater or lesser extent, by committing thefts, fraud and robbery. Survey methodologies are available that can track trends in the level of these drug-related acquisitive crimes. There is also strong evidence to show that it is possible to significantly reduce drug-related offending by engaging the most prolific offenders in treatment programmes.

3 ***Intoxication and behaviour.*** The way that an individual's behaviour is affected by drug use varies considerably according to the user's mood, the setting in which the drug is taken and the properties of the drug itself. There is a growing recognition that there is a particularly strong link between alcohol consumption, crime and nuisance. But many instances of crimes of violence have been reported where the perpetrator appeared to be acting under the influence of a controlled drug.

These three forms of crime differ in their causes, nature and the measures that are needed to tackle them. For example, violence associated with drug markets may be best controlled by law enforcement action, while property crime committed by drug addicts may be better reduced by offering them treatment to reduce their dependence. All three forms of crime are of concern to the public. Drug strategies should include measures to identify their extent and to assess those programmes of action aimed at their reduction.

OBJECTIVE 2
To reduce the numbers of deaths that result directly from the production, supply, purchase and use of drugs.

In the past, drug-related deaths have typically been defined narrowly as only those deaths that arise from an acute physical reaction to the consumption of drugs. This is an unacceptably narrow definition. For the purpose of evaluating drug strategies, we should be interested in three main causes of death.

1 ***Deaths caused by acute reactions to drug consumption (that is, overdose).*** These are most common in relation to the use of heroin and other opiates, but can also result from the excessive consumption of alcohol, tranquillisers, cocaine or ecstasy, as well as from the use of drugs (licit and illicit) in combination with each other. A wide range of programmes have been implemented by governments in an attempt to reduce the level of acute drug related deaths with varying degrees of success. These range from attempts to restrict the

availability of heroin (which arguably had some impact in Australia in 2001/2 – see Beckley Briefing Paper 4 for further discussion), to the provision of safer using information and environments (see Beckley Briefing Paper 3 for a review of the evidence on Drug Consumption Rooms).

2 ***Deaths from long-term health problems associated with drug use.*** Blood borne viruses (HIV and hepatitis) are discussed below. The focus here is on the chronic effects of long-term drug use on deaths due to heart, lung and liver disease. There is growing evidence that, for example, stimulant use can damage the heart. There is a great deal that is not yet known about the long-term impact on health of some drugs – this is particularly true for relatively new synthetic substances like ecstasy.

3 ***Deaths due to accidents caused by people under the influence of drugs.*** There is little evidence on the numbers of drug-related deaths in this category, and not much experience of attempts to reduce them. Recently, however, some countries have begun to extend campaigns to reduce road accidents to encompass advice, exhortation and roadside testing to deter people from driving under the influence of drugs. Similar considerations apply to deaths resulting from work place accidents in safety-critical industries (including transport). There are some surveys – and many case studies – that show a link between drug use and deaths in traffic accidents, falls and suicides.

In most countries, causes of death are classified by coroners according to the criteria published in the International Classification of Diseases (ICD) manual produced by the World Health Organisation. There are, however, significant variations between and within countries in the way that coroners record the contribution of drug use to a particular death, and this data does not cover deaths due to drug related accidents. Further research and surveys will be needed to build a fuller understanding of the extent and nature of drug related deaths. Furthermore, a satisfactory definition of the term 'drug-related death' is still under consideration.

OBJECTIVE 3
To reduce the number of people suffering physical health problems as a result of the use of drugs, particularly HIV and hepatitis infections.

A wide range of physical ailments are associated with controlled drugs. By far the greatest concern is the transmission of blood-borne infections through the sharing of equipment for drug injection in unsanitary conditions. There are survey methodologies that can reliably track levels of drug-related HIV and hepatitis infection in a given population (notably, those developed by UNAIDS). The World Health Organisation has estimated that around 30% of all HIV infections worldwide are caused in this way – and 75% of new HIV cases in Eastern Europe (WHO 2002) – and the onward transmission from drug injectors to their sexual partners is of equal concern (see WHO 2004 and UNAIDS 2004). There have been epidemics of HIV infection – which have been primarily due to drug injection – in South-East Asia, South America and – on the most worrying scale – in parts of Eastern Europe (see Beckley Briefing Paper 2). Some studies show prevalence rates of Hepatitis C to be as high as 90% amongst injecting drug users.

Both of these diseases have serious consequences for the sufferers. Despite significant advances in treatment, most sufferers eventually die from causes related to their infection. They also have significant implications for the treatment, health promotion and social welfare budgets of governments. Consistently and in a range of social and cultural settings, measures that encourage users into treatment, that provide them with information on how to avoid infection, that make clean injecting equipment easily available, and that encourage users to inject in safer environments, have proven to be effective in limiting or reducing the growth of epidemics.

OBJECTIVE 4
To reduce the number of people suffering mental health problems and addiction as a result of their use of drugs.

The primary concern here is the development of a physical or psychological addiction to a particular drug, which can undermine individual autonomy, welfare and dignity. There are a variety of definitions of 'addiction'. Increasingly, however, the classification that is being used across the world is the somewhat different notion of the 'problem drug user'(PDU). This has tended to shift the emphasis from the well being of the individual user to the wider range of problems associated with drug dependency. The EMCDDA definition of 'problem' use is 'injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines' (EMCDDA, 2003a), but the term PDU is often used, more broadly, to refer to drug use linked to crime, public nuisance and social problems.

It is important that drug strategies and evaluations do not lose sight of the particular kind of damage to the well being of individuals that results from physical or psychological dependency on a drug. In addition to consequential harms – such as crime and health damage – the fact that somebody is physically or psychologically dependent is a harm in its own right.

In addition, there is increasing concern regarding the contribution of drug use to other damaging mental health

conditions – for example, the impact of heavy cannabis use on the triggers of schizophrenia, the potential for cocaine use to induce episodes of paranoid psychosis, and the (as yet little understood) effects of ecstasy on long-term brain function. More research is needed to understand the extent of these links and the extent to which the greater availability of drugs is associated with increases in these types of mental health conditions. Bodies like the UN and the EU have an important role to play by helping to support and disseminate scientific research. The first Beckley Report emphasised the need for on-going scientific review and analysis of the effects of different substances, and for the dissemination of this evidence throughout the world. Currently, this is not being done effectively at international level.

OBJECTIVE 5
To reduce the social costs of drug use, including the impact on families and children and the numbers of people failing in education and employment as a result of their use of drugs.

Perhaps the most complex, and therefore difficult to measure, impact of widespread drug use is on the social well being of a community. It is possible that some forms of drug use (for example, recreational and occasional chewing of coca leaf in some indigenous Andean communities) cause little or no harm to social welfare and, indeed, may make a positive contribution to social cohesion. However, it is also clear that the use of illegal drugs can be linked to a wide range of social harms, from abuse or neglect of children, to failure in education or employment, or family dispute and break down. Increasingly, research has shown that these social harms are disproportionately associated with poverty and social disadvantage.

The EMCDDA's *2003 Report on the Drug Situation in the EU and Norway* includes a special focus on *Social Exclusion and Reintegration*. It reports that studies conducted in Denmark, France, the Netherlands and the UK show that up to 80% of homeless people living in shelters are drug dependent; that over half of prison inmates report using drugs in prison (54%) and around a third (34%) report injecting; and that up to 77% of people in treatment were living on social benefits (see EMCDDA 2003b, pp. 65-68). A UK study on behalf of the Advisory Council on the Misuse of Drugs – *Hidden Harm* (2003) – concluded that the lives of up to 350,000 children in the UK alone were blighted by their parents' drug problems – at a global level this will amount to many millions (ACMD, 2003). Where people lack legitimate economic opportunity this also increases the risks of involvement in the production and trafficking of drugs. An example of this is the recruitment of vulnerable women as drug 'mules'.

Policies themselves can create social costs. For example, there is strong evidence that the short prison sentences given to large numbers of drug users can entrench the social problems that trigger drug dependency problems in the first place (for example, where prisoners lose their accommodation, find it more difficult to secure employment on release or lose contact with families and other support networks). Similarly, policies that seek to punish early signs of drug use in young people can have the opposite effect to that intended (for example, by giving them a criminal record or excluding them from school).

OBJECTIVE 6
To reduce the damage to the environment caused as a result of the production, supply, purchase and use of drugs.

The impact of illicit drug markets on the environment is profound, both ecologically and socially. It ranges from damage to natural environments as a result of destruction of poppy and coca crops in countries like Afghanistan – where environmentally safe methods have not always been employed - to the despoilation of many urban environments through public drug use, discarded needles and syringes and open drug markets. The presence of air patrols in rural areas to monitor crop eradication or gang conflict in some of the world's major cities are themselves forms of environmental damage. Environmental despoliation is hard to quantify in a precise way, but it is a profoundly important form of drug-related harm. The impact of drug use, production and trafficking - and drug policies – on the environments in which people live their lives, whether rural or urban, should be a key consideration for policy-makers.

Another widely neglected issue is the impact of drug use and drug policy on what might be described as the civic and political environment. This is a particularly important issue in some trafficking countries. The illicit drugs trade is hugely profitable and is a source of vast wealth differentials in some of the world's poorest countries. This is a breeding ground for institutional corruption. Often the vast discrepancies between public service salaries (which can be inadequate in absolute as well as relative terms) and the massive hard currency returns that flow to the drug traffickers, leave police officers, judges and other public officials vulnerable to corruption. This undermines respect for the government and the rule of law in countries that are often politically unstable.

COMMENT
In formulating policies on illegal drugs, policy makers have to consider a wide range of potential harms. They are presented with a number of policy and programme options, with a varying degree of evidence of effectiveness. They need to take four further points into account.

1 The reduction (or increase) in harms will not simply result from drug policy measures, but will be a function of

broader social phenomena and policy. For example, the objective of reducing drug-related crime may be compromised by a general increase in unemployment. The relationship between drug problems, crime, health, mental health and social problems is complex.

2 An initiative that produces a reduction in one type of harm, may increase another type of harm, so trade off calculations are necessary.

3 A policy or initiative that is effective in reducing harm may violate human and civil rights, or the values and expectations of the community. Even if a policy of imprisoning suspected drug traffickers without trial had a positive impact on drug-related harm, it would be contrary to fundamental principles that bind the global community together and are explicitly recognised in UN and European Conventions.

4 Drug policies themselves can have unintended consequences that may defeat their own objectives in the longer term. For example, high rates of incarceration of non-dangerous offenders for drug offences not only puts pressure on the penal system, but tends to exacerbate problems like poverty, exclusion and family breakdown.

Given the complexity and sensitivity of the issues, it is understandable that politicians sometimes opt for policy with a simple emotional attraction that is easy to explain to the public. We now know enough, however, about the phenomenon of the use of controlled drugs and the effectiveness of government responses, to develop a more sophisticated and evidence-based set of responses.

PART TWO: A BRIEF SURVEY OF CURRENT EVALUATION PRACTICES

The second part of this report looks at a representative sample of drug strategies.

Its two main purposes are:

- to provide an overview of, and introduction to, the recent history and development of drug strategies across the world; and
- to develop some of the key themes already identified by looking critically at a range of objective-setting and evaluative methods.

It focuses on the evolution and distinctive characteristics of the drug strategies that have been developed by the United Nations, European Union, United States, Sweden, the United Kingdom and Australia. Selection has been partly determined by the linguistic competencies and specialist knowledge of the authors. But this sample is representative in the sense that it covers both international and national strategies, both prevalence-centred and harm-reduction focused strategies, and strategies that vary significantly in the range, precision and complexity of both their objectives and methods of evaluation. They are also amongst the most influential, in the sense that they have served as a model for other countries.

INTERNATIONAL STRATEGIES

1. THE UNITED NATIONS

Background

The UN Strategy was examined in the first Beckley Report – indeed, concerns about the limitations of the UN approach are one of the driving forces for the Beckley programme. In 1998, the Twentieth General Session of the UN General Assembly agreed a ten-year drug strategy, which was launched under the widely derided slogan 'A drug free world – we can do it!' Progress was subsequently reviewed at a meeting in Vienna in April 2003 at which Antonio Costa, the Executive Director of the UNODC, stated that the UN was making 'encouraging progress towards still distant goals' (UNODC 2003).

Targets

The overarching objective of the current UN strategy, then, is elimination or significant reduction in the use and availability of controlled drugs. This is to be achieved by a combination of supply-side and demand reduction measures, with three specific targets, as agreed at the 1998 United Nations Drug Summit:

- eliminating or significantly reducing the illicit cultivation of the coca bush, the cannabis plant and the opium poppy by the year 2008;
- eliminating or significantly reducing the illicit manufacture, marketing and trafficking of psychotropic substances, including synthetic drugs, and the diversion of precursors;
- achieving significant and measurable results in the field of demand reduction.

There are no specific references to harm reduction targets in the UN strategy, which represents a clear preference for reducing drug-related harms simply by the process of reducing the size of the illicit market.

However, the *UN Declaration on the Guiding Principles of Drug Demand Reduction* that emerged from the 1998 meeting also recognises the social dimensions of drug use and drug policy. It

clearly states that demand reduction programmes should 'embrace information, education, public awareness, early intervention, counselling, treatment, rehabilitation, relapse prevention, aftercare and social re-integration'. It continues: 'efforts to reduce the demand for drugs should be part of a broader social policy approach that encourages multi-sectoral collaboration. Such efforts should be comprehensive, multi-faceted, co-ordinated and integrated with social and public policies that influence the overall health and social and economic well being of people' (UNODC, 1998, *Guiding Principles of Drug Demand Reduction*, Nos 10 and 12).

Evaluation

Although the complexity of the UNODC's evaluation task is daunting, the clarity and ambition of the targets set at the 1998 UNGASS demand a serious attempt to evaluate progress. There are a number of UN instruments for monitoring and evaluation. These include Annual Report Questionnaires (ARQs), which are completed and returned by all Member States, and form the basis for the annual *Global Illicit Drug Trends* report. The UNODC has also initiated global programmes for measuring the cultivation of illicit crops (although these only cover six countries at present), and a global programme for policy and trend analysis.

In addition, the Declarations in 1998 set out a clear time frame for a mid-term review of progress in 2003 and another special session in 2008. However, serious evaluation against the headline objectives has been hampered by a number of problems.

1 The lack of clarification of definitions and counting mechanisms for the targets (as has been the case with many national strategies). While measuring the level of cultivation of coca, cannabis and opium is conceptually straightforward (if technically difficult) there is no clear methodology for measuring the scale of illicit manufacture, marketing and trafficking of psychotropic substances, and the diversion of precursors. Furthermore, it is unclear what is meant by 'significant and measurable results in the field of demand reduction' – nor were there any attempts to measure progress in this area at the 2003 mid-term review.

2 The variable quality of the information returned to the UNODC by the parties to the Conventions, with only a little over half even sending in official returns to the questionnaires issued by the UNODC. The information contained in these returns is of variable quality and reliability. There is a lack of proper epidemiological data available in many countries, making many of the returns simply the educated guesses of the authorities. Furthermore, national governments are, in effect, reporting on their own performance against the UN targets and they can hardly be considered as objective correspondents. This is exacerbated by the failure to make their returns available to public scrutiny, which would allow analysts to check government claims against the available data.

3 A clear mismatch between the returns provided by governments and the conclusions drawn. While sympathetic to the diplomatic pressures experienced by the UNODC, we cannot understand how the fact that 85% of countries reported stable or rising drug use in their territories in the 2003 review can be described as 'encouraging progress' at the mid-point towards an objective of eliminating or significantly reducing prevalence.

Comments

The UN has set strategic targets for drug policy with a focus on reducing prevalence, and has made provision for regular reviews of progress. It has invested in monitoring and research, although there are acknowledged problems with its evaluation systems. But UN drug policy has sometimes appeared to be unresponsive to the clear messages emerging from the evidence base.

The 2008 targets for production, trafficking, manufacture, marketing and demand for illicit drugs will not be met. But the UN has proven resistant to reviewing its strategy in the light of the evidence. Interestingly, a recent *Drugs and Conflict* debate paper has characterised the position as follows: 'the UN from its high position must be clear. Any doubts, hesitation or unjustified review of the validity of goals will only undermine our commitment. Our goals are noble and inflexible. We cannot retreat, we must be steadfast in our goals' (*Drugs and Conflict*, March 2003). This may make sense politically, but it is difficult to reconcile with a commitment to objective evaluation and evidence-based practice.

To refuse to review a set of objectives in the light of the evidence on whether they are achievable – even in theory – is not the responsible custodianship of global welfare to which the UN aspires.

There are promising signs that the UN may be shifting its position. The latest annual report from the International Narcotics Control Board (INCB) explicitly states that 'article 14 of the 1988 Convention requires parties to adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances, with a view to reducing human suffering. *The ultimate aim of the Conventions is to reduce harm.*' (INCB 2004, para 218 – emphasis added). Overall, while the UN has remained committed to widely derided and hugely ambitious targets for reducing use and availability, and some official pronouncements from UN bodies has to have implied a

blanket rejection of 'harm reduction' approaches, the reality is more complicated. There are now indications that the UN is beginning to move in new directions driven by the accumulated evidence.

2. THE EUROPEAN UNION

Background
The *European Union Drug Strategy 2000-2004,* adopted by the EU Council of Ministers in December 1999, is in marked contrast to the UN strategy. There are no promises of a drug free Europe. Harm reduction targets take their place alongside targets for prevalence and availability. While most of the key policies, actions and expenditure decisions in the EU are taken at national level, the EU strategy represents a shared commitment by member states to a set of principles underpinning drug policy and strategy, and a major step towards an approach that takes account of the full range of drug-related harms in determining policy objectives and evaluating effectiveness.

Targets
The EU Drug Strategy 2000-2004 articulates six objectives against which the progress of both European institutions and individual member states are measured:

- to significantly reduce the prevalence of illegal drugs over a five-year period;
- to substantially reduce the health damage associated with illicit drugs;
- to substantially increase the number of successfully treated drug addicts;
- to substantially reduce the availability of drugs;
- to substantially reduce drug-related crime;
- to substantially reduce money laundering and the trafficking of precursor chemicals.

This was one of the first strategies to articulate a clear set of fundamental objectives, striking a balance between prevalence and harm-reduction targets. This achievement was particularly remarkable because the objectives were agreed by all 15 member states, in spite of their differing views on how best to achieve them.

Evaluation
The 2000-2004 strategy explicitly incorporated a commitment to objective evaluation of these outcomes, and of the activities implemented at EU level.

Despite promising beginnings, progress on objective evaluation has been disappointing. When the six EU objectives were first announced, it was acknowledged that work needed to be done to agree precise definitions, indicators and procedures so that progress could be reported promptly and consistently by member states, and evaluated by EU institutions. For example, no decision has been made on what aspects of 'drug-related crime' should be measured. Nor is it clear what is meant by reducing 'availability' of drugs (for example, is this is to be assessed by estimating the size of the illegal market or the ease with which citizens can get hold of drugs?). Lack of clarification of objectives makes it difficult for states to report consistently on policy achievements.

The original strategy required a review of progress to be conducted at the end of 2002 (the "mid-term" review) and 2004. These reviews have been conducted by the European Commission and the EMCDDA. The mid-term review, which was published in November 2002, did not make any attempt to present a statistical analysis of progress against the six strategic objectives. This is not really surprising as there was little new information on how the situation had changed since 1999 due to the time lags between collection and analysis of statistics. A further two years on, it is a matter of growing concern that a meaningful evaluation framework has still not emerged. The final evaluation of the existing strategy is due to be published in October 2004, as part of the process of developing a new strategy to run from 2005 to 2012. It is to be hoped that the final evaluation document makes a serious attempt to measure progress against the six original objectives.

Comments
Member states and European agencies have highlighted methodological barriers to sophisticated analysis and evaluation. But there are ways to examine and assess progress against the sorts of objectives specified by the EU which can provide information of sufficient sophistication to inform policy decisions and political debate. Overall, despite the lack of a clear evaluation framework, there is sound research evidence from the EU over the last five years to show that, even though the desired reduction in prevalence has not been achieved, some policy initiatives are proving effective in reducing harms associated with drug use. More work should be done with the new EU Drug Strategy, due to be agreed in December 2004, to track progress against objectives, and understand which government initiatives and activities are effective.

Another weakness of the EU approach has been a failure to involve relevant experts and to engage the general public. Both EU review processes and the wider consideration of the drug strategy, have been almost exclusively conducted within the institutions of the EU and amongst government officials representing the member states. This may help to explain the tendency to concentrate on the institutional, methodological and 'process' aspects of the strategy, at the expense of outcomes. Of particular concern, the EU electorate has little knowledge of

what is being done on its behalf to tackle drug and drug-related problems, or of the effectiveness of the policies of the EU. There is a clear democratic deficit here, with surveys across Europe consistently showing that drug problems are a major issue of concern for ordinary Europeans.

NATIONAL STRATEGIES

1. THE UNITED STATES: MOVING TARGETS

Background
The emphasis of federal drug policy in the US has been subject to sharp and sudden changes over the past four decades depending on social, cultural and political factors and particularly on the political complexion of the White House. The USA has published 19 different national drug strategies in the last 25 years, each with its own set of priorities and targets. In the 1970s, a succession of US Presidents (Democrat and Republican) 'considered it impossible to eliminate the drug problem entirely and instead took the approach of reducing drug use consequences or harms by focusing on the most dangerous drugs' (Carnevale J and Murphy P, 1999).

In the 1980s and early 1990s – initially under the Presidency of Ronald Reagan – there was a complete change of direction. The emphasis shifted to a 'tough' law enforcement approach with the focus on reducing use and availability. Harm reduction measures were portrayed as an admission of defeat in the 'war against drugs'. During the Clinton Presidency in the 1990s, there was a temporary flirtation with the sort of approach that had dominated the 1970s. Drug abuse was identified as a public health problem, with five and ten year targets for reducing drug-related crime, public nuisance, health and social problems. The targets set in the *1998 National Drug Control Strategy*, included a 15% reduction in the rate of crime associated with drug trafficking and use by 2002; a 30% fall by 2007; a 10% reduction in the health and social costs associated with illegal drug use by 2002 and a 25% reduction by 2007. Since 2002, the Bush Presidency has abandoned the Clinton strategy (which was originally intended to run until 2007), including the PME assessment system (see below), and has re-focused US federal policy on reducing prevalence, with a particular emphasis on 'recreational' drug use by young people.

Since 1988, the overarching objectives for US drug policy have been formally determined by the Office of National Drug Control Policy (ONDCP), which was established by the Reagan administration's *Anti Drug Abuse Act*, with the stated aim of creating a 'drug free America' (perhaps the provenance of the UN slogan). The ONDCP is an Executive Office of the President and its Director is the President's chief spokesperson on drug control.

Targets
The three main goals for the US drug programme as stated by the ONDCP on its website are:

- to reduce illicit drug use, manufacturing and trafficking;
- to reduce drug related crime and violence; and
- to reduce drug-related health consequences.

The Bush White House has set three key priorities for drug policy (see White House, 2004):

- stopping drug use before it starts – including encouragement for students' drug testing and a National Youth Anti-Drug Media Campaign;
- healing America's drug users – by improving treatment and getting more people into treatment; and
- disrupting the market – law enforcement and other supply-side initiatives.

Since 2002, there have been two measurable targets, both focused on prevalence:

- to reduce youth drug use by 10% within two years and 25% within five years; and
- to reduce current use of illegal drugs by adults by 10% within two years and 25% over five years.

In 2004, it was claimed that the two-year goal for young people had been exceeded, with a *Monitoring the Future* survey showing an 11% fall in past month use of illicit drugs by young people between 2001 and 2003 (*Monitoring the Future 2003*, as cited in White House 2004).

Evaluation
The US Government spends more on research and evaluation of drug control related topics than any other country. However, the fundamental policy questions regarding progress in reducing drug use and related harm remain unanswered. In terms of prevalence, this is ironically the result of a surfeit of evaluation instruments, each producing regular survey results on the drug use of certain sections of the population, using a range of key indicators, and covering a wide range of substances. Outside of a few clear and generally accepted trends (for example, a reduction in overall drug use prevalence during the 1980s), the normal picture produced by this raft of data is of complex and constantly shifting drug use trends. At any given point in time, this information can encourage the optimist with an improving figure or confront the pessimist with a new threat.

Conversely, there is a paucity of regular surveys on trends in drug-related harms in the United States. There is no clear trend data on the number of problem drug users – a group not

adequately covered through general surveys – or on the level of drug-related crime or health damage.

The most serious attempt to broaden the focus of drug policy evaluation – the Performance Measurement of Effectiveness (PME) system, introduced with the Clinton strategy in 1998 – was perhaps overambitious in its technical complexity (see ONDCP, 2002). As is currently being experienced with the evaluation of the European Union drug strategy, reports from the PME have emphasised the methodological difficulties of producing 'pure' measures of effectiveness. It is, therefore, unsurprising that, when presented with a mass of complex and contradictory evaluation material, President Bush was able to abandon the previous administration's objectives and its painstakingly developed evaluation system. This has continued the cycle of the announcement of clear objectives and timescales in successive US drug strategies, followed by their abandonment when the political masters change, with little or no review of progress against them.

Comment
Current US federal drug strategy is characterised by its pre-occupation with prevalence and the absence of both harm reduction targets and any prioritisation of the more problematic forms of drug use. Current US drug policy documents are providing little detailed information on progress in reducing drug-related harms. For example, there is not a single reference to HIV in either the 2003 or 2004 National Drug Control Strategies. Targets for crime, health and social costs – which were included in the 1998 strategy – have not figured since 2002.

The best indicators are that drug-related harms remain widespread in the US. The 2002 PME report on the 1998 strategy concluded that, while progress had been made in reducing drug-related crime, the targets for health and social costs were off-track. There are over a million heroin addicts in the US. Recent research concludes that 'in some areas of the country, particularly around New York City with its large heroin addict population, the HIV rate among IDUs is close to 50%. Hepatitis, both B and the more newly discovered C strain, is rampant among IDUs' (MacCoun R and Reuter P, 2001, p. 22). There are also concerns about the negative consequences of what has often been a highly punitive approach to drugs. About a quarter of all US citizens who are sent to prison are there for drug offences, creating a massive pressure on federal and state budgets that is increasingly recognised as a factor in inhibiting investment in other social policy priorities (for further discussion, see *ibid*, pp. 24-32).

2. SWEDEN: A SUCCESS STORY IN THE 'WAR ON DRUGS'?

Background
Swedish drug policy has been characterised by a broad political consensus on two points: (i) that substantial reductions in the use of controlled drugs can be socially engineered; (ii) that reductions can be achieved by an uncompromisingly 'tough' approach that makes no concessions to 'harm reduction' policies. Sweden, like the USA, is explicitly committed to a 'drug free society'. The architects of Swedish drug policy believe that their experience has demonstrated that this is not an empty slogan, but an achievable policy goal. Since the late 1960s, penalities for drug offences have increased in Sweden and drug *use* itself has been criminalised (with urine and blood tests administered where people are suspected of drug use). The Swedish authorities claim that comparatively low levels of drug use in their country – and apparent sharp falls in the 1970s and 1980s – are evidence of the effectiveness of this approach. Equally striking are high levels of public support for 'tough' drug policies. For example, a recent survey of Swedish 16 to 24-year-olds found that over 90% opposed decriminalisation of cannabis.

Targets
Sweden now has a National Drug Policy Co-ordinator and a National Action Plan on Drugs, which was endorsed by the Swedish parliament in 2002 to run to 2004.The objectives of the National Drug Policy Co-ordinator are (i) prevention, (ii) to make quality treatment and rehabilitation available, (iii) to reduce the availability of drugs.

The key activities identified as priorities in the National Action Plan adopted in 2002 are:

- development of new school based prevention programmes;
- targeted interventions for vulnerable groups;
- appropriate assistance for drug addicts;
- action in the prison and probation service; and
- information and opinion-formation campaigns.

The specific objectives for treatment provision are to ensure that:

- every drug abuser can access treatment;
- advice and help reach those in need early in their drug careers;
- treatment results in a life free from drugs (abstinence);
- treatment is of good quality; and
- treatment is available for as long as it is needed.

Evaluation
The Action Plan has been criticised for its lack of precise and

measurable targets, and certainly the collection and evaluation of information on drug trends is less well-developed in Sweden than in many other countries (see, for example, Lenke L and Olsson B, 1999). This partly reflects the fact that responsibility for the development and implementation of drug policy is not subject to the same degree of central control as in many other jurisdictions, with responsibility devolved to local level. It also reflects the comparatively low level of drug use in Sweden and the widespread conviction that this is due to uncompromising law enforcement.

Things are starting to change, however. In 2000, the Swedish Drug Commission expressed its concerns about the lack of evidence-based practice and evaluation in Sweden and stressed the need to improve methods for the collection, analysis and dissemination of statistics on drugs and drug-related problems (*ibid*). In Sweden's 2002 report to the EMCDDA, a number of problems with Swedish mechanisms for collecting and evaluating data were commented on. These included: a lack of systematic data on the costs of Swedish drug policy; a shortage of epidemiological studies on severe drug abuse; a lack of systematic sources on the health status of drug users; a shortage of recent data on the social costs of drug use; the unavailability of estimates of total consumption, demand for drugs, expenditure on drugs, street prices, purity etc.

Comment

The Swedish drug strategy does not include the sorts of harm reduction targets outlined and discussed in Part One of this report, nor are there any proper systems in place to measure trends in drug-related harm. Thus, commenting on the drug strategy in 2003, a leading Swedish newspaper – *The Expressen* – declared that drug policy in Sweden was an article of faith, and had not been subject to analysis and review in the light of the evidence. It might be responded that this is testimony to the effectiveness of Swedish drug policy, which has meant that drug problems are far less widespread than in, say, the UK, United States or Australia. In fact, there is no conclusive evidence that low prevalence in Sweden is actually the result of its approach to drug policy. It is equally plausible to suggest that its rejection of harm reduction and its comparatively under-developed mechanisms for monitoring progress are themselves the result of low prevalence, not *vice versa*, and that this is itself largely a reflection of broader geographical, economic, social and cultural factors. Nor are there any grounds for complacency about the levels of drug-related harm in Sweden, which are not being routinely monitored at the moment. The 2002 Swedish report to the EMCDDA estimated, for example, that the number of people in Sweden who required hospital care for drug-related problems more than doubled between 1987 and 2000, from 1,800 to 4,500 and that more than half of the 9,200 people in prison in 2000 were drug users, of which 75% were severe drug users.

3. THE UNITED KINGDOM: HARM REDUCTION WITH A FOCUS ON CRIME

Background

The UK has seen a consistently high level of drug use since the 1970s, with prevalence rates amongst the highest in Europe, and comparable with those of Australia and the USA. The UK has also been prominent in the development of new trends in drug use in Europe, such as the rise in ecstasy and other club drug use in the late 1980s and the recent increases in the use of cocaine and crack.

What is perhaps most striking about UK policy, especially compared to countries like Sweden and the USA, is the explicit focus on 'problem drug use', and especially on the links between drug dependency and offending. The updated version of the UK drug strategy, which was published in 2002, begins with a blunt assertion of the need for 'a tougher focus on Class A drugs'. In the Foreword to this document, the UK Home Secretary, David Blunkett, focuses on drug-related harms, particularly crime. He writes: 'the misery [of hard drug use] cannot be underestimated. It damages the health and life chances of individuals; it undermines family life, and turns law-abiding citizens into thieves, including from their own parents and wider family. The use of drugs contributes dramatically to the volume of crime as users take cash and possessions from others in a desperate attempt to raise the money to pay the dealers' (Home Office, 2002).

The UK has only begun to articulate a national strategy to tackle drug problems relatively recently. The first truly national document, *Tackling Drugs Together*, was published in 1995 by a Conservative government. At the same time, a co-ordination unit was established by the national government to oversee activities aimed at reducing the country's drug problem. When the Labour government of Tony Blair came to power in 1997, they declared that drug policy would be one of their social policy priorities, appointed a high-profile drug 'czar', and produced a new, comprehensive 10-year strategy. Although the strategy underwent a process of updating in 2002, and the drug czar experiment was ended in 2001, most of the principles and activities established in the 1998 strategy document – *Tackling Drugs to Build a Better Britain* – remain at the core of drug policy in 2004.

Targets

Four key strategic objectives were articulated in *Tackling Drugs to Build a Better Britain*, and a range of government-supported activities were listed to be implemented during the early years of the strategy. The strategic objectives were:

- to reduce the prevalence of the use of illegal drugs, particularly among young people;
- to reduce the crime committed by drug users to fund their

purchases;
- to increase the number of people receiving treatment for drug problems; and
- to reduce the availability of drugs at street level in the UK.

The 1998 strategy set clear numerical targets, including, for example, a 50% reduction in drug use amongst young people by 2008.

In 2002 the strategy was updated. The 2002 strategy itself acknowledges that the approach set out in 1998 was not followed through. Some of the targets used were not clearly defined, and no clear methodologies emerged for baseline setting and measurement of progress. The original targets were reviewed in 2002, and replaced by a set of more operational objectives.

The 2002 strategy commits the Government to delivering on a range of outputs. These include, for example, creating capacity to treat 200,000 problem drug users by 2008, doubling the numbers of offenders on Drug Treatment and Testing Orders by 2005 (these court orders were introduced by the *Crime and Disorder Act 1998* as an alternative to imprisonment. They require offenders to participate in treatment programmes and to come off and stay off drugs) and ensuring co-ordinated systems of aftercare are in place in every local area for people leaving drug treatment or prison by 2005.

Evaluation
The UK strategy has been notable for its attempt to produce a comprehensive 'logical framework' within which the wide range of government and civil actions aimed at reducing the harm caused by drug use in the UK were intended to operate – what were the fundamental objectives, how would they be achieved, and what funding the government would provide. A strong commitment was also made to tracking progress against these objectives and to development of the evidence base. The focus on evaluation remains a feature of the UK strategy, and the structures set up for its implementation, but the 'logical framework' established in 1998 has gone.

The drug strategy objectives, while admirable in their intent, have been a somewhat confused list of process and outcome measures. The precise numerical targets (for example, to reduce prevalence of drug use amongst young people by 50% over 10 years) were widely considered as unrealistic, leading many professionals to question the appropriateness of such precise measures.

The process of developing practical methods and indicators to measure effectiveness against objectives has been only partially implemented in the UK, with still no agreement on how the crime and availability objectives should be measured. However, there has been some progress. In particular, regular school and household surveys allow prevalence to be tracked in accordance with international norms, and the numbers of drug users who are being provided with treatment are monitored annually. But overall this has to be seen as an opportunity missed.

In the late 1990s, there was public debate on whether the national drug strategy had the right objectives, and whether the targets were achievable. However, no review of progress against the original four objectives has been published to date and the government has produced little evidential basis for public or professional debate on the effectiveness of the current strategy, despite an annual investment of over £1 billion per year. The updated drug strategy only partially addresses these problems, and the process of updating the strategy did not include formal consideration of progress against the 1998 objectives or any public or political debate on progress achieved.

Comments
The evolution of the UK strategy has been groundbreaking in its focus on reducing drug-related harms. In the 1980s, the swift introduction of harm reduction initiatives – such as needle and syringe exchange – to prevent the spread of HIV/AIDs means that the UK now has one of the lowest rate of infection amongst injecting drug users in the EU, at around 1%. More recently, the emphasis has been on crime and public nuisance. Although there is no specific methodology for measuring it, there are indications that drug-related crime is being reduced. Prevalence targets have proven more illusive. No sophisticated method for measuring drug availability has been identified. But it is clear from the limited information available that overall prevalence has remained broadly stable in the UK, with variations in individual drug trends (for example, reductions in ecstasy use and increases in crack use).

4. AUSTRALIA: HARM REDUCTION AS A GUIDING PRINCIPLE

Background
The foundation to the Australian drug strategy was laid in 1985, with the Government's decision to take a comprehensive integrated approach to drug control, striking a balance between supply and demand reduction activities. Drug strategies are implemented over five year periods, and have been independently evaluated since 1997. The recommendations of the first evaluation led to the adoption of the *National Drug Strategy Framework* (NDSF) as the foundation for all future policy developments.

The 1997 evaluation celebrates the achievements of the drugs strategy, such as the development of the National Drug and Alcohol Research Centre into a leading research institution.

Targets
The 'almost unique stance' taken in Australia is characterised by four key features:

1 adoption of harm reduction as the overarching principle based on acceptance that drug abuse can never be totally eradicated;

2 the comprehensiveness of the approach encompassing the harmful use of licit drugs, pharmaceuticals, illicit drugs and other substances (inhalants and kava);

3 the promotion of partnerships between health, law enforcement, and education agencies, community based organisations and industry;

4 the commitment to a balanced approach between supply, demand and harm reduction, and between the Commonwealth, States and the Territories.

In addition, the National Drug Strategy highlights the wider issues of social justice and welfare. It aims to set drug control interventions in a broader context. The particular needs of minority and marginal groups are recognised, and local communities are involved as strategic partners.

The 1998/9 – 2002/3 drug strategy sought to operationalise the four principles through 12 specific objectives:

1 to increase community understanding of drug-related harm;

2 to strengthen partnerships;

3 to strengthen links with other strategies;

4 to reduce drug supply and use;

5 to prevent the uptake of harmful drug use;

6 to reduce drug related harm for individuals, families and communities;

7 to reduce the level of risk behaviour associated with drug use;

8 to reduce the risks to the community from drug related crime and antisocial behaviour;

9 to reduce the personal and social disruption, loss of quality of life, loss of productivity and other economic costs associated with the harmful use of drugs;

10 to increase access to high quality services;

11 to promote evidence-based practice through research and training;

12 to develop mechanisms for the dissemination of research.

Evaluation
The impact of drug policy in Australia is being tracked by a wide and diverse set of data sources. These include prison statistics for drug related offences, surveillance data from the National HIV Centre and data on drug related morbidity. In addition a series of national household surveys has been initiated.

Comments
It has been claimed that 'Australia has one of the most progressive and respected drug strategies in the world' (Single E and Rohl T, 1997). Certainly, it has a long history of producing and reviewing strategy. It has produced drug strategy documents since the mid-1980s and has submitted them to a meaningful review process since the early 1990s, far earlier than most other jurisdictions. More recently, it has led the world on developing review procedures that are independent of Government. Since 1997, it has led the way by commissioning external strategic evaluations (it has since been followed only by Portugal).

There are, however, limitations to the available data and it is often difficult to map existing data sets onto the identified objectives. In particular, the evaluators report an 'inability to obtain readily available information on the harms associated with drugs, particularly illicit drugs … and the concentration of available data on trends in drug use rather than harms associated with use of drugs' (Single E and Rohl T, 1997). This last limitation is a serious difficulty given that the cornerstone of the National Drug Strategy is the principle of harm minimisation. In addition, and in common with the UK strategy, the 12 objectives identified in the current strategy are a combination of process and outcome indicators, and simple institutional aspirations.

One change that has been attributed to the strategy is the reduction of HIV prevalence among injecting users from 3% in 1994 to 0.9% in 2001. There was also a decrease in heroin overdose deaths from 958 in 1999 to 306 in 2001, with prices reportedly rising from $40-$300 a gram over the same period. However, it is yet to become clear to what extent, if at all, these achievements are attributable to law enforcement efforts or effective public health measures (for a more detailed discussion, see Beckley Briefing Paper 4).

CONCLUSION

This survey of existing drug strategies raises a number of more general issues.

1 ***Precision of targets and objectives.*** If objectives are too vague, then politicians and other policy-makers have more latitude to avoid facing up to policy failures. But there are also problems with objectives that are too precise, especially if they specify strict numerical targets to be achieved by set dates (say, a 50% fall in drug use over 10 years). There is an unconvincing randomness about these kinds of targets (why 10 years, not 8 or 12 for example?) and they can also result in major achievements (say, a 40% fall in 12 years) being represented by political opponents simply as a failure to hit the pre-ordained target. Furthermore, if performance against numerical targets becomes the main criteria for evaluating policy, the debate will tend to become dominated by statisticians and technocrats, excluding the general public and obscuring the key trends and issues.

2 ***Political change.*** In the United States, the Clinton Presidency published a detailed 10-year National Drug Control Strategy in 1998, with targets on crime, public nuisance and health. With the election of George W Bush in 2002, this strategy was abandoned. This illustrates two general points. First, in the absence of political consensus, the development of long-term strategies and targets (say, for 10 or 25 years ahead) can be a way of avoiding rather than ensuring political accountability. Second, given the waste of resources, and the negative impact on those working in the drug field, associated with sudden changes in policy it is important to build the maximum level of political consensus. A national drug strategy should aim to set long-term goals on the basis of a consensus between political parties – ideally, with formal processes for cross-party endorsement – but stick to shorter-term objectives and evaluations for policy initiatives that are not supported by other major political stakeholders. The ideal, of course, is to move to a position where there *is* a high level of consensus on the aims of drug policy. This should be a natural by-product of better evaluation practices, so long as there is agreement on the importance of an evidence-based approach.

3 ***Evidence-based evaluation.*** It is important to be clear that the development of strategies and methods of evaluation is itself an evidence-based practice, which builds on expertise and experience. A decade ago many drug policy specialists argued that it was important to set precise numerical targets and monitor performance through highly sophisticated evaluation systems. This has proven much more difficult than was originally anticipated, and has had some unanticipated negative consequences. So, the balance of opinion now favours broader policy objectives and more transparent and accessible forms of evaluation. The business of strategy development and evaluation itself is a matter of trial and error, the gradual evolution of best practice and an openness to learning from experience.

The strategic evaluation of drug policies at national and international levels is improving. Governments and international agencies are increasingly willing to articulate the objectives of their policies, and to set out proper timescales and processes for the review of progress. The definitions and methodologies required to provide meaningful analysis of effectiveness are being refined and improved, so as to provide the evidence base for decisions on policy direction. However, there is still a long way to go if future drug policy is going to be based on objective assessment of the evidence.

A summary report of the global experience so far might read: while most policies and strategies set out objectives and timescales, in only a few instances has a meaningful attempt been made to measure and report on progress when the promised reviews are due. It is hard to avoid the conclusion that this reluctance to openly review progress is linked to the fact that most objectives have aimed exclusively at a reduction in the supply and use of controlled drugs and, regrettably, these objectives have generally not been achieved. Politicians are understandably reluctant to publicise policy failures that could be seized on by their opponents. This is one reason why it is important to begin to develop common approaches to drugs that span the political divide. While there will always be a place for principled political disagreement about drug strategy, everyone should be able to agree on the importance of reducing harm and the need to be guided by the best available evidence in developing policy.

What is needed now, as well as the political commitment to review progress openly, is to further refine methodologies and ensure that the best evaluative practice is promoted. The international community, including the United Nations, could play a more pro-active role in this process as champions and facilitators of evidence-based drug policy – for example, by providing resources and expertise to help less affluent states to develop their evaluation and research capacity. Drug policy should not be the exclusive preserve of politicians, experts and diplomats. The drug-related harms identified by the Beckley programme will affect hundreds of millions of people right across the world – users, families, neighbourhoods and communities. The issues need to be better understood and more widely debated. The challenge is to find effective ways to communicate the emerging evidence on drug use and drug policy to ordinary people, and to convey a sense of the profound importance of these issues for all of us.

REFERENCES

Advisory Council on the Misuse of Drugs (2003), *Hidden Harm – responding to the needs of children of problem drug users*, Home Office, London.

Carnevale J and Murphy P (1999), 'Matching rhetoric to dollars: twenty-five years of federal drug strategies and drug budgets', *Journal of Drug Issues*, No 29(2).

EMCDDA (2003a), *National prevalence estimates for problem drug use in the European Union 1995-2000, EMCDDA project CT.00.RTX.23 – Final report – Volume 1 – results*, EMCDDA, Lisbon.

EMCDDA (2003b), *Annual Report 2003: The state of the drugs problem in the European Union and Norway*, EMCDDA, Lisbon.

Home Office (2002), *Updated Drug Strategy 2002*, Home Office, London.

INCB (2004), *Report 2003*, United Nations, New York.

Lenke L & Olsson B (1999), 'Swedish drug policy in perspective' in Derks J, Van Kalmthout A and Albrecht H J (eds), *Current and future drug policy studies in Europe*, pp 135-166, Max-Planck-Institut fur Auslandisches und Internationales Strafrecht.

MacCoun R and Reuter P (2001), *Drug war heresies – learning from other vices, times and places*, RAND Studies in Policy Analysis, Cambridge University Press, Cambridge.

ONDCP (2002), *2002 Final Report on the 1998 Drug Control Strategy – Performance Measures of Effectiveness*, ONDCP, Washington.

Single E and Rohl T (1997), *The national drug strategy: mapping the future*, Australian Government Publishing Service, Canberra.

UNAIDS (2004), *2004 Report on the Global Aids Epidemic*, UNAIDS, Geneva.

UNODC (1998), *Political Declaration: Guiding Principles of Drug Demand Reduction and Measures to Enhance International Co-operation to Counter the World Drug Problem*, UNODC, Vienna.

UNODC (2003), *The Executive Director – 'Encouraging progress towards still distant goals' – Progress report by the Executive Director as a contribution to the mid-term (2003) review of UNGASS*, UNODC/ED/2, 8 April 2003, UNODC, Vienna.

White House (2004), *National Drug Control Strategy 2004*, White House, Washington.

World Health Organisation (2002), *Tuberculosis, HIV/AIDS and Malaria*, Regional Committee for Europe, Fifty-Second Session, EUR/RC52/9, WHO Regional Office for Europe, Copenhagen.

World Health Organisation (2004), *Harm Reduction Approaches to Injecting Drug Use*, WHO, Geneva.

Drugs and Conflict Debate Paper No 6 (March 2003), *An agenda for Vienna – change of course* (Editorial), The Transnational Institute, Amsterdam.

USEFUL WEBSITES

www.internationaldrugpolicy.org

www.beckleyfoundation.org

www.drugscope.org.uk