Through the looking glass

Evidence-based policy rightly forms the backbone for how we tackle problem drug use. But we must recognise the limits of a purely scientific approach, says **Marcus Roberts**.

It is undesirable to believe a proposition when there is no ground whatsoever for supposing it is true
Bertrand Russell

Before you walk out that door, prove I don't love you no more
Aretha Franklin, 'Prove it'.

The Wikipedia entry for 'evidence-based policy' suggests that it "can be traced back as far as the fourteenth century, but it was more recently popularised by the Blair government in the United Kingdom". The attempt to trace a line of historical provenance from the Black Death to the No 10 Policy Unit deserves full marks for historical sweep, nor perhaps is it entirely fanciful. But the specific association of evidence-based policy with New Labour suggests that something has been happening in the UK in the last 10 years or so that would have been less conspicuous in the court of Edward III.

In 1999, a White Paper declared that the new government would strive to "produce policies that really deal with problems, that are forward-looking and shaped by evidence rather than a response to short term pressures". By 2006, Rebecca Boden and Debbie Epstein observed in their paper, Managing the research imagination? Globalisation and research in higher education, that "routines of evidence-based policy making have been hard-wired into … government" in the UK, but proceeded to coin the pejorative term 'policy-based evidence' to describe what they saw as a "fundamentally flawed" process, where "government … seeks to capture and control the knowledge producing process".

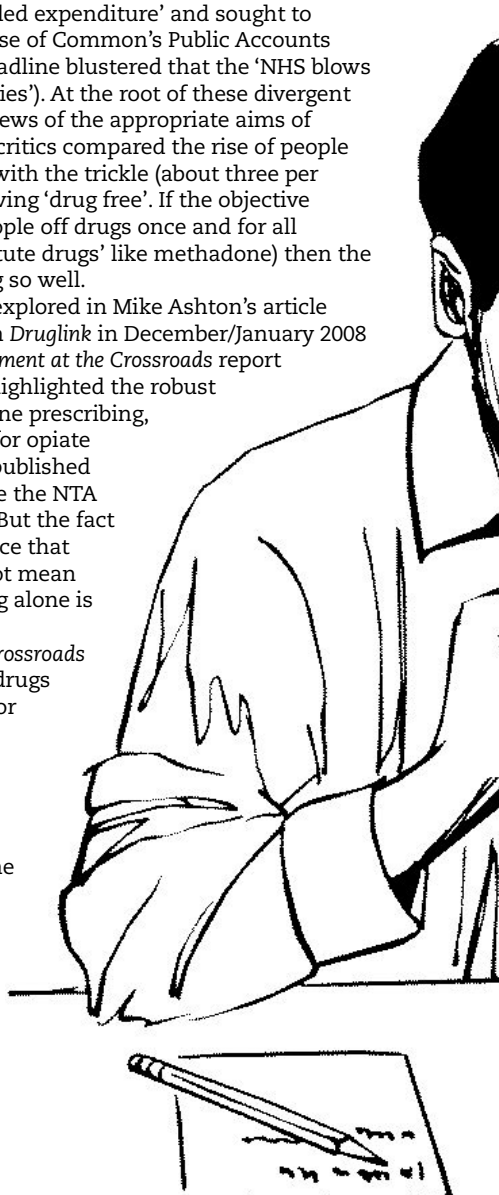
Drug policy provides fertile terrain for assessing the results and prospects of 'evidence-based policy'. At the core of DrugScope's mission over the past 10 years has been a commitment "to ensure responses to drug use are based on evidence of what works", in an area where "sensationalism and misinformation" constantly threaten to overwhelm a rational assessment of the evidence.

The value and the boundaries of evidence-based policy were a key issue in the furore which followed the publication of the National Treatment Agency's (NTA) annual report in October 2007. The NTA was able to announce that numbers in treatment had more than doubled since 1998, waiting times had been slashed, most people in services were staying long enough to make real progress and acquisitive crime was in decline too.

In response, the then Shadow Home Secretary, David Davis, declared that these figures revealed that investment in drug treatment was 'massive failed expenditure' and sought to refer the matter to the House of Common's Public Accounts Committee (while a *Sun* headline blustered that the 'NHS blows £130 million curing 70 junkies'). At the root of these divergent responses were different views of the appropriate aims of drug treatment. The NTA's critics compared the rise of people going into drug treatment with the trickle (about three per cent) completing it and leaving 'drug free'. If the objective of treatment was to get people off drugs once and for all (including so-called 'substitute drugs' like methadone) then the system was not performing so well.

These arguments were explored in Mike Ashton's article 'The New Abstentionists' in *Druglink* in December/January 2008 and DrugScope's *Drug Treatment at the Crossroads* report in March 2009. The report highlighted the robust evidence base for methadone prescribing, which was recommended for opiate dependency in guidelines published by NICE only months before the NTA report sparked the debate. But the fact that there is clinical evidence that methadone 'works' does not mean that methadone prescribing alone is adequate or acceptable.

A core message of the *Crossroads* report was that substitute drugs may provide a base camp for recovery, but should not be used as a form of chemical warehousing – not least, because people with drug problems typically have multiple needs. This was the rational kernel at the core of the New Abstentionist case. The evidence-base can tell us a lot about means to ends, but less about what the

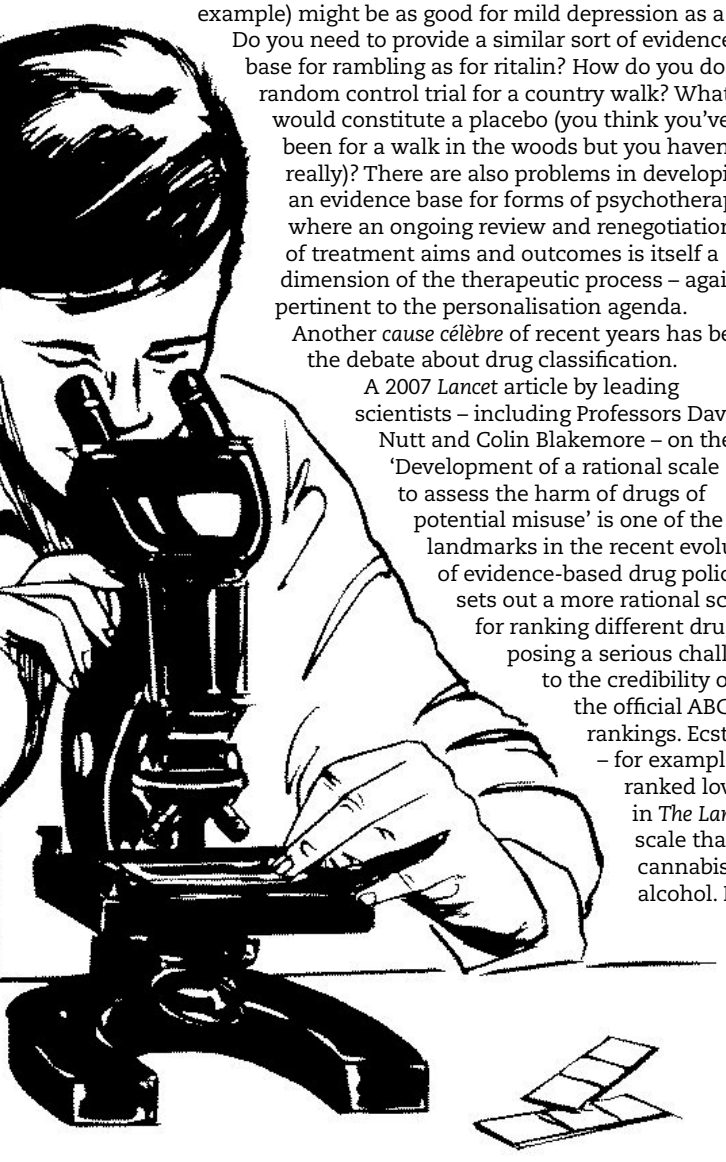


ends should be – although it has an important role in helping to determine what goals are realistic. There can, of course, be evidence-based approaches to bad goals.

Two further issues arise in the context of the New Abstentionist critique. First, there is a widespread allegiance to both 'evidence-based' policy and service user involvement (including the so-called 'personalisation' agenda). A lot of service users appear to want abstinence now. But what if research evidence and clinical judgement suggests this is unrealistic? What if service users want 'alternative' therapies? This is not to imply that service user involvement and evidence based practice are irreconcilable – they most definitely are reconcilable, and both should be at the core of drug policy. It is to suggest, however, that there are some difficult questions about how we best reconcile the two, and that these have not really been resolved.

Second, the development of a relatively robust evidence base for substitute prescribing (for example) is partly a reflection of the focus of research investment at a particular time. What gets researched will, in turn, be shaped by the priorities that are driving public policy (for example, a focus on reduction of drug-related crime might favour methadone maintenance prescribing more than a focus on social re-integration would).

When I was working at the mental health charity Mind we had trouble making the argument that 'green exercise' (a walk in the country or a spot of gardening or fishing, for example) might be as good for mild depression as a pill. Do you need to provide a similar sort of evidence base for rambling as for ritalin? How do you do a random control trial for a country walk? What would constitute a placebo (you think you've been for a walk in the woods but you haven't really)? There are also problems in developing an evidence base for forms of psychotherapy where an ongoing review and renegotiation of treatment aims and outcomes is itself a dimension of the therapeutic process – again pertinent to the personalisation agenda.



Another *cause célèbre* of recent years has been the debate about drug classification. A 2007 *Lancet* article by leading scientists – including Professors David Nutt and Colin Blakemore – on the 'Development of a rational scale to assess the harm of drugs of potential misuse' is one of the landmarks in the recent evolution of evidence-based drug policy. It sets out a more rational scale for ranking different drugs, posing a serious challenge to the credibility of the official ABC rankings. Ecstasy – for example – ranked lower in *The Lancet* scale than cannabis or alcohol. It is arguable, however, that this exercise revealed almost as much about the limits of an evidence-based approach to comparative harm as it did about what one would look like.

In the end, how meaningful or useful is it to determine whether, say, cocaine is more harmful than ketamine or alcohol is more harmful than LSD or tobacco? Why go beyond describing the various harms of each substance and attempt to place them in a league table? It is only the current legal framework that makes comparative harm a compulsory topic for drug policy. It has consumed a huge quantity of scientific endeavour and expertise in the last decade – is this game worth the candle? And David Nutt's dismissal as chair of the Advisory Council on the Misuse of Drugs by the then Home Secretary Alan Johnson in 2009, of course, raised basic questions about the relationship between science and politics that remain unresolved.

DRUG POLICY MUST BE GUIDED BY EVIDENCE AND REASON – THIS, AS THEY SAY, IS A NO-BRAINER. BUT WE ALSO NEED TO RECOGNISE THE LIMITS OF SCIENCE TO PROVIDE CLEAR ANSWERS ON DRUG POLICY

Drug policy must be guided by evidence and reason – this, as they say, is a no-brainer. But we also need to recognise the limits of science to provide clear answers on drug policy. The term 'wicked' has recently been coined to refer to public policy issues that are resistant to any final and irrevocable solution. In the words of Brian Head in his 2009 paper, *Evidence-based policy: principles and requirements*: "these systematic and complex problems are marked by value divergence, knowledge gaps and uncertainties, and complex relationships to other problems… One of the features of complex social problems is that that there are underlying clashes of values, which are sometimes not adequately recognised and addressed."

If the last 10 years have seen evidence-based policy gain real ground (constantly vulnerable to the pull of its dark matter in the form of 'policy-based evidence'), perhaps the next stage in the long evolution of the evidence-base from the 1300s to the 21st century is to embrace this kind of wickedness?

As we're on the subject of original sins and the evidence base, the last word goes to another aphorism from Bertrand Russell: "If a man is offered a fact which goes against his instincts, he will scrutinise it closely, and unless the evidence is overwhelming, he will refuse to believe it. If, on the other hand, he is offered something which affords a reason for acting in accordance to his instincts, he will accept it even on the slightest evidence."

It is worth fighting to defend every inch of ground gained in the battle for evidence-based drug policy in the last decade. But we would all do well to be more attentive to the psychology of policy debate too – nobody ever has or could confront a research programme or a table of figures in a way that is wholly unmediated and unsullied. And, of course, we are operating in a democratic polity in which governments are constrained by priorities and ideologies, pledges and preferences.

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