

Drugs – facing facts

The report of the RSA Commission
on Illegal Drugs, Communities and Public Policy



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Communities and Public Policy

March 2007

RSA

RSA

Encouraging enterprise
Moving towards a zero-waste society
Developing a capable population
Fostering resilient communities
Advancing global citizenship

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The views expressed are not necessarily those of the RSA or its Trustees.

The RSA encourages the development of a principled, prosperous society. Through a far-reaching programme of projects and events promoting creativity, innovation and good practice, and with the support of its diverse network of influential Fellows, the RSA challenges convention, provokes debate and instigates lasting change.

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Further details on the RSA Commission on Illegal Drugs, Communities and Public Policy are available at the website www.rsadrugscommission.org

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RSA Commission on Illegal Drugs, Communities and Public Policy

Terms of Reference

Objectives

- 1.1 To examine, as an independent body, all aspects of the relationship between public policy and the use and abuse of illegal drugs.
- 1.2 In pursuit of the RSA manifesto challenge ‘fostering resilient communities’, to investigate, among other things, the practical impact of current drugs policy on communities.
- 1.3 To encourage informed discussion among those with a particular interest in policy on the misuse of drugs – legislators, policy-makers, the police, the medical and legal professions, service providers, academics, private companies, educators and the media.
- 1.4 To raise the level of public understanding and debate about public policy on the use and abuse of illegal drugs.

The commission is expected to decide its own mode of working which may include:

- a. determining topics for briefing and research papers to inform its deliberations
- b. publishing briefing papers, research papers and reports as may be thought appropriate
- c. inviting written or oral evidence from individuals and organizations with particular experience of the issues under discussion
- d. convening seminars of experts in the field for discussion of the issues
- e. staging public lectures to promote awareness and debate of the issues under discussion
- f. visiting organizations or individuals affected by public policy on drugs – in the fields, among others, of education, treatment and criminal justice
- g. devising a plan for the dissemination of its findings.

Terms of Reference

The commission is asked to:

- a. look for answers to two questions:
 - i. if current policy and practice on illegal drugs are not working, why not?
 - ii. what might be done to improve policy and practice?

- b. publish a report incorporating its answers in the form of recommendations
- c. enter into discussions with interested parties and current stakeholders, including the Government, on how its recommendations might be implemented.

For these purposes, “illegal drugs” is taken to include benzodiazepines and glue and to exclude alcohol and tobacco.

Operation of the Commission

The commission has been established by the RSA as an independent body and is not expected to represent the views of the Trustees or staff of the RSA; nor can it be taken to do so.

The commission has been established as an interdisciplinary and wholly impartial body, and is not expected to represent the views of any one political party or other body.

The commission’s internal meetings will be confidential. Meetings held with an audience will be conducted under the Chatham House Rule: the proceedings may be reported, but no statement will be attributed to any individual without their express consent, nor reported if its authorship is obvious even if it remains unattributed.

The commission’s research will be conducted ethically. All discussion of the ideas of others will be appropriately referenced. Anyone invited to take part in research undertaken by the commission will be offered confidentiality and anonymity.

The RSA will provide the commission with the resources essential to carrying out its work.

The RSA will provide the Secretariat of the Committee and take responsibility for:

- i. administrative coordination
- ii. financial support
- iii. commissioning the briefing papers or other research required by the commission
- iv. publishing or co-publishing the commission’s report
- v. implementing the plan for disseminating the commission’s recommendations.

The RSA Commission on Illegal Drugs, Communities and Public Policy

Biographies

Chair

Anthony King has been Professor of Government at Essex since 1969 and has also taught at Princeton and the University of Wisconsin, Madison. His books include *SDP; The Birth, Life and Death of the Social Democratic Party (with Ivor Crewe)*, *Running Scared: Why America's Politicians Campaign Too Much and Govern Too Little and Does the United Kingdom Still Have a Constitution?* (the 2000 Hamlyn Lectures). Professor King writes regularly for *The Daily Telegraph* and broadcasts frequently on politics and elections for the BBC. He served between 1994 and 1998 on the Committee on Standards in Public Life (the Nolan Committee, latterly the Neill Committee) and in 1999–2000 served on the Royal Commission on the Reform of the House of Lords.

Project Champion

Stephen O'Brien is Joint President of London First, whose mission is to engage business in promoting and improving London. From 1983–1992, he was Chief Executive of Business in the Community and he continues as Vice President. He is also, among other posts, Chairman of Tower Hamlets Primary Care Trust, President of the University of East London Development Fund, a Trustee/Director of Teach First and Chair of International Health Partners (UK) Ltd. Prior to leading business involvement in community work, his business career culminated as Chairman of Charles Fulton Holdings and Chairman of the Foreign Exchange and Currency Deposit Brokers Association. Former community activity included Chairman and Co-founder of Project Fullemploy and Co-founder of Cranstoun, the drug rehabilitation charity. He was awarded the CBE in 1987.

Members

Susan Deacon has been MSP for Edinburgh East and Musselburgh since the creation of the Scottish Parliament in 1999 and was Scotland's first Minister for Health and Community Care following devolution. She established and is Co-Convenor of the Cross Party Group on Sexual Health and has served on a number of Parliamentary Committees. In her earlier career, Susan worked at a senior level in local government, management consultancy and in higher education. Susan has spoken and written widely on a range of public policy issues and has a particular interest in the management of change.

John Dixon is Director of Adults' Services for West Sussex County Council. He has been Director for nine years, and has over 30 years' experience in the Probation Service and in Social Services. John has recently been elected Vice President of the new Association of Directors of Adult Social Services. He is the Association of Directors lead on drug and alcohol services. John's background is in substance misuse services – his first social work job was with Cranstoun Projects as a residential worker.

Philip Johnston has been the Home Affairs Editor of *The Daily Telegraph* since 1997. He started in journalism in 1981 as the Political Correspondent for Thomson Regional Newspapers. Between 1985 and 1988 he was the Political Correspondent for *Today* newspaper, before moving to become Political Correspondent on *The Daily Telegraph* in 1988.

David McCoy graduated as a medical doctor from Southampton University. He worked as a junior doctor for two years before spending ten years working in South Africa. He has a doctorate in public health from London and is now active in the international public health field. He is co-managing editor of *Global Health Watch*, a bi-annual alternative world health report, and writes and speaks on a variety of topics including the research and development of medicines, health systems policy and global health governance. He has recently been working as a public health registrar in London, during which time he helped develop a mental health strategy for Haringey.

Helen Mountfield is a barrister at Matrix Chambers. She specialises in public law and human rights, including European and international law. She has a particular interest in medical law, the law of education and social welfare law. She is the co-author of "Blackstone's Guide to the Human Rights Act 1998" (4th edition, 2007, OUP), editor of the *Education Law Reports* and on the editorial board of the *European Human Rights Law Review*. Helen also talks, broadcasts and lectures widely on legal and human rights issues.

Fatima Roberts is a community worker, working primarily in women's services and with sex workers. She has also been involved in substance misuse education for younger children.

Steve Rossell is Chief Executive of Cranstoun Drug Services, a national voluntary sector provider of drug treatment and rehabilitation services within residential, community and criminal justice settings. Prior to his association with Cranstoun Steve had worked within the voluntary sector and substance misuse field, since 1988. His previous experience within the substance misuse field includes: the provision of high care residential treatment and rehabilitation; client service delivery in ‘street agencies’, needle exchanges and community outreach settings; drug work within the criminal justice system, in both the UK and Europe; and, the development and management of community-based drug and alcohol services. Steve is a member of the Institute of Directors, a Director/Trustee of the European Association of the Treatment of Addiction (EATA) and a Fellow of the RSA.

Joan Ruddock has been MP for Lewisham Deptford since 1987. She rose to national prominence in the early 1980s as Chair of CND. Joan’s career in Parliament has included a number of opposition spokesperson roles including transport and the environment. She was the first full-time Minister for Women in the new Labour government in 1997. She is now a member of the International Development Select Committee.

Nigel South is Pro-Vice Chancellor (Academic and Regional Development) and a Professor of Sociology and Criminology at the University of Essex, Colchester. His research interests include illegal and legal drug use and related health and crime issues. He has reviewed drug treatment programmes involving vocational and educational opportunities, and studied drugs (and wider) illicit markets. More broadly, he has interests in crime, inequalities and citizenship, as well as public health and interdisciplinary health and community safety initiatives. At the University of Essex he has served as Director of the Health & Social Services Institute, Head of the Department of Health & Human Sciences and as the Director for Health Partnerships.

Andy Taylor lives in Stroud, Gloucestershire, where he runs a small conservation company called Conservation Care. Andy has had close associations with drug treatment facilities and self-help groups over a period of years. He currently works in a voluntary capacity with a number of these and is involved at street level with helping and supporting addicts to find ways to get and stay clean. Due to his work at the forefront of drug addiction he is very aware of the issues of drug abuse and its effects on individuals, families and society as a whole.

Clyde Williams is the Chairman of 2XL Recruitment & Training. Clyde's career includes working with IBM across Europe, Middle East and Africa to facilitate their sales transformation and IT alignment processes. Clyde established a London Computerland franchise, which grew into a network of 14 branches across the UK, and employed 400 staff. Clyde is co-author of *Computers can be Managed* and *The PLATFORM*, which offers a common language to improve communications between technical and non-technical staff.

John Yates is Assistant Commissioner, Operational Services Business Group, Metropolitan Police Service. Since joining the Metropolitan Police Service in September 1981 he has held, among other posts, the position of Staff Officer to Sir Paul (now Lord) Condon throughout the period of the Macpherson Inquiry into the death of Stephen Lawrence; Commander of the Crime portfolio for Territorial Policing, with responsibility for street crime, burglary and rape investigations; Deputy Assistant Commissioner for Serious & Organised Crime, with responsibility for homicide, child protection, tackling organised criminal networks, gun crime and covert policing and he is ACPO lead on rape and serious sexual offences. He also led the UK policing response following the South East Asia Tsunami on Boxing Day 2004.

Executive summary

This summary falls into two parts. The first provides a brief summary of the report as a whole. The second sets out the Commission's main recommendations and proposals.

The Commission was appointed as an independent body under the auspices of the RSA and started work in January 2005. Its members are drawn from various fields and disciplines, some from the policing and treatment of drug abuse, but others from business, local government, health and social services, parliament, the professions and academia. The Commission has not conducted its own research or held public hearings but has made extensive use of the large volume of material that is already available. In addition, we have consulted widely and taken advice from a range of experts in the drugs field.

The reader should note that our focus is mainly on English practice in the field of drugs policy, although we refer frequently to Scottish, Welsh and Northern Ireland practice. We are conscious that, although the statute law relating to illegal drugs applies to the whole of the United Kingdom, the actual development and implementation of policy outside England are largely in the hands of the devolved administrations.

Part I Summary

- 1 People have always used substances to change the way they see the world and how they feel, and there is every reason to think they always will. The idea of a drugs-free world, or even of a drugs-free Britain, is almost certainly a chimera. The main aim of public policy should be to reduce the amount of harms that drugs cause. These harms include harms to the health of individuals, to friends and family, to whole communities and, not least, harms that take the form of crime.
- 2 For these purposes, the concept of 'drugs' should be extended to include alcohol, tobacco, solvents and a range of over-the-counter and prescription drugs. All psychoactive substances, not just illegal drugs, can cause harms and do.
- 3 Unlike most other such substances, however, illegal drugs have been demonized – by politicians, by the media and to some extent by the general public. Illegal drugs and drug users are frequently depicted as evil and a threat to society. In our view, demonization does more harm than good. Our view is that society's approach to illegal drugs and to those who use them should be calm, rational and balanced.

4 It needs to be recognized that illegal drugs are a business, a business that, though illegal, operates in most other ways like any other large-scale business. It operates in a global market. That market is highly competitive. Marketing of its products is intensive. The intensity of competition ensures that prices remain low. Far from illegal drugs being expensive because they are illegal, they are in fact remarkably cheap – and their prices, instead of rising, tend to fall. There is no reason to think that the illegal-drugs business and its accompanying market can simply be closed down. Certainly all efforts so far to close them down have been dismal and often expensive failures.

5 The use of illegal drugs, both problematic and non-problematic, is by no means confined to any one section of the population. Although a majority of drug users are young, an increasing number are old. A majority of drug users are boys and men, but drug use is increasing among girls and women. Drug users live in rural areas and small towns as well as big cities. A majority of drug users are white, and the evidence suggests that, although drug use is rising in some black and Asian communities, the incidence of drug abuse is lower in black and minority ethnic communities than among the white population. Drug use is also to be found in all social classes, with more and more drugs crossing the ‘class divide’ in both directions.

6 The use of illegal drugs is by no means always harmful any more than alcohol use is always harmful. The evidence suggests that a majority of people who use drugs are able to use them without harming themselves or others. They are able, in that sense, to ‘manage’ their drug use. They are breaking the law in possessing illegal drugs, but they are not breaking the law in any other way. The effects that drugs have depend to a large extent on the individuals who use them, the drugs that they use, the ways in which they use them and the social context in which they use them. The harmless use of illegal drugs use is thus possible, indeed common. Nevertheless, all illegal drugs, like all other psychoactive substances including alcohol and tobacco, carry risks. Some people die as a result of their misuse of drugs, many more are made ill, some of them very ill, and drug use can compound, as well as be caused by, problems of mental health. Drug use and crime are closely associated. The cumulative costs to society, including in purely monetary terms, are enormous.

7 Why do people use drugs? They do so for all kinds of reasons: to have fun, to enjoy the company of friends, to relieve pain, even as a means of spiritual enlightenment. Some people simply experiment. Sadly, in the case of some individuals, whatever their

initial reasons for using drugs, they become dependent upon them. Problematic drug users are to be found in all sections of society (rich as well as poor, old as well as young), but they are disproportionately to be found among the poor, the jobless, the homeless, young people who have been in care and those who are in one way or another socially excluded. Although no one has succeeded in identifying an ‘addictive personality’, some people are more likely than others to become dependent on drugs, legal or illegal, especially if they have difficulty in dealing with pain, stress, uncertainty, loneliness, frustration and boredom.

8 Much that is true of the reasons why people use illegal drugs is, of course, also true of the reasons they use alcohol, tobacco and other substances; and users of alcohol and tobacco may well become dependent users. Indeed, in their different ways, alcohol and tobacco cause far more harm than illegal drugs. For that reason, we recommend that illegal drugs, alcohol, tobacco and other psychoactive substances should be brought within a single regulatory framework, one capable of treating substances according to the amount of harms they cause.

9 The medical profession at one time took the lead in developing and administering drugs policy in the UK. However, in recent decades the lead role has increasingly been played by the Home Office, the police and other law-enforcement agencies. What was once conceived of primarily as a health problem is now seen to a large, even an overriding extent, as a crime-prevention and criminal-justice problem. To the extent that the two approaches sit together, they sit together uneasily. The substantial volume of drugs legislation and regulation enacted in recent years suggests that successive governments have recognized that their approach and their initiatives have been less than wholly successful.

10 One major difficulty with current policy is that, while much of the rhetoric is prohibitionist (that is, it advocates total abstinence from illegal drugs), much of the implementation of policy accepts that drugs will be used and seeks to reduce the amount of harm they cause. Current policy, at best, gives mixed messages and, at worst, is dishonest. Moreover, in skewing the implementation of policy in the direction of the criminal-justice system, current policy neglects other approaches: those centred on individual health, public health, families, education, housing, social care and so forth. What we have is a system centred on crime and the criminal-justice system. What we should have is a more holistic system, one that explicitly acknowledges that any approach that has total prohibition as its principal objective is bound to fail.

11 In an ideal world, it might be desirable to halt altogether the importation of illegal drugs into this country and the production of them within this country. In an ideal world, it might also be desirable to halt their distribution and sale in this country. None of these things, however, is possible and at the moment large amounts of money are wasted in attempting to achieve the impossible.

12 In our view, the success of drugs policy should be measured not in terms of the amounts of drugs seized or in the number of dealers imprisoned but in terms of the amount of harms reduced. The fight against the supply of illegal drugs should not stop, but it should be refocused so that it concentrates on organized criminal networks rather than on largely futile efforts to interdict supply.

13 The ideal way of reducing the demand for illegal drugs would be, of course, to discourage people from wanting to use them. One of the best ways of reducing the amount of actual harm caused by them is to alert people to the risks that the use of them entails. As in other connections, current policy is confused, telling people to say no but also telling them what to do if they decide to say yes. Ministers should publicly acknowledge that they are both trying to discourage people from using illegal drugs and trying to encourage those who do use them, or are thinking of using them, to use them sensibly and safely.

14 In the field of drugs education, there has been too little evaluation for anyone to be certain what works, but it is clear that much of it fails to achieve its objectives. Too much of it is inconsistent, irrelevant, disorganized, couched in inappropriate language and delivered by people without adequate training. The 'Just say no' approach has manifestly not worked. In the Commission's view, the aims of policy should be, of course, to alert people to the risks of using drugs at all, but also to postpone first use, if any, until as late a date as possible. We recommend that drugs education should be focused more on primary schools and less on secondary schools, and that more heightening of knowledge and awareness of drugs should take place outside the formal school setting.

15 For the reasons already alluded to, we believe that policy on the use of illegal drugs and other psychoactive substances including alcohol and tobacco should in future be pragmatic rather than moralistic, with its means well adapted to its ends. It should be aimed, above all, at reducing harms. It should be honest and straightforward in its statement of aims. It should be consistent and coherent. It should not be ghettoized as in

some ways it is now but should be given greater prominence in the context of broader social policy.

16 ‘Treatment’ in this context encompasses, or should encompass, the need to address the full range of drug users’ needs, not only their physical and mental-health needs. The delivery of treatment has improved considerably in recent years, but the present position is still not satisfactory. Availability of treatment varies widely across the country. Much treatment is wasted. Government-mandated targets are inappropriate. Not least, those who have committed a criminal offence have easier access to treatment than those who have not. A user of illegal drugs who commits a crime and who gets caught has a better chance of receiving treatment than someone who, apart from possessing drugs, has not committed any offence. At present, people who commit offences and who are non-problematic drug users are actually getting preferential treatment over those with problematic drug use who have not committed any other offence.

17 The Commission draws attention to a wide range of ways in which drugs treatment services could be improved. We recommend that access to treatment should be made easier for non-offenders, that access to residential rehabilitation should be improved, that specialist drugs treatment should continue to be provided but that it should be closely related to and supportive of drugs treatment in mainstream health and other social services, that GPs should no longer be able to opt out of providing drugs treatment, that the government’s alcohol and drugs strategies should be merged, that more emphasis should be placed on treatment better tailored to meet the needs of women, members of ethnic minorities and families as a whole, and that more attention should be paid to ‘wraparound’ services such as employment and housing.

18 As regards the criminal justice system, the Commission believes the policy of universal testing on arrest is ineffective, wasteful and ultimately unsustainable and recommends that it should be abandoned forthwith. Greater use should be made of specialized drug courts.

19 In addition to problems with policy as it now exists, there are major problems with the way in which policy is delivered. The wrong data are collected. Information is not shared among different agencies when it should be. Local Drug Action Teams lack sufficient clout and are inadequately resourced. Initiatives and plans are heaped one upon another. Far too much money that should be used for treatment and other support services drains away into target-meeting and bureaucracy.

20 The Commission believes that reform should start at the top and recommends that the Home Office should no longer be the lead Whitehall department dealing with drugs policy. The lead department should be the Department of Communities and Local Government. Only in that way can the current criminal-justice bias of the whole system be corrected. The Home Office or the Department of Justice, if one is created, should continue to play a large role, but it should not be the lead role.

21 More generally, we believe that, administratively as well as in policy terms, the government should bring all psychoactive substances, whatever their legal status, under the same umbrella. Illegal drugs should no longer be treated as a special case.

In addition, much more should be done at the local level to encourage and enable local authorities and local communities to take responsibility for the substance-abuse problems in their areas. At the moment, central government, at least in England, stifles local initiatives and requires local bodies to administer centrally determined policies regardless of local circumstances. We recommend that serious consideration should be given to making local Drug Action Teams statutory bodies and to giving them enhanced status, authority and responsibilities. The lead role within them should probably be given to local authorities.

22 The law as it stands is not fit for purpose. The principal statute, the Misuse of Drugs Act 1971, is now more than thirty years old. It is unwieldy, inflexible and at some points addresses problems that no longer exist. It fails to embrace alcohol, tobacco and other harmful substances. It is driven more by 'moral panic' than by a practical desire to reduce harm. It relies too heavily on discretion in its enforcement. It sends people to prison who should not be there. It forces people into treatment who do not need it (while, in effect, denying treatment to people who do need it). Efforts to implement the law as it stands waste a great deal of money. Not least, the law as it stands embodies a classification of illegal drugs that is crude, ineffective, riddled with anomalies and open to political manipulation. We recommend that the Misuse of Drugs Act 1971 and the subsequent legislation associated with it be repealed and be replaced by a comprehensive Misuse of Substances Act.

23 The new Misuse of Substances Act should acknowledge that, whether we like it or not, drugs are and will remain a fact of life. On that basis, the aim of the law should be to reduce the amounts of harms caused to individuals, their friends and family, their children and their communities, certainly by alerting people to the risks of using potentially harmful drugs as far as that is

possible. The use of criminal sanctions should be confined to the punishment of those offences connected with drugs that cause the most harm, and only the most serious drugs-related offences should attract custodial sentences – and those sentences should be long rather than short.

24 The focus of the law should not be on individual drugs as such – as with the existing ABC classification – but on the harms that drugs cause. The new law should be flexible and capable of being adapted to take account of new drugs and new scientific findings in relation to drugs. It should require ministers to take into account the best available scientific evidence relating to drugs and their use. If ministers reject the advice of their scientific advisers, the new Misuse of Substances Act should require them to state formally and publicly their reasons for doing so.

25 We recommend that at the heart of the new law should be an index of substance-related harms. The index of substance-related harms should take into account not merely the substances themselves but the people who use them, the ways in which they use them and the kinds of crimes, if any, that are associated with them. The index should underlie not only the law itself – and the choice of penalties to be imposed for drugs-related offences – but also other aspects of government policy relating to drugs and other harmful substances, including education, the determination of policing priorities and the allocation of funds for different kinds of treatment and harm-reduction programmes.

26 Drafting our proposed Misuse of Substances Act and its associated index of substance-related harms is beyond our competence, and we have not attempted to do so. It is for ministers, on the basis of the best available scientific evidence, to determine how the new law should be drafted and how in detail individual potentially harmful substances should be regulated. On the basis of the large-scale survey of the general public that we commissioned from the polling organization YouGov, we believe that the general public knows more about drugs and is readier to contemplate changes in the laws relating to drugs than most politicians realize and that ministers and other political leaders have more room for manoeuvre than they think they have.

Part II Main recommendations and proposals

The government's National Drug Strategy is up for review in 2008. Now is the time for a substantial rethink of drugs policy.

What should drugs policy be like?

- Drugs policy should be better integrated into broader policy, not ghettoized in some ways as it is now. Policy on substance misuse needs to remain a high priority but in a different way: not singled out for separate treatment but absorbed into the policy mainstream. That said, care needs to be taken, especially in the early stages, to ensure that the special needs of problematic drug users are taken fully into account. Drugs policies should be better integrated into policies in such areas as social exclusion, housing and homelessness and regeneration, just as they are increasingly being integrated into policies on children and young people.
- Drugs are a broad social issue, not exclusively a crime issue or a health issue. Just as social exclusion contributes both directly and indirectly to problematic drug use, so problematic drug use is an important component in social exclusion. Drugs should be seen at least partly as an issue for communities to handle for themselves at the local level. The ‘communities’ strand of the drug strategy should be revived, rehabilitated and broadened.
- Drug use should be seen in the context of our use of alcohol and tobacco, which is often far more harmful. Drugs policy should, like our policy on alcohol and tobacco, seek to regulate use and prevent harm rather than to prohibit use altogether. Illegal drugs should be regulated alongside alcohol, tobacco, prescribed medicines and other legal drugs in a single regulatory framework. The remit of the Advisory Council on the Misuse of Drugs, or any similarly constituted body, should be extended to include alcohol and tobacco.
- The aim of drugs policy should be to reduce harm. The widest possible promotion of harm reduction measures should be an integral component of a pragmatic drugs policy. For example, drug consumption rooms should be made available where it is in the public interest to do so.

Reducing supply (Chapter 10)

- The fight against the supply of illegal drugs should not stop, but it should be refocused so that it concentrates on organized criminal networks rather than on largely futile efforts to interdict supply.
- A larger proportion of the criminal justice expenditure within the drugs budget should go into recovering criminal assets and investigating the financial systems that support drugs trafficking. There should be more Financial Investigation Units within police services, financed from assets recovery at the local level.
- Police services should use the local Prolific and Priority Offenders schemes more systematically to tackle the problems

- of drug supply and demand in their localities.
- Police services should be given more specific drug-related performance indicators, with targets linked to local conditions and possibly related to the local PPO scheme.
- These targets should be shared with other agencies.

Discouraging demand (Chapter 11)

- The emphasis in school drugs education should be shifted away from Key Stages 3 and 4 and onto primary education, as a part of a wider move towards developing general awareness of health issues and decision-making capabilities in young children.
- Identifying the conditions for potential drug misuse should form a standard part of early interventions to support the development of young children.
- The only practical message for universal drugs education, in the later stages of secondary education at least, is harm reduction.
- A greater proportion of the resources that go into increasing awareness and discouraging the abuse of drugs should be spent on work outside schools to reach young people in their own social settings and should focus on those who are most vulnerable to getting caught up in either using or supplying illegal drugs.

Treating problematic use (Chapters 12-13)

- Drugs treatment should be viewed primarily as a health and social issue and should be less heavily influenced by the demands of the criminal justice system.
- Drugs treatment should be located within a public health framework that emphasizes not only clinical treatment but also the ‘wraparound’ services that enable people to overcome dependency: housing, education, employment, child care and family support.
- Access to treatment should be as easy for drug users who have committed no other offence as it is for drug-using offenders.
- Specialist drugs treatment should continue to be provided, but it should be closely related to, and not separated off from, mainstream health and other social services.
- Drugs treatment should be included in the annual list of NHS priorities.
- There should be easier access to treatment through primary care. GPs should not have the option, given to them in the recently revised GP contract, of completely opting out of providing drugs treatment. The important role of other providers within the health service, such as pharmacists, should be recognized.
- Drug users should have a greater range of treatment options, including:

- heroin prescribing wherever appropriate, as an essential component in a policy aimed at reducing drug-related harms, including crime;
- a better and more consistent standard of methadone prescribing, for the same reasons;
- easier access to residential rehabilitation;
- more effective support in the community;
- a wider availability of good quality counselling and psychological therapies;
- better resourced self-help methods such as web-based therapy packages;
- treatment for whole families.

Front-line providers need to be in a position to offer these options. If such options are not available, ‘user involvement’ means very little.

- Treatment services need to be better tailored to specific groups: for example, women, black and minority ethnic groups, drug users in rural areas, older users, stimulant users and polydrug users.
- There should be better integrated services:
 - for alcohol and drug treatment, as in other European countries;
 - for people with a dual diagnosis of drug and mental health problems;
 - for parents and children.
- Treatment in prisons should be improved as a matter of urgency. Funding should be made available to support the Department of Health’s new proposals.
- Wraparound services should also seek to provide a wider range of options.
 - Employment should be an integral part of treatment, not tacked on to it at the end. There should be a far wider spectrum of employment opportunities provided by the statutory, voluntary and private sectors.
 - Housing must be recognized as critically important in sustaining the gains made through treatment. On grounds of cost-effectiveness as well as grounds of principle, more funds should be earmarked for drug users from the Supporting People fund.
- The criminal justice system should be used in a more strategic way to get people into treatment. Universal drug testing on arrest for trigger offences should be abandoned. The Drug Interventions Programme should be restricted to the confines of the Prolific and Priority Offenders scheme. Drug courts should be extended, under the aegis of the government’s current community justice initiative.
- Treatment effectiveness should be measured in terms of more humane and realistic outcomes.

Improving delivery of drugs policy (Chapters 15-17)

- Many drug services need to be devolved to a greater degree (though some specialist services such as high care residential rehabilitation may benefit from improved regional or national commissioning and delivery).
- Services need to be better tailored to local needs. They require joined-up working at the local level.
- The lead in developing the UK drug strategy should be removed from the Home Office:
 - because giving the lead to the Home Office brands drugs principally as a crime issue;
 - because in delivering policy in England the Home Office favours centralized solutions that impede delivery of a devolved, joined-up policy.
- To reinforce the view that drugs are primarily a social issue, and one to be handled at the local level through multi-agency partnerships, the lead in the drug strategy should be given to the Department for Communities and Local Government, the department with responsibility for combating social exclusion, for promoting partnership working at the local level and for overseeing local authorities.
- Drug Action Teams should be given an enhanced status and profile. In order to ensure a holistic approach to the problems surrounding illegal drugs, attention should be given to making DATs work more effectively as bodies that cross disciplines and sectors.
- DATs should be given statutory powers and responsibilities.
- DATs should be disentangled from Crime and Disorder Reduction Partnerships and represented on Local Strategic Partnerships in their own right.
- Local authorities should be given a leading role within DATs.

A new legal framework (Chapters 18-21)

- The Misuse of Drugs Act 1971 is no longer fit for purpose. It should be scrapped and replaced with a new Misuse of Substances Act that:
 - sets drugs in the wider context of substance misuse alongside alcohol, tobacco and other psychoactive substances;
 - is linked to an evidence-based index (reviewed on a regular basis) that makes clear the relative risks of harm from individual substances;
 - seeks to focus punishment mainly on harmful behaviours stemming from drug use rather than the simple possession of drugs.

Introduction

Drugs policy in its present form has largely been a failure. We know it has substantially failed because in the nearly four decades since the Misuse of Drugs Act came into force the number of addicts and others dependent on drugs has soared and the social problems associated with substance abuse have worsened dramatically.

We seek in this report to begin the process of revolutionizing the way in which policy makers in Britain tackle the problems associated with the use and abuse of illegal drugs. We do so not by advocating instant solutions and eye-catching panaceas but by recommending an entirely new approach to the problems posed by both illegal drugs and other psychoactive substances such as alcohol, tobacco and tranquillisers.

We are conscious that on this issue, as on most others, policy makers do not start with a clean slate. They find themselves weighed down by a heavy load of laws, regulations, administrative arrangements and habits of mind inherited from the past. Fresh thinking is difficult. Putting fresh thoughts into practice is, if anything, even more difficult. Policy makers could not shed the whole burden they have inherited from the past even if they wanted to. The question for policy makers is never 'Where do we go?' but always 'Where do we go from here?' We have been acutely aware throughout our deliberations that change almost always comes incrementally and that we should never allow the best to become the enemy of the good. We hope that, when they look back in five or ten years' time, those who work in the drugs field – and politicians and officials who work in the same field – will believe that this report contributed significantly towards broadening the public debate about drugs and introducing greater realism and rationality into drugs policy.

As readers of our report will quickly discover, all of our recommendations and suggestions are founded on two core beliefs. One is that drugs and other psychoactive substances are simply not going to go away. People have used them for thousands of years, widespread demand exists, supply is plentiful, and the illegal-drugs industry, not to mention the alcohol, tobacco and legal drugs industries, are among the best organized and most market-oriented in the world. Prohibition is no more a viable policy in Britain today than it proved to be in America during the 1920s and 1930s. With regard to illegal drugs, young people, in particular, are often told 'Just say no'. That may sometimes be good advice. The only trouble is that there are, and always will be, large numbers of people who, for whatever reason, ignore

that advice and choose to say yes. Drugs are a fact and, in our view, need to be accepted as a fact. We believe, as our choice of title suggests, that policy and the administration of policy should be based on a cool appraisal of the facts, not on fantasy and wishful thinking. In the words of Reinhold Niebuhr's famous prayer:

God, give us the serenity to accept what cannot be changed;
Give us the courage to change what should be changed; and
Give us the wisdom to distinguish one from the other.

Our second core belief is related to the first. If drugs cannot be eradicated, then the principal object of public policy should be to reduce as far as is humanly possible the great harms that they may cause – and far too often do cause. Our acceptance of drugs as a fact of life does not mean that we are minded in any way to live with the harms that drugs cause: to individuals, to their friends, families and workmates and too often to the communities in which drug users and drug dealers live. On the contrary, it was precisely because we believed that drugs could be exceedingly harmful, and because we wanted to reduce the amount of harm that they cause, that we formed this Commission. Drugs are serious. They can cause problems, big problems. In our view, those problems should be tackled in the most efficacious ways possible.

Our overriding concern with reducing harm could lead casual readers to dismiss our recommendations and suggestions as being 'liberal' or 'soft' or 'left-wing'. They are none of those things. They are neither soft nor hard, neither left-wing nor right-wing. They are purely pragmatic: that is, they are aimed at identifying the best means of working towards the desirable end of reducing the substantial amounts of harm that drugs cause in our society. Our proposals are hard only in the sense of being hard-headed. We are concerned with what works and with what might be made to work, not with anything else. For far too long, the public debate about drugs has been blighted by a widespread disposition to talk the simple-minded language of 'hard' and 'soft'. That language is meretricious, vapid and out of date. It is unfit for purpose – unless, of course, the purpose is to frighten people.

Because we maintain in this report that public policy should emphasize harm reduction rather than total abstinence or prohibition, critics of our report may be tempted not only to dismiss our recommendations as being 'soft' but to ask in addition 'What do these people know about drugs and the ravages that drugs cause?' The short answer is: a lot. The membership of

our Commission includes, to be sure, a businessman and two professors, but it also includes a recovering addict, an East End community worker, a specialist provider of drugs treatment, a doctor working in public health, a former Scottish health minister, a director of social services and a senior police officer. We are not all ‘men in grey suits’, and none of us is remotely unworldly. Moreover, although only a minority of our members qualify as experts in the drugs field, the Commission’s members collectively have devoted more than two years to reading, thinking, consulting and taking advice about the issues we cover in the chapters that follow.

The members of the Commission have one additional qualification. All of us were recruited on the basis that, while we undoubtedly had views and prejudices about drugs, we had no fixed or settled views about what future public policy towards drugs should look like. In other words, none of us came to our work with an empty mind, but all of us came to it with an open mind. Those with axes to grind or a settled agenda to promote were expressly excluded from our membership. The only view that we shared from the outset was the belief that, whatever future drugs policy should be like, present drugs policy was largely failing. No one can say of drugs policy in Britain that ‘it ain’t broke, so don’t fix it’. As will become clear, we believe that it is broke and that it badly needs fixing – not by us but by the responsible ministers and officials acting, we hope, in the light of our report.

Those ministers and officials have heavy responsibilities. We can recommend. They have to live with the consequences of accepting our recommendations – or, indeed, with the consequences of not accepting them. None of our burdens is political. Theirs are heavily political. They have to face the public and the media; they have to face re-election and the consequences of their actions. As John F. Kennedy once observed, ‘The President carries the burden. His advisers may move on to new advice.’ Largely with that in mind, we seek in this report to offer advice on the reorientation and general direction of policy, not to pronounce on, for example, what the legal status of specific drugs should be. We mean to be helpful rather than pontifical. Fortunately, we believe, as we say later in this report, that public opinion on many of the issues connected with drugs is far better informed and therefore far less dogmatic than many elected politicians and journalists apparently think it is. In our view, policy makers in Britain have considerably more room for manoeuvre than many of them seem to think they have. It is up to them to take advantage of their room for manoeuvre and to show creative leadership and greater honesty in dealing with these difficult issues.

We need to make three final points at this stage.

One is that our focus in this report is mainly on English practice in the field of drugs policy. But we are conscious that, although the statute law relating to illegal drugs applies to the whole of the United Kingdom, the actual development and implementation of policy outside England are largely in the hands of the Scottish Parliament and Executive, the Welsh Assembly and Government and, in Northern Ireland for the time being, the relevant Secretary of State. And we are also conscious that on-the-ground policy varies considerably from one part of the United Kingdom to another. If policy is what actually happens, as distinct from what the law says it is, then the UK at the moment operates four different drugs policies rather than just one. We have tried in our report to allow for this variation, and indeed we refer frequently to Scottish, Welsh and Northern Ireland practice. Even so, we realise that a report of this kind focusing on Scotland, Wales or Northern Ireland would be addressing somewhat different problems and would be making somewhat different recommendations and suggestions. We apologise to readers in the rest of the UK for the traces of Anglocentricity that they will undoubtedly find here and recognise that further work needs to be done to reflect the different challenges elsewhere. In this context we hope that the Scottish Parliament's Futures Forum will find our report useful in its year-long examination of alcohol and drugs policy in Scotland.

We also need to stress at this stage that, although we largely eschew moral and philosophical issues in the chapters that follow, we do as a Commission have a strong bias in favour of the freedom of the individual. People should be free to choose what they want to do unless their behaviour harms others or harms themselves to such a degree that it impinges unacceptably upon others. If people are harming neither themselves nor others, the state, in our view, should not intervene. Our overall approach is thus not liberal in the sense of being soft, but it is liberal in the sense of assuming that, where the state does not have a duty to intervene, it has a duty not to intervene. In connection with drugs policy, the paradox exists that some of those who most wish to restrict the powers of the state in general are at the same time among those most anxious to try to prohibit individuals from using drugs, even when they are alone or with friends inside their own home. To repeat: our primary concern is with harm, not with drug-taking that does not cause harm.

Finally, we must emphasise that one of our main purposes in publishing this report is to try to encourage policy makers and

those who seek to influence them to 'cool it', to debate the relevant issues, of course, but to debate them calmly, rationally and on the basis of evidence, not on the basis of panic, hysteria, political point-scoring and misplaced moral outrage. There is, of course, a need for moral outrage, but it should be focused on drug barons and big-time drug dealers, and on the politicians and propagandists who seek to exploit the drugs issue for their own advantage, not on drug users who have committed no other crimes, let alone on individuals who desperately need medical help and other kinds of support to help them deal with their dependence on drugs. Much of the current debate about illegal drugs, especially in Parliament and the press, strikes us as positively mediaeval, with drug users demonized as though at the beginning of the 21st century we were still in the business of casting out demons and burning witches. As one of this Commission's members put it, 'it's time to get real'.

Part I Drugs at the moment

1 The drugs people use

People have always used substances to change the way they see the world and how they feel about both it and themselves. The substances have included organic products such as alcohol, opium, coca, mescaline, cannabis, khat and tobacco and, more recently, substances that are manufactured from these organic products such as heroin and cocaine and, in addition, synthetic compounds such as ecstasy, amphetamines and LSD. Some of these substances have been selected to be prohibited, and new substances are constantly being added to the list.

The substances most commonly used apart from alcohol and tobacco fall into three main groups:

- *opiates/depressants* such as heroin and methadone, which produce a sense of well-being and of being cut off from physical and psychological pain;
- *stimulants* such as cocaine and amphetamine, which increase energy, alertness, excitement, stamina, concentration and confidence; and
- *hallucinogens* such as cannabis and LSD, which heighten the senses and cause perceptual distortions as well as bringing changes in thought, mood, personality and self-awareness.

Within these broad headings, what the individual user actually uses will vary by type, quality and purity. For example, over a thousand different strains of cannabis have been produced from the two main plant varieties (*cannabis sativa* and *cannabis indica*), with different tastes, strengths and effects. There are hundreds of different brands of ecstasy, varying widely in the proportion they contain of MDMA/ methylenedioxymethamphetamine, their primary psychoactive agent. Some brands of ecstasy will be relatively pure; others will contain other drugs or substances with no psychotropic effect at all.

The table below sets out the most commonly used drugs, the category in which each belongs (though some may combine the properties of more than one), whether or not each is addictive and its principal sources. ‘Addictiveness’ and ‘addiction’ are much contested terms. ‘Addiction’ is used in our report to mean a physical or psychological compulsion to repeat a behaviour regardless of its consequences. It may be compounded of physical dependence, broadly defined as including a growing tolerance resulting in the need to take ever larger doses to achieve the same effect and

the appearance of characteristic withdrawal symptoms if the drug is suddenly discontinued, and psychological dependence, that is, the need to continue taking the drug for the pleasurable effects it produces as a result of its action on the brain's chemical systems.

¹ Taken from Drugscope website and 'Street drug prices 2006' survey in *Druglink* September/October 2006.

The table below also summarises the desired effects for which each drug is used. The undesired effects, physical, psychological or social, will be dealt with separately in Chapter 5. The table includes, as well as the most common illegal drugs, various groups of substances that are legally obtainable, on prescription or over the counter, but are used to produce the same effects as illegal substances. Substances are listed in alphabetical order, not according to any hierarchy of harmfulness.

Table 1 Commonly used psychoactive substances

Drug	What is it?	Desired effect	Addictiveness	Source	Current price ¹
Alcohol	Liquor containing alcohol, usually ethyl alcohol or ethanol, a natural by-product of the fermentation of fruits, vegetables or grains. Legal.	Sedative hypnotic drug that depresses the nervous system. Relaxes, reduces inhibitions and increases sociability.	Psychological and physical dependence can develop. Long-term heavy drinking produces increased tolerance. Withdrawal symptoms are severe.	Both domestically produced and imported from all over the world.	Prices vary according to the type of drink. A 300ml can of lager from a supermarket costs less than 50p. Wine can be less than £3 per 70ml bottle. The cheapest vodka is less than £10 per litre.
Alkyl nitrites/poppers	Liquid chemicals which dilate the blood vessels. Legal.	Stimulants. Produce dilated blood vessels and a rushing sensation. Used in clubs and for enhanced sexual pleasure.	Not addictive.	Much is imported from the US.	£3–5 per bottle.
Amphetamine	Synthetic drug which can easily be produced on a small scale. Can be snorted, swallowed or smoked or, less frequently, injected.	Stimulant used for a 'buzz' of alertness and energy and the sense that anything is possible. Relieves boredom and tiredness. Effects last for about six hours.	People can become dependent on the psychological effects; and although amphetamines do not create physical withdrawal, stopping can produce strong feelings of depression and anxiety.	Much comes from Holland and Eastern Europe and there is now some UK production.	£8–12.50 per gram. A proportion of a gram may be enough for one person to 'speed' for a night, depending on initial strength.
Anabolic steroids	Naturally occurring hormones, such as testosterone. Legal.	Used to improve body image.	Can lead to psychological dependence.	Pharmaceutically manufactured.	£20 for 100 tablets.
Benzo-diazepines	Tranquilisers, including diazepam (brand name Valium, the most widely-prescribed drug in the world), temazepam (brand name Restoril) and nitrazepam (brand name Mogadon). Taken as tablets, capsules, injections or suppositories. Legally prescribed but illegal when used off-prescription.	Depressants/sedatives. Reduce anxiety and tension and promote relaxation. Legal as prescription drugs, but with much illicit use in polydrug cocktails. Used with heroin, amphetamine, cocaine, ecstasy and LSD, often as a means of 'coming down' after the use of stimulants.	Highly addictive.	Pharmaceutically manufactured.	Around £2 a tablet.

Drug	What is it?	Desired effect	Addictiveness	Source	Current price ¹
Cannabis	Naturally occurring plant used as leaves, ('grass', 'ganja', 'marijuana', 'weed') resin ('hash', 'hashish') or oil. Smoked or eaten. There are many different varieties of varying strengths. Around 100 varieties have high levels of the psychoactive component tetrahydrocannabinol (THC). These are often given the generic name 'skunk'.	A mild hallucinogen that also has some sedative and disinhibiting properties. Induces relaxation and heightens the senses. Positive uses to relieve symptoms in chronic illnesses like multiple sclerosis and glaucoma are being actively researched.	There is little evidence of physical dependence associated with cannabis use, or of withdrawal symptoms. It may be psychologically addictive if people depend on it as part of a coping strategy or as a way to relax.	Cannabis herb grows easily in many parts of the world and almost anywhere using hydroponics. More than 60 per cent of cannabis consumed in Britain is grown here. It is also imported from Africa, South America, Thailand and the West Indies. Resin is mostly imported from Morocco, Pakistan, the Lebanon, Afghanistan or Nepal.	Standard herbal: £35–110 an ounce. Good herbal: £90–160 an ounce. Resin: £30–80 an ounce.
Cocaine	Derived from natural coca leaves. Usually snorted as a powder but can be injected or smoked.	A powerful stimulant to the central nervous system and a local anaesthetic. A dose lasting 15–40 minutes gives a powerful physical and psychological rush of exhilaration and excitement, alertness, confidence and strength within three minutes of ingestion.	High. Produces psychological dependence, due to changes in the brain. Does not produce physical dependence to the same degree as heroin, but its physical effects are powerful and withdrawal creates very unpleasant symptoms.	Grown mostly in Latin America. British suppliers import most of their cocaine from Colombia, Peru and Bolivia.	£30–55 per gram, with 10–20 'lines' per gram.
Crack cocaine	Smokeable version of cocaine, derived by 'freebasing': heating cocaine powder with water and a reagent such as baking soda. Called crack after the crackling sound it makes when smoked using a pipe, glass tube, plastic bottle or foil.	Stimulant. Has the same effects as cocaine, but far more intense: crack makes users feel alive, exhilarated, confident and wide awake. It kills all feelings of pain, tiredness and hunger.	Potentially very high. The very steep high and 'come-down' can produce strong and immediate cravings which can rapidly develop into a 'binge' pattern of drug use.	Crack is rarely imported in that form, but produced very close to the point of consumption, usually by the dealer.	£10–25 per rock.
Ecstasy	Synthetic drug, derived from chemical methylenedioxy-methamphetamine (MDMA). Usually taken in tablet form.	Stimulant. Gives a rush of alertness and energy and a feeling of being in tune with one's surroundings and other people. The effects can last three–six hours.	Not considered to be physically addictive, but it is possible to build up a tolerance and require larger doses to achieve the same effect. May be psychologically addictive.	Much is produced in Holland and Eastern Europe, some in South East Asia.	£1–5 per pill.
GHB	Synthetic chemical gammahydroxybutyrate.	Depressant and anaesthetic. Lowers inhibitions and increases libido. Used as a club drug. Associated with date rape.	May produce physical and psychological dependence.	Pharmaceutically manufactured.	Up to £15 a bottle.
Heroin	Painkiller derived from the morphine from the opium poppy. Injected, smoked or snorted. When pure, a white powder, but usually brownish–white by the time it is sold on the street.	Depressant. Acts to depress the nervous system and slow down body functioning. Users experience a rush, a warm sensation and sense of being cut off from physical and psychological pain.	Very high. No instant dependency, but physical dependence will develop if it is used for a number of days consecutively, even at relatively low levels.	Primarily Afghanistan. Also Pakistan and Myanmar.	£25–100 per gram. Most commonly found in 2006 at c.£40.

Drug	What is it?	Desired effect	Addictiveness	Source	Current price ¹
Ketamine	Synthetic chemical, ketamine hydrochloride, found as liquid or tablets.	Anaesthetic. Can produce euphoria at lower doses, hallucinations and out-of-body experiences at higher doses.	May produce psychological dependence. Tolerance develops quickly.	Pharmaceutically manufactured.	£10–50 per gram.
Khat	A green-leaved drug chewed for centuries in parts of Africa and some Arab countries, and popular with refugee communities in the UK. Legal.	Mild stimulant effects, similar to amphetamine.	May cause some psychological dependency.	Produced mainly in Ethiopia, Yemen and Kenya.	Around £4 per bunch.
LSD	Synthetic chemical lysergic acid diethylamide known as LSD or acid. Usually sold as tiny squares of paper, often with pictures on them, but also found as a liquid or as tiny pellets.	Hallucinogen, mind and mood altering. Effects, which may last up to 12–20 hours, include heightened experiences of colours and music (such as synaesthesia – tasting colours or smelling words), sensations of time or movement speeding up or slowing down.	Not addictive.		£1–5 per tab.
Magic mushrooms	Mushrooms growing in the wild. There are two main types: psilocybe/liberty cap and amanita muscaria/fly agaric. Can be eaten raw, cooked in food or made into tea.	Hallucinogens, producing much the same effects as LSD, only milder.	Not addictive, but tolerance may develop, resulting in increasing use during the short growing season.	Grown in the UK; the season runs from August to September.	£6 for one ounce, dried.
Methadone	Synthetic opiate used as a legal substitute to stabilise or reduce heroin use. Swallowed as syrup or pill, but can also be injected.	Depressant. Provides some of the effects of heroin.	Produces physical dependence. Users report that withdrawal from methadone is difficult.	Pharmaceutically manufactured.	Prescribed price around £4 per 100ml dose. Street price varies widely.
Meth-amphetamine	Synthetic drug. Can be swallowed as pills, snorted as powder, smoked as crystals.	Stimulant. Produces euphoric effects similar to those of cocaine, but longer lasting.	Highly addictive.	Easy to produce on both large and small scale. Much produced in the US and Mexico. European mainland and UK production now well established.	Crystals sell for about £10 to £25 for a large rock, pills from £3 to £10, powder for roughly £10 a gram.
Ritalin	Synthetic drug, methylphenidate, similar in chemical composition to amphetamine. Legal.	Stimulant. Prescribed for attention deficit hyperactivity disorder but also abused for appetite suppression, wakefulness and euphoria.	Can become addictive.	Pharmaceutically manufactured.	Bought online, without prescription, around \$1.50 or 75p per tablet.
Tobacco	Naturally occurring plant containing nicotine, smoked in dried form in cigarettes, cigars and pipes or sniffed in powder form as snuff.	Stimulant, but may also have relaxing effects.	Highly addictive.	Most tobacco smoked in Britain comes from the USA but the majority of cigarettes are domestically produced. Britain is home to three of the five largest cigarette manufacturers in the world, British American Tobacco, Imperial Tobacco and Gallaher.	The cheapest cigarettes are around £4 per packet of 20.

2 ‘Demon drugs’

Some of the psychoactive substances introduced in the previous chapter, most notably alcohol and tobacco, are legal and freely available. Others are prohibited. There is a separate story behind the prohibition of each illegal substance, but a combination of medical, moral, political and economic factors was usually at work.

The changing legal and social context of drug use

In the early 19th century, opium, morphine and cannabis were all available legally and were used unquestioningly, mostly as medicines. By the 1860s questions had begun to be raised about the health hazards of some drugs, and the 1868 Pharmacy Act introduced a list of substances, including opium, that could be sold only by ‘pharmaceutical chemists’. In the years that followed, growing concerns about the effects of drugs on the health of the working class were fed by cases of children dying from the use of opium as a cough suppressant and sedative and were inflamed by press reports of the ‘luxurious’ use of drugs (as distinct from their medical use) in Chinese ‘opium dens’ in the docks of Britain’s major cities. The decline of Britain’s officially sanctioned opium trade to China encouraged these moral reservations to be expressed more freely.

In the first years of the 20th century, policy was increasingly shaped by international treaties, which in turn were influenced by the rise of the United States to great-power status and the position it had assumed as a ‘moral entrepreneur’. As a signatory to the Hague Convention of 1912, Britain agreed to pass national laws to limit the manufacture, trade and use of opiates to medical purposes, to close opium dens, to penalise unauthorized possession of opiates and to prohibit their sale to unauthorized persons. The climate of emergency during the First World War fostered even greater concern about drug use by soldiers on leave and key workers in factories. The Defence of the Realm Act 1914 was eventually extended to embrace drug use, criminalizing the unauthorized supply and possession of cocaine and opium.²

During the interwar and immediate postwar periods, drug use in Britain was relatively limited. In 1926 the prescription of opiates became a legitimate medical treatment for addiction, under the ‘New British System’ recommended by the Rolleston Committee, and the number of opium and cocaine addicts fell and then remained relatively stable. Between the wars, drug use was largely the preserve of ‘the dilettante rich and the louche’.³ The existing pattern was of ‘middle-class morphine addicts ministered to by largely sympathetic medical practitioners’.⁴

² The Defence of the Realm Act was passed as a watered-down form of martial law on the outbreak of war in 1914. The same law banned ‘Malthusian appliances’ (contraception) and quack medicines and established legal closing times for pubs.

³ H Cohen, ‘Dances with Drugs: Pop Music, Drugs and Youth Culture’, in ed. N South, *Drugs: cultures, controls and everyday life*, Sage, 1999, p. 19.

⁴ R Yates, ‘A Brief History of British Drug Policy, 1950–2001’, *Drugs: education, prevention and policy*, Vol. 9 No. 2, 2002.

During the late 1940s and much of the 1950s, the number of known addicts in Britain was fewer than 100, and the majority were older people.

However, in the late 1950s there began to be media reports of a new 'epidemic' of drug misuse associated anecdotally with jazz clubs and ethnic minorities and compounded by over-prescribing on the part of a small group of doctors. But it was not until the 1960s that a new youth culture revived recreational drug use on a large scale and at the same time changed the age and class profile of users. As late as 1961 addicts over the age of 50 comprised the largest group; by 1965, only four years later, the largest group consisted of people aged 15 to 34. The main drugs of choice were now cannabis, LSD and amphetamines, the latter being acquired largely by diversion from licit sources. Amphetamines had been supplied to soldiers during the 1939-1945 war as energisers, and they were prescribed very widely during the 1950s as slimming aids. Medical use of barbiturates such as Amytal and Seconal increased rapidly during the 1950s. The 1960s saw the widespread introduction of benzodiazepines and other prescription tranquillisers. They would be prescribed in ever-increasing quantities over the next twenty years and they remain the most commonly prescribed mood-altering drugs in Britain. The punk revolution of the 1970s further promoted amphetamine use to which was added solvent abuse.

The rising use of drugs during the 1960s led to the introduction of a succession of new laws. In 1961 Britain signed the UN Single Convention on Narcotic Drugs. There may never have been much scope for individual countries to develop legally regulated models for the production and supply of psychoactive substances (other, of course, than alcohol and tobacco); but, if there had been, the 1961 Convention ended it. Three years later the Dangerous Drugs Act 1964 brought cannabis within the scope of the law, and the Drugs (Prevention of Misuse) Act 1964 went on to control amphetamines. Signing the 1971 UN Convention on Psychotropic Substances also required Britain to restrict LSD. The UK's own Misuse of Drugs Act 1971 consolidated all these prohibitions in one piece of legislation. (The Misuse of Drugs Act is discussed in detail at pp. • below.)

Until the 1970s there had been relatively little smuggling of drugs into Britain from abroad, but in 1979 shifts in global trafficking patterns brought a cheap and plentiful supply of heroin to Britain from South Asia and patterns of drug use changed again, with a rapid expansion of intravenous drug use. Heroin in inner city areas became a major political issue in the early 1980s, and

treatment provision – now centred on specialist Drug Dependence Units rather than on general practitioners – was greatly increased. The advent of HIV/AIDS brought a closer focus on the serious public health problems associated with injecting drug use and a greater stress on harm reduction.

The rave culture of the 1980s to some extent shifted attention away from heroin and HIV/AIDS and back to the recreational use of drugs. The rave culture brought with it an unexpected increase in the use of ecstasy and other synthetic stimulants. Illegal drugs were now being used not, as in most previous decades, mainly by ‘mad, bad and sad’ junkies and glue-sniffers but by ‘ordinary’ people. Drugs became part of some people’s leisure lifestyle. The culture surrounding drug use thus changed, it came in from the margins. Later, the 1990s saw a sharp increase in the use of cocaine and its smokeable derivative ‘crack’.

The emotional context of drugs policy

As we have seen, the evolution of drugs policy in Britain has owed a great deal to the evolution of policies and attitudes towards drugs on the international scene. It has also owed a great deal to domestic concerns about the individual and public health implications of the use of drugs and concerns about the connections between the use of drugs and the committing of crimes.

But there is no escaping the fact that the formulation and implementation of drugs policies takes place in a peculiar atmosphere, one that differentiates drugs policy from most other policy fields. The field of drugs policy is not ‘ordinary’, ‘matter of fact’ or ‘routine’. It is highly charged, sometimes even hysterical, with people, including the media and politicians, emotionally involved in a quite unusual way. The emotional climate in some policy fields is relatively cool. The emotional climate in the field of drugs policy is almost always exceedingly hot.

Why should this be so? We need to know the answer to that question if we are to suggest, as we seek to do in this report, that the issues surrounding drugs should be discussed in an altogether calmer fashion than they have been in the past.

The strong feelings that people have about drugs are undoubtedly derived to some extent from people’s concerns about the health issues that drugs give rise to, and are they probably even more derived from the connections that undoubtedly exist between drugs and crime. But in our view one cannot understand the emotionally charged atmosphere in which the debate about drugs takes place unless one appreciates the extent to which drugs are

seen as a peculiarly moral issue and unless one further appreciates the extent to which, and the ways in which, both drugs and the users of drugs have been demonized.

⁵ R Room, 'Addiction concepts and international control' in *Global Drug Policy: Building a New Framework*, Senlis Council, 2004.

The conviction is widespread, especially in the United States and much of Protestant Europe, that seeking to alter consciousness through drug use – whether for enlightenment, pain relief or simply fun – is terribly dangerous and morally wrong. This conviction may be rooted in fundamental values, it may be unreasoned and emotional, and it may be, and often is, both at the same time. We do not presume in this report to lay down what we believe people's moral stance on this overarching issue should be. That is not our business (though we do note in passing that people have been using consciousness-altering substances for thousands of years and that in modern Europe the use of consciousness-altering substances such as alcohol and tobacco is considered perfectly normal and acceptable.) Rather, our concern is with the habitual demonization in Britain and elsewhere of drugs and those who use them. Demons are diabolical, evil spirits, and are therefore to be slain. In our view, using such language and thinking in such terms is childish, if not mediaeval. It stifles rational and realistic debate and makes it harder, not easier, to deal with the very serious matters at hand.

Demonizing drug use

Demonization of people or behaviours can be subconscious or deliberate. When deliberate, its purpose is to justify an all-out assault on the people or behaviours in question. The target of the attack is put beyond the bounds of normal considerations of respect, compassion or legal entitlement. Demonization is achieved through the careful choice of vocabulary or visual imagery, by direct attack or by association of the target with other objects of hatred, fear and contempt.

Addiction has been demonized in the past as a form of possession, by an evil substance rather than an evil spirit, with the victim's will mysteriously overpowered by a force outside themselves.⁵ Any culture that celebrates individualism, free will and independent self-hood is liable to regard loss of control as an iniquity and a threat. The UN's Single Convention on Narcotic Drugs of 1961 uses the heightened language of transgression and menace: addiction is described in it as 'a serious evil for the individual... fraught with social and economic danger to mankind'.

The Victorians portrayed alcohol in much the same terms: as a route to moral decay and financial ruin. The 'demon drink' was attacked on both spiritual and practical grounds. Bodily

self-indulgence would surely lead to a degradation of the soul; artificial short cuts to pleasure and to rewards without effort flew in the face of the Protestant work ethic. Moreover, drinking not only blighted the lives of the working man's family but also drastically reduced his productivity. Many of the same arguments were still being rehearsed in much the same language in America in the years leading to Prohibition, with links carefully made between alcohol and a remarkable range of other social and physical evils:

'Alcohol – the indispensable vehicle of business of the white slave traders'

'The *Titanic* Carried Down 1503 People – Drink Carries Off 1503 Men and Women Every Eight Days'

'Deaths, Defects, Dwarfings in the Young of Alcoholised Guinea Pigs'

'Drinking Mothers Lost More than Half Their Babies'

'One Insane Person in Every Four Owes His Insanity to Drink'

'The Full Father and the Empty Stocking'.⁶

The faintest tinge of the same attitudes is perhaps perceptible in the current British preoccupation with 'binge drinking', a label that the media often use as a symbol of the decline of modern youth.

'Drugs' have been demonized in Britain most readily by lumping them all together. The current Chief Executive of the National Treatment Agency complained in his evidence to the House of Commons Home Affairs Select Committee in 2001 that the media were prone to amalgamate the prevalence of cannabis with the damage done by heroin.⁷ Refusing to differentiate between drugs makes it possible to attribute the evils of the most harmful of them to all of them alike: 'Cannabis may as well be heroin, a weekend amphetamine user a crazed addict, a young woman who gives a friend an ecstasy tablet a drugs baron.'⁸ It was in the apocalyptic style of famine, pestilence and flood that the then Secretary of State for Scotland introduced the 'Scotland Against Drugs' campaign in 1995:

The drugs epidemic is a scourge as terrible as any medieval plague. Let us, as a nation, make a New Year resolution that 1996 is the year in which we will turn back the tide of drug abuse which is engulfing our young people and threatening our civilisation.

In general, the language of drugs policy in Britain has not been as obviously the language of war, purge and crusade as that dominant in the United States, but those shaping policy have been just as adept over the years in the technique of implying guilt by association. Association, of course, can be a positive as well as a negative tool. Alcohol and tobacco advertisements have

⁶ Fliers released by the Anti-Saloon League between 1910 and 1920.

http://www.wpl.lib.oh.us/AntiSaloon/printed_material/fliers.html

⁷ The National Treatment Agency (NTA) is a special health authority, responsible to the Secretary of State for Health, created by the Government in 2001 'to improve the availability, capacity and effectiveness of treatment for drug misuse in England'. Parallel structures have been established for the devolved administrations.

⁸ H Parker et al, *Illegal leisure: the normalization of adolescent recreational drug use*, Routledge, 1998, p.10.

always operated largely by linking their products with style, status, strength, speed and sport. But drugs – which in the eyes of many of their users could equally be associated with all of those things – have consistently been linked with madness, squalor, subversion and ‘foreignness’. Rather as Hogarth blamed gin for all the vices of London in ‘Gin Lane’, drug use can be made the scapegoat for many contemporary ills, on the basis that it is easier to denounce drugs than attempt to tackle, for example, poverty and family breakdown. (Dickens wrote of ‘Gin Lane’, ‘Gin drinking is a great vice in England, but wretchedness and dirt are a greater.’)⁹

⁹ ‘Gin Shops’, 1835.

¹⁰ See S Blackman, ‘Drug prohibition and the “assassin of youth”’ in *Chilling Out*, Oxford University Press, 2004, pp. 16ff.

¹¹ K Murji, ‘White Lines: Culture, “Race” and Drugs’, in ed. N South, *Drugs: Cultures, Controls and Everyday Life*, Sage, 1999.

Drugs have been demonized above all by their persistent association with crime. This coupling was a blunt instrument in the hands of Harry Anslinger, first chief of the American Federal Bureau of Narcotics and author of a publication entitled ‘Marijuana: Assassin of Youth’. The volume contained a succession of case studies of rape, assault and murder allegedly committed by people under the influence of the ‘killer weed’ including that of a Florida axe-wielding ‘addict’ who turned his family home into a ‘human slaughterhouse’.¹⁰ Though the link has rarely been made as crudely since then, the suggestion that drug users are the kind of people who commit crimes and that drugs are themselves a trigger for certain kinds of crime has never gone away. It has been interrogated and challenged by physiologists, psychologists and criminologists alike, and it is well established that the relationship between crime and drug use is far more complicated than is often acknowledged (see pp.64–65 below). Yet it still seems to be easiest for a drugs policy to seek to justify itself and consolidate its funding if it is presented first and foremost as a means of fighting crime, conveniently ignoring the fact that the illegality of drugs is itself a catalyst for much drug-related crime.

In the same vein, suspicion of drug use has been boosted by linking it with immigration and the presence of resented minorities. ‘Drugs in general always seem to be represented as coming from “outside” or “somewhere else”.’¹¹ Just as opium was associated at the turn of the twentieth century with the Chinese migrant labour that threatened American jobs, and marijuana similarly with Mexicans in the 1930s (the choice of the term ‘marijuana’ itself being designed explicitly to establish that link), cannabis was first coupled in Britain with West Indian jazz musicians in the 1950s. Overtly in America, less explicitly in Britain, drugs were connected with race and race with sexual menace.

Early drugs prohibitionists in America argued that drugs brought a decline in morals through contamination with ‘degenerate

racess’. Men like Hamilton Wright, US Opium Commissioner, argued that young American women were being seduced by Chinese men through the use of opium and raped by black men made superhumanly powerful by cocaine. The *New York Times* later reported that ‘Southern sheriffs had switched from .32-caliber guns to .38 pistols to protect themselves from drug-empowered Blacks’. Britain too had its ‘White Girls Hypnotized by Yellow Men’ stories.¹² They were particularly common after the First World War, when the popular press first began to take up drugs as an issue and used post-war anti-alien sentiment to create an extra frisson of outrage. The British Board of Censors banned a film entitled ‘Cocaine’ at this time, on the grounds that it was said to portray ‘sleek young men and thinly clothed girls (many of them the “real thing”) [who] jazz and shimmy and foxtrot under the influence of late hours and excitement, nigger music and cocktails, drugs and the devil.’¹³

¹² S Blackman, *Chilling out: the cultural politics of substance consumption, youth and drug policy*, Oxford University Press, 2004.

¹³ Quoted in V Berridge, *Opium and the People*, Free Association Books, 1999, p.266.

The image of the young girl equally at the mercy of drug-crazed predators and of the drugs themselves is one that has been employed repeatedly to sustain drugs’ demonic status. From the actress Billie Carlton, dead allegedly of an overdose of cocaine at 21 in 1918, to Leah Betts, featured on posters throughout Britain as an 18-year-old casualty of ecstasy use in 1995, and student Rachel Whitear, photographed in death clutching the syringe that is supposed to have killed her, the media have used the fates of young women to convey a dual message: that drugs are evil and that a society in which even young girls take drugs is a society in crisis.

In the 1920s cases like those of Billie Carlton were used in the press as ammunition to condemn the ‘emancipated woman’. Since then, particular drugs have often been associated with various different sub-cultures and the relationship has been made to reflect poorly on both of them. The pot-smoking hippies of the 1960s were taken to be (and frequently were) generally opposed to ‘the system’, and using cannabis was portrayed as a political gesture as well as a pastime. Amphetamines such as Purple Hearts were associated more with Mods and therefore with seaside street battles. To the energy and aggression of amphetamine, punks added the squalor of sniffing glue. Clubbing and raves meant ecstasy and amphetamines again.

Ecstasy use in Britain was reputed to have started in gay clubs and bars, and much media attention has been given to the relationship between homosexuality and drug use:

‘Gay lifestyle is fuelled by drugs, research reveals’
(*Observer*, 9 November 2003)

'Fears over gay community drug use' (BBC website, 3 June 2005)

'Gay club drug banned' (Gay.Com, 3 January 2006).

Drugs such as amyl nitrites, GHB, ketamine and methamphetamine are used to increase energy and enhance sexual pleasure, and some newspapers find the combination of drugs, sex and 'deviance' irresistible.

The consequences of demonization

Overall, the demonization of drugs seems to us to have had a seriously detrimental effect on the quality of the policy discussion around illegal drugs. Cool deliberation and informed dialogue become difficult or even impossible, and public debate becomes overheated and polarised. Politicians often seem afraid to raise the subject in general terms lest they be quizzed in a hostile way about their own experiences. An exaggerated interest in individual drugs and their properties distracts attention from the social factors – poverty, homelessness, unemployment – that often underlie drug use.

In addition, policy itself may be skewed by the fear and distaste surrounding the whole subject. Recent developments in Scotland illustrate the point. A series of high profile cases have involved the children of drug users. They included the death of a 2-year-old boy who drank his parents' methadone, an 11-year-old girl treated for heroin withdrawal and a 3-year-old boy found starving and alone with the decomposing remains of his mother who had died 6 weeks earlier, and they sparked a flurry of media interest and a clamour for action. In response, Jack McConnell, Scotland's First Minister, launched a wholesale review of the methadone programme and signalled that more children of drug-using parents would be removed from their parents. More draconian measures – oral contraceptives added to the methadone of drug users, for example, and methadone withheld unless users sign a 'social contract' agreeing not to conceive – while not adopted as official policy, have influenced mainstream debate, particularly within the Scottish Labour Party whose emergent policies for the May 2007 Scottish Parliament elections take a hardline approach.

The influential *Hidden Harm* report produced in 2003, and the recent response to it, did not shrink from highlighting the many problems that parental drug use can cause for children. It clearly emphasized the importance of protecting children against these dangers. However, *Hidden Harm* was balanced in its approach in acknowledging that the parents also have needs and that taking children into care poses its own problems. There is widespread concern in Scotland that this measured approach is under threat

and that policies are being driven more by political and presentational imperatives than by considered debate and evidence.

Policy may also be stalled altogether if drugs and drugs users are treated as a class or a caste apart. For example, epidemiologists and drug treatment providers have been pointing with growing alarm to the rise in cases of Hepatitis C among injecting drug users (discussed below in Chapter 14) and the apparent lack of official interest in tackling it. If left untreated, Hepatitis C can lead to cirrhosis, cancer and liver failure. The disease constitutes a public health risk that the Department of Health recognized some years ago as a ‘major challenge’ requiring ‘intensified action’.¹⁴ However, the treatment – with antiviral drugs such as interferon taken alone or in combination with ribavirin – is very expensive. The demonization of drug use appears to have led to a situation where drug users infected with Hepatitis C are not considered worth the money it would cost to treat them. It is hard for those working in the drugs field to believe that a health risk on this scale would be being neglected if it affected a different group of patients.

The effect of the demonization of drugs on public opinion in general is very hard to gauge. The media wield the most influence where a phenomenon is new and people have not had the opportunity to judge it for themselves. The information about drugs that they pass on to the public is inevitably mediated by the public’s own experience of drugs, and it may well be that people dismiss much of what they see on television or read in the tabloids as inaccurate and sensational. But the effect of the demonization of drugs on the practical politics of the issue is impossible to ignore.

3 Drugs as a business

The preceding chapter described how the demonization of drugs has made life difficult for policy makers, polarizing public debate and making cool deliberation near impossible. This chapter explores a more substantial difficulty facing policy makers: the nature of the drugs trade. If the effect of the demonization of drugs is impossible to ignore, so too is the inconvenient truth that the drugs trade will not go away.

The drugs industry’s reach is global. The most recent report from the United Nations Office on Drugs and Crime (UNODC) acknowledges: ‘Some 200 million people, or 5 per cent of the global population aged 15–64, have used illicit drugs at least once

¹⁴ In the Chief Medical Officer’s infectious diseases strategy *Getting Ahead of the Curve*, 2002.

http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4014338&chk=27khk1

in the last 12 months. Among this population are people from almost every country on earth. More people are involved in the production and trafficking of illicit drugs and still more are touched by the devastating social and economic costs of this problem.' This is the position despite the worldwide campaign to prohibit drugs, not to mention the American-led 'war on drugs'.

The United Nations Office on Drugs and Crime has an annual budget of well over \$200 million, made up largely of voluntary contributions from signatory nations. (The United States, Italy and the United Kingdom are among the largest contributors.)¹⁵ This modest sum pales into insignificance beside the \$12.7 billion that the United States spends on its domestic drugs strategy, or even beside the United Kingdom's £1.5 billion.¹⁶ Given the strength of the opposition to it, how has the use of illegal drugs become so widespread? The answer lies in an industry that is one of the most successful in history, one that resembles other major businesses in its economic logic and in conforming to market signals and the laws of supply and demand.

The worldwide drugs 'business'

It is extraordinarily difficult to assess the extent of the worldwide drugs trade in the absence of any of the figures by which the scale of a legal enterprise would be measured. Since all its operations are kept secret or disguised with the help of expert lawyers and accountants, we do not know exactly how much of the various products of the drugs trade are manufactured, exported, imported or consumed, or exactly what the costs and prices are at each stage. The statistics have also become highly politicized. There are incentives to exaggerate the size of the trade and the scale of the problem in order to justify the large budgets being consumed in fighting it. Equally, there is countervailing pressure to calculate the totals differently in order to suggest that the trade, and the problem, is being contained.¹⁷ The only certainty is that the drugs business that remains hidden is very much larger than the part of it that becomes visible to us as a result of drug seizures and the number of drug users presenting for treatment.

No one would deny that illegal drugs are a multi-billion dollar global commodity. The United Nations Office on Drugs and Crime's best estimate of the value of the market in 2003 was \$13 billion at the production level, \$94 billion at the wholesale level (taking seizures into account) and \$322 billion at the retail level (based on retail prices and taking seizures and other losses into account).¹⁸ According to the same UNODC calculations, the value measured at retail prices is higher than the Gross Domestic

¹⁵ The UNODC's consolidated budget for 2004/5 was some \$225 million. *UN system engagement with NGOs, civil society, the private sector, and other actors: a compendium*, 2005, p.180.

¹⁶ Projected expenditure for 2004/5, according to the Home Office website, 'Government direct annual expenditure on the Drug Strategy', <http://www.drugs.gov.uk/drug-strategy/funding/?version=1>

¹⁷ FThoumi, 'Numbers Game: let's all guess the size of the illegal drug industry', *Journal of Drug Issues*, Winter 2005.

¹⁸ UNODC, *World Drug Report 2004*. Subsequent reports do not contain revised figures.

Product (GDP) of 88 per cent of the countries in the world and equivalent to about three quarters of Sub-Saharan Africa's total GDP. The sale of drugs measured at wholesale prices was equivalent in 2003 to 12 per cent of the global export of chemicals (\$794 billion) and 14 per cent of global agricultural exports (\$674 billion) and it exceeded global exports of ores and other minerals (\$79 billion).

The largest market is for cannabis herb (with a retail market size in 2003 of \$113 billion), followed by cocaine (\$71 billion), the opiates (\$65 billion) and cannabis resin (\$29 billion).¹⁹ The ATS [amphetamine type stimulants] markets together (methamphetamine, amphetamine and ecstasy) amounted to \$44 billion.

As for trends in the world market, the UNODC concluded in 2006 that the overall market is growing, though to different degrees for different drugs.²⁰ The market for opiates is up following a renewed supply-push from Afghanistan, which had good opium harvests in 2003 and 2004. (After a dip in 2005, the harvest for 2006 reached record levels.) The overall market for cocaine is up; production is increasing, and the market is diversifying with a particularly noticeable rise in demand in Europe. There is no sign of any slowing in the consistent increase of the market for cannabis; perhaps more significantly, the numbers of people in treatment for cannabis is growing worldwide. The market for amphetamines and ecstasy, having declined slightly, would appear to be increasing again, largely as a result of increased use of methamphetamine in East and South East Asia. In terms of profitability, cocaine is perhaps the world's number one drug, thanks to the combination of high demand and a relatively high price, as compared with heroin (high price but relatively low demand) and cannabis (high demand but relatively low price).

The structure of the drugs trade

The drugs business, like any other, has different stages which involve millions of people worldwide: cultivation of crops, wholesaling of raw materials, processing and manufacturing, transport and distribution, retailing, money management and investment of proceeds. Besides the farmers, manufacturers, producers, marketers, traffickers and lower-level dealers, there is a large financial infrastructure of accountants, lawyers and bankers operating in a 'grey economy' between the 'black' and legitimate economies.

Generally speaking, the industry is characterized by competition rather than cartelization, and there is little evidence of central

¹⁹ The document continues, 'While UNODC is reasonably confident with its estimations on opiates, cocaine and the ATS [amphetamine type stimulants], the degree of certainty is far lower for cannabis, notably for cannabis herb, as information for production and consumption of this substance is highly contradictory. If better information becomes available, a major revision cannot be ruled out.'

²⁰ UNODC, *World Drug Report 2006*.

price fixing. This leads to larger production, lower prices and faster growth in response to world demand.²¹ One American source reported in 2000:

Despite finding that some dealers within the US have enormous incomes and traffic in large quantities, no researcher has found evidence, except on the most local basis (e.g. a few blocks) that a dealer organization has the ability to exclude others or to set prices, the hallmarks of market power... Even at the trafficker level, market power seems elusive. Notwithstanding references to the Medellin and Cali “cartels” [trafficking cocaine in Colombia], these seem to be only loose syndicates of independent entrepreneurs who sometimes collaborate but who also have to compete with other, smaller Colombian smuggling enterprises. ... The continuing decline of prices over an almost twenty-year period at all levels of the market suggests that, if market power ever existed, it has now been dissipated.²²

It is no longer believed that there is a single integrated structure to the drugs industry, nor any one ‘Mr Big’, or even a handful of ‘Mr Bigs’, at its head. For years the trend has been towards growing decentralization. The trade is certainly closely intertwined with organized crime networks, as one of their many ‘earners’, but these criminal organizations themselves take many forms and do not necessarily have uniform structures, stable hierarchies or long-established leaders.²³

In some cases, drugs networks may be vertically integrated to a greater or lesser degree, with the same network controlling several stages in the process, from production to retail. This may be the case, for example, where the trade is in the hands of immigrant communities. Immigrant groups may have strong links with countries that produce drugs or lie on the main transit routes – Turkey or Pakistan, for example. Such immigrant groups speak languages that the police rarely understand and have close ties of loyalty, making them more likely to form communal businesses. There may exist some organizations that resemble corporations: large, formal hierarchies with well-defined divisions of labour that are also more likely to be vertically integrated. But there are other types of organization, ‘freelancers’, for example, small, non-hierarchical entrepreneurial groups that tend only to operate at one or two levels, or ‘family businesses’, cohesive groups that have a clear structure and authority derived from family ties but are not organized on the same scale as ‘corporations’.²⁴ It is not always clear how lower-level retail markets, where the freelancers and family businesses may both be operating, are linked to the upper-level distribution systems.

²¹ W Byrd and C Ward, World Bank, ‘Afghanistan’s drug economy: a preliminary overview and analysis’. [http://www.af/resources/mof/recosting/chapter1/Recosting per cent 20Chapter per cent 201 per cent 20Annex per cent 202.pdf](http://www.af/resources/mof/recosting/chapter1/Recosting%20per%20cent%20Chapter%20per%20cent%20Annex%20per%20cent%20202.pdf)

²² P Reuter, ‘Epilogue: connecting drug policy and research on drug markets’, in ed. M Hough and M Natarajan, *Illegal drug markets: from research to prevention policy*, *Crime Prevention Studies*, Volume 11, 2000.

²³ See, for example, N Dorn, K Murji and N. South, *Traffickers: Drug Markets and Law Enforcement*, Routledge, 1992.

²⁴ M Hough and M Natarajan, ‘Illegal drug markets, research and policy’, in ed. M Hough and M Natarajan, op.cit.

In general, the various different business functions involved in the drugs trade are accomplished by a range of loosely aligned associations of independent producers, shippers, distributors, processors, marketers, financiers and wholesalers. It is this loose, flexible and adaptive nature that makes the drugs trade so difficult to disrupt. The 2003 report on drugs from the British Prime Minister's Strategy Unit observed that the drugs industry is helped in sourcing and supplying heroin and cocaine by the wide choice of routes and methods of transport, the types and sizes of organizations involved, the constant variation in the size of consignments, the varying degrees of central organization, the numbers of players involved and the degree of integration in the supply chain.²⁵

²⁵ Strategy Unit, *Drugs Report: Phase 1 – Understanding the issues*, May 2003.

²⁶ *Economist*, 26.7.01 and 25.11.04.

This is an industry of considerable technological sophistication, with a recruitment process as wide-reaching and rigorous as that of any multinational corporation, an apparently inexhaustible supply of new recruits and, in some areas, growing levels of managerial expertise. The *Economist* comments:

Mexican distributors operate with great professionalism, sometimes employing top managers with degrees in business studies, and relying heavily on honour, credit and collateral... “We dealt with a team a while ago that had a director of operations and a director of finance, and they actually called them that,” says Bill Hughes, director-general of the new UK Serious Organised Crime Agency.²⁶

Profits in the drugs trade are concentrated not in the production process but in the distribution chain. High premiums are paid to traffickers and dealers for the taking of risk, inflating the price at each stage of the process, with the result that the producers of some drugs – the farmers of coca and opium, for example – receive no more than 1 per cent of the eventual retail price. Prices, and therefore profits, vary from time to time and from drug to drug, but the overall mark-up between the production price and the retail price is invariably steep.

The Prime Minister's Strategy Unit was commissioned in 2003 to carry out a scoping exercise on the efficacy and cost-effectiveness of law enforcement designed to reduce the supply of illegal drugs. The Unit produced a report in two phases, both of which were kept confidential, despite repeated efforts to gain access to them under the Freedom of Information Act. They became public only when they were leaked to the press in 2005. Phase 1 – ‘Understanding the issues’ – argued that drug production in developing countries cannot be halted as it has intractable economic and social causes. Trafficking cannot be significantly

curtailed: consignments would have to be seized at a rate of between 60 and 80 per cent for the trade to be seriously affected and no more than 20 per cent has ever been achieved. The availability of drugs has never been reduced enough to have any significant effect on the prevalence of consumption: use has continued to rise. The Strategy Unit suggested that even if reducing the availability of drugs were to cause prices to rise, the only significant effect might be to boost drug-related crime by increasing the cost of a regular drug habit. In Phase 2 – ‘Diagnosis and Recommendations’ – the Unit argued that less emphasis should be placed on supply reduction and more on reducing demand by ‘gripping high harm users’ in coerced treatment. This line of argument lay behind the clauses in the Drugs Act 2005 that introduced drug testing on arrest for specified trigger offences, followed by assessment and referral for treatment.

²⁷ A cutting agent is a less expensive chemical used to adulterate an illicit drug. Common cutting agents include glucose and other sugars, caffeine and ephedrine. A relatively expensive drug may be cut with a less expensive one – e.g. heroin with paracetamol. *Observer*, 21.4.02.

²⁸ Strategy Unit, *Drugs Report: Phase 1: Understanding the issues*, May 2003.

²⁹ S Levitt and S Dubner, *Freakonomics: a rogue economist explores the hidden side of everything*, Morrow, 2005.

³⁰ P Reuter, op.cit.

To take the heroin trade as an example, an *Observer* report in 2002 stated that Afghan-originated heroin, transported in bulk, costs as little as £600 per kilo. The so-called ‘Turkish route’ importers will trade tens of kilos for around £7,000 per kilo. Middle-level brokers will purchase a single kilo for about £22,000. At this level, it will often be bulked out with cutting agents before being sold for up to £1,000 an ounce (£35,000 a kilo), a mark-up of 60 times the original price.²⁷ Prices to the consumer on the street may change, but that kind of mark-up remains constant. These inflated profits appear to be largely concentrated near the top end of the chain, in the hands of major traffickers. The Prime Minister’s Strategy Unit claimed in its 2003 report that the annual turnover for a major Afghan opium trafficker would be £11–37 million in annual profits, allowing for seizures. The profit margin per kilo would be between 26 per cent and 58 per cent. By way of comparison the Unit cited private sector profit margins that were generally much smaller, with only luxury goods such as champagne, perfume and designer handbags showing similar margins.²⁸

Detailed evidence is lacking on profits further down the chain – for example, for middle-market distributors – but the large profits almost certainly do not reach the lower levels of street dealers. In a chapter of their book *Freakonomics* focussing on low-level crack dealers in Boston, Stephen Levitt and Stephen Dubner ask, ‘Why do drug dealers still live with their moms?’²⁹ The answer is that they cannot afford to move out. Broader academic research seems to confirm that at the lowest level dealers are often poorly paid.³⁰ (They may make relatively more profit per gram than dealers at other levels, but deal in much smaller quantities.)

The drug trade's economic effects

The drugs trade can have a considerable impact on the economies of the countries where it takes hold, most significantly in the less developed countries that produce its raw materials. Here the trade undeniably produces short-term profits, bringing relatively large amounts of money into the local economies and improving the trade balance, while providing thousands of jobs for farmers, itinerant labourers, laboratory workers, wholesale distributors and their employees. A UNESCO report outlines these profits, making the point that whole economies can become dangerously dependent on them:

The example of Colombia... shows how large a part this [drugs] sector can play in the national economy of a large country, affecting not only employment, incomes, investments... commerce, economic property, financial flows and the external balance of payments, but also the rules, standards, regulations and laws which govern the functioning of that economy... In situations where there is little supervision by government institutions, the presence, withdrawal or rerouting of this trade can enable whole medium-sized towns to develop or cause them to falter. In such places the redistribution of the profits involved may also sustain large sections of a region's economy or firms belonging to the officially recognized economy. Together with the proceeds of other criminal activities, they swell the funds in these regions' financial and banking systems in an utterly disproportionate way... In the great metropolitan conurbations, drug money can make a considerable difference to neighbourhoods, indeed to whole city districts.³¹

These short-term gains are counteracted, the United Nations Office on Drugs and Crime has argued, by more severe long-term economic damage.³² According to the UNODC, money from the illegal drugs trade will ultimately have the effect of destabilizing the economy in producer countries through inflating the domestic currency, crowding legal businesses out of the export market, disrupting monetary policy and diminishing financial control, reducing access to legitimate sources of finance. This 'dirty' money, however abundant it may be, will not benefit the economy because it is more likely to go into conspicuous consumption, often on imported goods, or into non-productive sectors such as real estate and gambling.

In the worst case, drugs profits will be used directly to destabilise political regimes in less developed countries, through the financing of electoral campaigns, straightforward corruption or actually subsidizing insurgency and terrorism.³³ More obliquely, political and economic stability may be affected by large-scale

³¹ UNESCO, 'The economic and social transformations connected with the international drug problem', in *Globalisation, Drugs and Criminalisation*, 2002. UNESCO is the United National Educational, Scientific and Cultural Organisation.

³² UNODC *World Drugs Report*, 1997.

³³ H van der Veen, 'The international drug complex. When the visible hand of crime fractures the strong arm of the law. Understanding the intertwined dynamics of international crime, law enforcement and the flourishing drug economy', CEDRO 2000.

money laundering related to the drugs trade. It has been suggested that money laundering has contributed to financial crises in poorer countries – for example, in Mexico in 1994–5 and Thailand in 1997.³⁴ In richer consumer countries, where most drugs profits are made and reinvested, the sums involved, even though they are much larger, will not have the same destabilizing effect because of the relative size of the countries' economies, but it is not clear precisely what the impact of these transactions may be. Does 'dirty' money become 'gentrified' – for instance, in the establishment of new companies, mixed with other funds? Is it hoarded to be handed on as an inheritance? Is it transferred into real estate or valuables that can be traded? What happens to it after it is moved to tax havens? Does it flow into the capital market? 'There is a near total vacuum of knowledge...with regard to criminal money flows and money laundering'.³⁵

The drugs trade and market conditions

Like any other business, the drugs trade adapts to market conditions and changing preferences. Preferences may be influenced by shifting fashions in youth culture but will also be related directly to price. It is now generally accepted that the drugs industry is not set apart by the nature of its products but behaves much as other industries. It used to be thought, because of the addictive nature of many of the commodities and consumers' special relationship with them, that demand for many drugs was inelastic and would remain steady regardless of price; but it is now acknowledged that the position is more complex. People may tolerate high prices for heroin for a while without any change in their behaviour. Equally, higher prices may force people who previously were not committing any crimes into stealing to finance their habit. However, rising prices might force addicts into treatment and off the market or else push them sideways for a while into using a different drug in a different market.³⁶

The most obvious recent example of a distinct change in market conditions in Britain, resulting from a change in the law relating to illegal drugs, was the reclassification of cannabis from Class B to Class C in January 2004. A year later some sources were claiming that this relaxation in the law had prompted a sales drive from the industry. The Metropolitan Police, for example, identified changes in the approach of organized crime networks involved in drug trafficking. 'One of the biggest growth areas is the shifting of organized crime towards cannabis importation,' a senior officer was quoted as saying. 'The supply side has reacted to the liberalization because they think law enforcement has

³⁴ UNESCO, 'The social and economic impact of drug trafficking' http://portal.unesco.org/en/ev.php-URL_ID=6906&URL_DO=DO_TOPIC&URL_SECTION=201.html

³⁵ TransNational Institute seminar on the economic impact of the illicit drugs industry, Amsterdam, December 2003.

³⁶ J Cave and C Godfrey, 'The Economics of Addiction and Drugs', Foresight BSAD, 2005.

taken its eye off the ball. We are now recovering tons of the drug at one time and that is something we were never doing before.³⁷ In contrast, the decriminalization of cannabis in South Australia, Portugal, the Netherlands and a number of individual American states would not appear to have increased its prevalence in the long term.³⁸ The relative dearth of research in the drugs field worldwide, however, makes it more than usually difficult to establish cause and effect relationships with any certainty.

³⁷ *Observer*, Feb 20, 2005.

³⁸ R McCoun and P Reuter, 'Evaluating alternative cannabis regimes', *British Journal of Psychiatry*, 178, 2001.

³⁹ Cave and Godfrey, op. cit.

Mapping responses to market conditions is further complicated by the fact that many, if not most, drug users use more than one substance at the same time or on different occasions. Very many use alcohol as well as illegal drugs and use drugs in a growing range of combinations. Suppliers both respond to this practice and encourage it – by selling, for example, combination packs of heroin and crack for simultaneous injection as 'speedballs'. Many suppliers have chosen to specialise in catering for polydrug use. It is not clear what happens if one substance is made more difficult or expensive to obtain. Some maintain that the natural response is to switch to another. Others argue that, on the contrary, tightening policy on one drug may reduce consumption of another. In particular, increasing the price of alcohol will often reduce both drinking and marijuana consumption. There are similar overlaps between smoking and marijuana use and between drinking and the use of both heroin and cocaine.³⁹

It is not easy to predict how the drugs market may adapt to accommodate new technological possibilities. The 2005 Foresight study on *Brain Science, Addiction and Drugs* sought to 'provide a challenging vision as to how scientific and technological advancement may impact on our understanding of addiction and drug use over the next 20 years'. Among other projections, it raised the prospect that 'minimally refined agricultural products' (e.g. the 'big three' of heroin, cocaine and cannabis) may be threatened by 'high-tech' synthetic alternatives. A development along these lines could well present problems for countries like Britain that have advanced biotechnology sectors and therefore the means to take a lead in this particular market. The central point is that the drugs industry is not static; it is highly dynamic. It presents those who seek to enforce the law with a constantly moving target.

The drugs trade in Britain

It is hard to estimate the current scale of the drugs industry in Britain. According to the 2003 Strategy Unit report:

Less is known about the UK drugs market than about drug production and trafficking overseas. Data across the UK drug

supply chain has not been consistently collected, analysed and interpreted. UK drug suppliers are numerous, operate in a fluid fashion and adapt effectively to surveillance efforts. As a result, there are still significant gaps in government knowledge about the UK market in drugs: the typical number of links in the domestic supply chain is estimated at between four and seven, but there is insufficient evidence to be certain; the buy and sell rates at the various points in the chain (other than wholesale and retail) are largely unknown; revenues and profits along the chain can only be estimated; though the numbers of individuals involved in the chain can be estimated, there is little hard evidence or intelligence available.

Five years ago the Office of National Statistics estimated the size of the drugs market in the United Kingdom as between £3.9 and £8.5 billion a year. A Home Office Research Study in 2001 made a more precise estimate of £6.6 billion but suggested that this figure might be inflated.⁴⁰ A more recent Home Office study proposes an estimate of between £4 and £6.6 billion.⁴¹ In 2003, however, the Strategy Unit valued the heroin and cocaine market alone as worth more than £4 billion. The Independent Drugs Monitoring Unit, a drug-prices research company, estimated the value of the drugs market in 2004 as a means of indicating how much the industry could be worth to the Treasury were the government to legalize and tax it. They calculated that the market had a current value of between £2.12 and £6.54 billion.⁴²

There is some domestic production of drugs within the UK. About 60 per cent of cannabis consumed in Britain is now cultivated here, with an increasing amount home-grown for personal consumption but also a sharp rise in the amount being grown by organized networks.⁴³ In London, in particular, the involvement of Vietnamese criminal networks in the large-scale manufacture of cannabis has increased dramatically since April 2005. Some police forces have been reporting seizures of cannabis that have gone up by 600 per cent in the last couple of years and a national crackdown on illegal factories was launched in September 2006. There is also some level of production of synthetic drugs in the UK. One report in 1999 suggested that a quarter of all ecstasy tablets seized in Britain (about one million in total) had been manufactured here, and that the UK was actually exporting ecstasy to the US.⁴⁴ The report also claimed an increase in the manufacture of amphetamines, with precursor chemicals brought in from Eastern Europe, where there is much corruption in the chemical and pharmaceutical industries. Recently police reports have suggested that the number of

⁴⁰ E Bramley-Harker, 'Sizing the UK market for illicit drugs', Home Office RDS No. 74, 2001. www.homeoffice.gov.uk/rds/pdfs/occ74-drugs.pdf

⁴¹ ed. N Singleton, R Murray, L Tinsley, *Measuring different aspects of problem drug use: methodological developments*, Home Office Online report 16/06, 2006.

⁴² M Atha, 'Taxing the UK Drugs Market', Independent Drugs Monitoring Unit, 2004. <http://www.idmu.co.uk/taxukdm.htm>

⁴³ Joseph Rowntree Foundation, *The domestic cultivation of cannabis*, 2003.

⁴⁴ *Independent*, 20.6.99.

methamphetamine laboratories, previously believed to be very low, has started to increase.

⁴⁵ *Economist*, 25.11.04,
<http://cocaine.org/cokecrime/prices.html>

However, most of Britain's involvement in the international drugs trade takes the form of import, distribution, retail and money laundering. The Strategy Unit report offered rough estimates of the numbers of people who were involved in the heroin and cocaine trades in Britain in 2003: 80–120 major importers of cocaine selling to 'hundreds' of major distributors and 'thousands' of wholesalers, and 30–50 major importers of heroin selling to 120–160 major distributors and more than 1,500 wholesalers.

⁴⁶ T Bennet and K Holloway, *Understanding drugs, alcohol and crime*, Oxford University Press, 2005, p.66.

Import and distribution at the middle-market level are largely dominated by a relatively small number of criminal groups, but again these groups are less like tightly organized and centralized units than networks or partnerships of independent traders or brokers. This is particularly evident in the case of the cocaine trade, according to a 2004 report in the *Economist*:

The market is opening up... The London-based Colombian importers who traditionally controlled the import and wholesale trades now contract freely with British entrepreneurs. A recent trend is for Britons living in Spain to deal directly with Central American suppliers before selling on to Colombians in London or directly to an army of middlemen.⁴⁵

The middle market remains a shadowy area in Britain, though an increasing body of information is being accumulated through the study of organized criminal networks and through projects such as the 'Street Level Up' initiative being piloted in several areas. 'Street Level Up' seeks to promote the pooling of intelligence at different levels and between different agencies in order to trace drug supply routes from the final point of delivery on the streets back through every step in the supply chain to the point of entry into the country and even beyond. This initiative should yield more information about the networks of distributors and wholesalers lying behind the host of street dealers who are more visible to the police.

With no recourse to law for protection or help in enforcing contracts, the drugs trade is frequently dangerous and brutal. There are links with gun crime, particularly in the crack cocaine trade. Dealers frequently carry guns, sometimes sell guns and occasionally accept guns as part payment for drugs.⁴⁶ Violence is frequently used or threatened in order to deter fraud, betrayal, theft and dishonesty. It is also used to settle disputes over territory between rival dealers, to eliminate informers and to punish lesser players for selling adulterated drugs or failing to pay debts.

Despite all this, the drugs trade at the lower levels in Britain often operates much like any other small-scale trading operation. Research in 2005 into the views of drug dealers, conducted among offenders from Nottinghamshire and Leicestershire, revealed a trade that seemed neither a menacing nor a glamorous one, which many had entered because they had no other means of earning money.⁴⁷ Most claimed that their dealing of drugs was demand-led. They do not actively promote drugs to people who are not already using them because they do not need to do so: there is already a market that is too big for existing suppliers to meet. For the same reason, competition between dealers is not often a major issue at this level. When it does become an issue, one dealer may try to under-cut his neighbours by offering 'freebies' or discounts on bulk purchases. Some small dealers buy from a range of suppliers, different ones for different drugs, chosen for their reliability, convenience and availability and the quality, price and economy of their products. Some dealers said they are prepared to give short-term credit, others will accept goods instead of cash. A few disclosed that they would occasionally accept sex.

⁴⁷ K Broadhurst et al, 'Research into the views and perceptions of drug dealers', PRC International, 2005.

A demand-led industry

The illegal drugs trade in Britain has proved no less difficult to eradicate than its global counterpart. Billions of pounds have been spent on this objective, but production, supply and consumption continue, largely because the drugs trade obeys the same laws and is subject to the same market forces as any other industry.

Companies shut down and industries decline because of a sudden or structural reduction in demand. This is unlikely to occur in the case of the illegal drugs trade. Changes in taste and the emergence of cheaper, more cost-effective alternatives may shape future demand, but such developments are likely to be gradual and there is nothing to suggest that the alternatives will be legal. Indeed, market pressures and competition have worked together to keep illegal drugs ever more affordable.

As long as there is a demand for illegal drugs, the drugs industry will be ready to meet it. Because the trade is so diverse and because it involves such a multiplicity of organizations and individuals, it is extraordinarily resilient. Every time a dealer is arrested or a network shut down, another takes their place. On the basis of the simplest economic measures, this is a highly successful business, in some ways more efficient and better equipped than the agencies that seek to disrupt it. The resources at the disposal of the drugs trade, combined with its incentive

to continue trading, mean that it is unlikely to be eradicated any time soon.

We will return in Chapter 10 to the issue of how resources should be allocated in order to reduce the supply of illegal drugs. The next chapter, however, explores in greater detail the nature of demand in Britain and the pattern of illegal drug use.

4 Illegal drug use in Britain

Just as policy makers need to face the realities of the trade in illegal drugs, they must also acknowledge actual patterns of drug use. Unfortunately, if there is one fact on which drugs policy makers are agreed, it is that drug statistics are inevitably incomplete. Available data tend to place a disproportionate emphasis on people who have experienced problems with their drug use while overlooking those who have not. Even among the population of problematic drug users, the data almost certainly under-estimate the size of a group that prefers to remain hidden or falls beyond the reach of the agencies that could count it.

A wide range of figures is gathered: on seizures of drugs, trafficking offences, possession offences, dealers' assets confiscated, drug-using offenders referred into treatment, people presenting voluntarily for treatment, hospital admissions for drug-related illness or injury and drug-related deaths. They are collected in different ways, in ways that are not always consistent with each other, by a range of different agencies: police, Customs, treatment providers, Drug Action Teams, the Office of National Statistics and the National Treatment Agency. In addition, there is the British Crime Survey, which includes a supplementary section on knowledge of drugs, attitudes to drug use and actual experience of it. (The British Crime Survey is limited to England and Wales: Northern Ireland and Scotland publish their own crime surveys.) Research is carried out by universities, the Home Office, the devolved Administrations and other public bodies. In addition, market research agencies such as YouGov and MORI regularly conduct surveys on drug use and public attitudes towards it, which provide snapshots of prevalence. YouGov conducted two such surveys for the RSA in collaboration with *The Daily Telegraph* in June 2006, to which this report makes reference.

Both official statistics and survey data leave gaps in the overall picture of drug use. If National Treatment Agency data include only those users who have presented for treatment, and arrest data cover only those believed to have committed a crime, there is no record of the very large number of users who have

not committed a crime and do not seek treatment, or who have committed a crime that has not been reported, or who do need treatment but are not getting it. Current statistics do not include data gleaned from outreach workers, who are more likely than anyone else to have information about ‘hidden’ users known neither to the police nor to treatment services. Surveys similarly omit some of the most vulnerable groups – groups that are unlikely to volunteer for such exercises. In any case, when an act is illegal, self-reporting is unlikely to be accurate. The British Crime Survey, for example, covers only households, so it excludes the homeless, people in prison or in the army and people living in student halls of residence and residential treatment centres: in other words, a large proportion of the most likely users. General surveys rarely ask exactly how people administer drugs or how often they use them, they do not ask whether or how people combine different drugs or use drugs with alcohol, and they do not ask why people move from one drug to another.

How many people in Britain use illegal drugs?

For all these reasons, many of the figures on which policy is currently based are likely to be significant underestimates. That said, the most recent calculation of the number of people in England and Wales who have ever used illegal drugs suggests a figure of almost 11 million, some 34.9 per cent of people between the ages of 16 and 59. (The estimated percentage for Scotland is lower, at 24 per cent.)⁴⁸ A third of those people – 13.9 per cent of the whole age group, around four and a half million – have used Class A drugs. These figures include people who have experimented briefly, perhaps only once, with drugs and have then stopped. A much lower number – less than three and a half million or 10.5 per cent of this age group – had used drugs in the previous year (2005) and a lower proportion still – 6.3 per cent, around 2 million – in the last month. (Having used drugs in the last month is sometimes taken as a rough equivalent of being a current user.) Just over 1 million people in England and Wales used Class A drugs in 2005; 750,000 used powder cocaine, 500,000 used ecstasy. Almost one in ten people in this 16–59 age group – 8.7 per cent – used cannabis. Just over 500,000 people in England and Wales had used Class A drugs in the last month.⁴⁹

A large majority of the people who have ever used drugs are between 16 and 24 years old. In England and Wales, some 2,750,000 people in this age group – around 45 per cent – have used illegal drugs at least once in their lives and around 1,500,000 did so during 2005, 25.2 per cent of all

⁴⁸ Drug Misuse Information Scotland, *Drug Misuse Statistics Scotland 2005*.

⁴⁹ All statistics in this paragraph are from Home Office Statistical Bulletin 15/06, *Drug Misuse Declared: Findings from the 2005/06 British Crime Survey*.

young adults. More than half of that number – 15.1 per cent of the age group – reported having used drugs in the last month.⁵⁰

Over one million 16–24 year olds in England and Wales have used Class A drugs at least once in their lives. The British Crime Survey for 2004/5 reported 34,000 people in this age group as saying they had used heroin, 9,000 of them in the last year, 5,000 in the last month. The Survey for 2005/6 reports, by comparison, that 531,000 people in this age range have used cocaine, 350,000 in the last year and 127,000 in the previous month. The figure of 350,000 represents 5.9 per cent, or more than one in twenty people of this age. A similar proportion – 4.3 per cent – said they had taken ecstasy in the previous year. The percentage taking cannabis was very much higher: 21.4 per cent overall and 30 per cent of young men.⁵¹

A separate set of statistics suggests the numbers of school children in England between the ages of 11 and 15 who have taken or are taking drugs.⁵² The overall proportion has remained fairly steady in recent years at around 28 per cent (as compared with 39 per cent who have ever been offered drugs). Nineteen per cent of those surveyed said they had used drugs in the last year, 11 per cent in the last month.⁵³ Only 1 per cent said they had ever used heroin or cocaine, but 4 per cent had used Class A drugs, suggesting a higher level of ecstasy use. Twelve per cent of children in the overall age group had used cannabis, 1 per cent of 11 year olds and 27 per cent of 15 year olds. The use of volatile substances was also relatively high, at 7 per cent of 15 year olds and 4 per cent of 11 year olds, a slight rise in levels on the previous year. (Glue sniffing in this age group has increased sevenfold over the last ten years.)⁵⁴ Of those children who said they had taken drugs in the last year, over a third said they had taken them at least once a month and 7 per cent said they had taken them most days.

From the treatment perspective, it is less important to know exactly how many people are taking drugs than to know how they are taking them and therefore what the consequences are likely to be. Drug users can be broadly divided into three groups: young experimental users; moderate social users; and heavy chaotic users.

Anyone using any drug is running a degree of risk. The distinction often made between ‘recreational’ and ‘problematic’ drug use tends to suggest that ‘recreational’ use is safe. Though recreational use is made of virtually every illegal drug, the term ‘recreational’

⁵⁰ Ibid.

⁵¹ Ibid.

⁵² National Statistics, *Drug use, smoking and drinking among young people in England in 2005, 2006*.

⁵³ Scottish statistics from the Scottish Schools Adolescent Lifestyle and Substance Use survey 2004 revealed that 35 per cent of 15-year-olds and 13 per cent of 13-year-olds reported that they had never used drugs. 31 per cent of 15-year-olds and 16 per cent of 13-year-olds reported that they had used drugs in the previous year. 20 per cent of 15-year-olds and 7 per cent of 13-year-olds reported that they had used drugs in the previous month.

⁵⁴ Institute for Public Policy Research, *Freedom's Orphans: raising youth in a changing world*, November 2006.

is most usually applied to the social use of drugs at parties, clubs and dance events by the first two groups above – young experimental users and moderate social users. The drugs most commonly labelled as ‘club drugs’ or ‘dance drugs’ include ecstasy, amphetamine, ketamine and GHB. Treatment providers point out that these drugs are different in their chemical composition and in their effects: ecstasy is an empathogen, amphetamine a stimulant, ketamine a dissociative anaesthetic and GHB a depressant. To lump them together and label them as ‘recreational’ drugs risks trivializing kinds of drug use that should not be assumed to be entirely safe, even if they are experimental and moderate.

However, it remains true that the vast majority of health harms, drug-related crimes, ruined family relationships and disrupted lives are suffered and inflicted by the third and smallest group above: heavy chaotic drug users.

Problematic drug users

Current government policy focuses most closely on ‘problematic drug users’ as distinct (though this is not explicitly spelled out) from people who take drugs for pleasure without doing significant harm either to themselves or to other people. Problematic users may be defined as people who experience (and sometimes cause) a variety of social, psychological or physical problems that are related to intoxication, regular excessive consumption or dependence on drugs. A significant proportion of problematic users are injecting heroin users.

One study calculated the number of problematic drug users in England in 2001 at 287,670 and the number in the United Kingdom as a whole at 360,811.⁵⁵ The most recent study from the Home Office has increased the estimate for England to 327,466.⁵⁶ Another study speculates that the upper figure may be nearer 500,000.⁵⁷ Other observers suggest that the important point is that whatever the figure is, it remains largely constant from year to year. It is also worth noting that, while the total number of problematic drug users in Scotland was recently estimated to be 51,582,⁵⁸ the *rate* of problem drug use is higher in Scotland than elsewhere in Britain. The rate of injecting drug users in Scotland is higher still, at more than twice the UK average.⁵⁹

Comparative levels of drug use

According to the latest UN figures, Britain has the highest proportion of opiate users in the world. We also have the highest levels of cocaine and amphetamine use in Europe and a level of cannabis use second only to that of Spain.

⁵⁵ M Frisher et al, ‘Prevalence of problematic and injecting drug users for Drug Action Team areas in England’, *Journal of Public Health* 2006 28(1): 3-9.

⁵⁶ ed. N Singleton, R Murray, L Tinsley, *Measuring different aspects of problem drug use: methodological developments*, Home Office Online report 16/06, 2006.

⁵⁷ C Godfrey et al, *The economic and social costs of Class A drug use in England and Wales, 2000*, Home Office Research Study 249, 2002.

⁵⁸ G Hay et al, ‘Estimating the national and local prevalence of problem drug misuse in Scotland: executive report’, Centre for Drug Misuse Research, University of Glasgow, 2005.

⁵⁹ Reitox, *United Kingdom Focal Point Report 2005*, p.53. The rate of problem drug use per thousand population in England in 2000/01 was 8.91, whereas in Scotland in 2000 it was 16.65. The rate of injecting drug use in England was 2.89, in Scotland it was 7.737. The UK average was 3.2.

The table below has been compiled from lists setting out the annual prevalence of drug consumption worldwide in the *UN World Drug Report 2006*. The figures represent the percentage of each country's population thought to be using that drug.

Table 2: Percentage of country's population thought to be using particular drugs, 2006

	Opiates	Cocaine	Cannabis	Amphetamines	Ecstasy
Australia	0.5	1.2	13.3	3.8	4.0
US	0.6	2.8	12.6	1.5	1.0
UK	0.9	2.4*	10.8	1.5	2.0
Czech Rep	0.4	0.1	10.9	1.1	2.5
France	0.4	0.3	9.8	0.2	0.3
S Africa	0.3	0.8	8.4	0.4	0.4
Netherlands	0.3	1.1	6.1	0.6	1.5
Ireland	0.6	1.1	5.1	0.4	1.1
Portugal	0.7	0.3	3.3	0.1	0.4
Sweden	0.1	0.02	2.2	0.2	0.4
Thailand	0.1	0.01	1.5	0.7	0.1

Source: Figures are from the *UN World Drug Report, 2006*. The figures in the UN report are taken from different years and some are not recent; for instance, the British figures for heroin are for 2001, while the Australian figures are for 2004 and the French ones for 1999.

*Figure refers to England and Wales only.

The table reveals some interesting features of drug use in other countries. First, the Netherlands, which is well-known for more liberal policies towards cannabis use, has lower levels of consumption than Britain, not only of cannabis but of any drug. Second, Portugal, which in recent years has decriminalized the possession of drugs, has similarly low levels of consumption. Third, Sweden, which pursues a policy of strict prohibition combined with extensive education and intensive treatment, has a far lower rate of drug use than the USA where prohibition is not similarly embedded in a programme of social care. Above all, the table suggests that levels of drug use are determined not simply by the accessibility of drugs or the stringency with which they are regulated but also by the social cultures within which drug use takes place.

The Home Office, however, observes that the ways in which figures are gathered vary from country to country. Figures for the United Kingdom are collected using methods different from those used in other countries, and a degree of caution should therefore be exercised in making comparisons between countries.

Who is using what?

Sweeping statements about drug use are also fraught with danger because different people take different drugs for different reasons and in different ways. Drug use is more common among adults with lower than average incomes, but it is also more common among adults with higher than average incomes. Teenagers may take drugs because they are friendless and isolated, or because they have drug-taking friends and go out more. Teenagers may take drugs in order to be different from adults, or because they have drug-taking parents and drug-dealing role models. So while certain general patterns can be observed, it is necessary to qualify these and to explore the variations which the overall statistics often mask.

Descriptions of drug use in the press, in books and in films are populated with stereotypes, which non-users embrace eagerly as a means of distancing the phenomenon from themselves and their families. The stereotypes do exist, but they obscure a very much wider range of people and types of use: users in their fifties and sixties, Asian users, primary school children, refugees, country dwellers, people on diets and frequenters of gyms in search of a good physique.

Some generalizations, however, are supported by the available data:

Age

A majority of drug users are young. People between the ages of 20 and 24 have the highest rate of drug use, followed closely by people between 16 and 19. The majority of problematic users are slightly older, around 28–30, judging by the age at which people first present themselves for treatment. However, the age at which people first report drug use is falling. One study of pre-teen children suggested that 30 per cent of 10–12 year olds interviewed in Glasgow and Newcastle had been exposed to drugs and a small but significant proportion of the sample (4 per cent of the total) had used them: mostly cannabis, but also LSD, heroin and cocaine.⁶⁰ That study suggested that 60 children below the age of 13 in Glasgow had used heroin. A more recent report from the Scottish Children's Reporter Administration revealed that children as young as eight are being referred to the Reporter with drink and drug problems.⁶¹ Drug use among pre-teens is associated with drinking and smoking and with drug use in the family. It is more common among children living in step-families than in either two- or one-parent families. Although people under 15 are still the smallest group reporting for treatment in Scotland, their numbers are rising fastest.⁶² The number receiving treatment has quadrupled in the last seven years to 418.

⁶⁰ N McKeganey et al, 'Pre-teen Children and Illegal Drugs', *Drugs: education, prevention and policy*, Vol. 11, No. 4, August 2004.

⁶¹ Scottish Children's Reporter Administration figures for 2004/5 presented in August 2006. http://www.drugscope.org.uk/news_item.asp?a=1&intID=1346

⁶² *Drug Misuse Statistics Scotland 2004*, ISD Scotland 2005.

Equally, the number of older drug users is growing. Some of these are simply people who started using drugs when they were young and have never stopped, others are people who have started drug use later in life than has previously been the norm. A larger proportion of people now continue to use recreational drugs into their thirties.⁶³ (A recent study in Australia suggested that a small number of people over 45 are using ecstasy: mothers and grandmothers, for example, ‘to assist in renewing sexual relations with Viagra-enhanced fathers and grandfathers’.)⁶⁴ Statistics for Scotland in 2003 revealed that the percentage of drug misusers over 40 had increased from 5 per cent in 1999 to 8 per cent in 2003.⁶⁵ The refinement of methadone treatment has also enabled a greater proportion of heavily dependent heroin users to survive into old age, but some doctors report seeing a new group of patients with ‘late onset’ drugs problems as well as ageing existing users.⁶⁶

Gender

The majority of drug users are male. In general, men are more likely than women to take drugs – the British Crime Survey for 2004/5 says almost twice as likely. There are also more men in treatment as problematic users, in the ratio of approximately 3 to 1 (slightly less in Scotland).⁶⁷ The use of Class A drugs in the past year amongst men aged 16 to 59 has increased over the last eight years, whereas amongst women it has remained stable.⁶⁸ Women take fewer ‘hard’ drugs, prefer to swallow than to inject, take drugs less often and would seem to give up earlier. More women are in treatment for ‘softer’ drugs – recreational use of ecstasy, for example, or dependence on sedatives. But where some forms of data capture are concerned, women remain something of a ‘hidden population’, so statistics may be misleading. The situation is fluid and generalizations can be deceptive. For example, a recent study of gender differences in drug taking in the European Union observes that where drug taking is most prevalent (and that would include the United Kingdom), the ratio between the sexes is more equal than elsewhere. The same study also found that female drug taking is increasing more rapidly in schools, which would suggest that there will be more similar drug-taking patterns between sexes in future and a considerable increase on overall prevalence levels. Finally, the study found that the ratio of male to female users is more equal for occasional recreational use than for regular drug taking, and that the ratio of male to female users of cannabis and ecstasy is more equal at school than in adulthood.⁶⁹

Some commentators reject the once-common idea that female drug use is somehow more pathetic and culpable than male

⁶³ Reitox, *United Kingdom Focal Point Report 2005*, p.27.

⁶⁴ P Williams, ‘Correlates of ecstasy use in middle age and beyond’, *Drug and Alcohol Review*, January 2005.

⁶⁵ *Drug Misuse Statistics Scotland 2004*, op.cit.

⁶⁶ See, for example, presentation given by consultant psychiatrist Daphne Rumball at the Society for Study of Addiction conference, November 2005, York.

⁶⁷ M Hickman et al, *Estimating prevalence of problem drug use: multiple methods in Brighton, Liverpool and London*, Home Office online report 36/04, 2004. *Drug Misuse Statistics Scotland 2006*, 2006, puts the male attendance rate at more than twice the female attendance rate.

⁶⁸ Home Office Statistical Bulletin 15/06, *Drug Misuse Declared: Findings from the 2005/06 British Crime Survey*.

⁶⁹ ECMDDA, *Differences in patterns of drug use between women and men*, 2005.

use and have emphasized that women are just as likely as men to use drugs for pleasure.⁷⁰ It remains true that women may use drugs differently: a recent study suggests that women perceive risk differently, being more likely than men to acknowledge wider social as opposed to personal harms and to be aware of them at an earlier age.⁷¹ And there are suggestions that some groups of women may be at particular risk of misusing some drugs – stimulants during dance events, for example.⁷² In general, single people are most likely to take drugs, followed by people who are cohabiting, with married and widowed people being the least likely.⁷³

Other generalizations about drug use – about race, class and the areas to which drug use are confined – are more misleading:

Geography

Not all drug users live in inner cities. It is true that generally speaking the greatest concentration of drug use occurs where the population is densest, as here it is easiest to find dealers and other users. Levels of Class A drug use in particular are highest in inner cities, where there are more opportunities for the acquisitive crime and sex work that often funds problematic drug use. In England and Wales in 2004 the main areas of illicit drug use were London (with 14.7 per cent of the population between 16 and 59 involved in it), the South West, the North West and the South East. The North West had more people in contact with treatment services than any other government region: 22 per cent of the national total, a total of 27,909 people in 2003/04. One in every hundred residents between the ages of 16 and 44 was in contact with services, mostly for opiate use.⁷⁴ The North West area includes Liverpool and Manchester, and certainly large cities like these, including Cardiff, Birmingham, Leeds and Bristol, all have serious drug problems. But so do Torbay, Milton Keynes, Eastbourne and Ipswich, all of which featured in the British Crime Survey statistics for 2003/4 as towns with drug-related crime statistics above the national average. Levels of drug use may be rising faster in suburbs than in city centres.⁷⁵ And, while rural areas have the lowest prevalence over all, most small towns and villages are within reach of dealers from urban centres and can soon develop their own local entrepreneurs. (In Penzance in Cornwall, the price of heroin was brought down from £60 to £40 a gram in 2005 by an influx of dealers from the Liverpool area, 400 miles away.)⁷⁶ Reports of drugs ‘invading’ remote communities are commonplace, and the problems that drug use causes are compounded by the relative scarcity of treatment services in rural areas and the stigma that a drug habit can attract in a close community.⁷⁷

⁷⁰ For more on this, see Sheila Henderson, ‘Drugs and Culture: the Question of Gender’, in ed. N South, *Drugs: Cultures, Controls and Everyday Life*, Sage, 1999.

⁷¹ Drug and Alcohol Education and Prevention Team, ‘A briefing paper for drug education practitioners: gender and drug education’, Alcohol Concern and Drugscope, 2005.

⁷² J McCambridge et al., ‘Can it really be this black and white? An analysis of the relative importance of ethnic group and other socio-demographic factors to patterns of drug use and related risk among young Londoners’, *Drugs: education, prevention and policy*, Vol 12, No. 2, April 2005.

⁷³ *British Crime Survey 2003/04*.

⁷⁴ Analyses of the National Drug Treatment Monitoring System, ‘Drug treatment in the North West of England’, 2003/04.

⁷⁵ R Aust and J Condon, ‘Geographical Variations in Drug Use: key findings from the 2001/02 British Crime Survey’, 2003.

⁷⁶ ‘Street drug prices 2006’, *Druglink*, September/October 2006.

⁷⁷ See, for example, a BBC news report on 14 October 2005 entitled ‘Drugs fears for rural youngsters’, <http://news.bbc.co.uk/1/hi/scotland/4241696.stm>, which suggested that addiction rates in largely rural Dumfries and Galloway are higher than those in Edinburgh and Aberdeen.

Ethnicity

The prevalence rates for the use of most drugs are higher among white people than in black and minority ethnic communities. Levels of cannabis use among Black Caribbeans and whites are similar; levels of heroin use are higher among whites, while Black Caribbeans report higher levels of crack cocaine use. Drug use has in the past been less common in Asian communities but it would be a mistake to suppose that young Asians are uniquely protected by their culture against the social, emotional and psychological pressures which lead any other young people to take drugs. Professor Kamlesh Patel, the government's chief adviser on mental health and ethnicity, suggests that they are actually subjected to additional stresses – discrimination, conflicts of identity and alienation from the values of their parents – and he reports that drug use among South Asian populations (Pakistani, Indian and Bengali) has been growing at a faster rate than in the white population over the past five years.⁷⁸ He notes that Pakistani communities dominate the heroin market in the north of England, making access to the drug easier, and Bangladeshis dominate the market in areas like Tower Hamlets in London. Service providers report that many Pakistani and Bangladeshi youths begin their drug use with heroin, bypassing both cannabis and alcohol.⁷⁹ Heroin use has also been reported in Vietnamese communities, in London and elsewhere, both among young people and among older people who came to England as refugees, many of them from refugee camps in Hong Kong.⁸⁰ Drug use, primarily the use of cannabis, is reported to be increasing in some Chinese communities, although it remains at a lower level than in other ethnic groups.⁸¹

The Bangladeshi community would appear to be particularly at risk, as the youngest, fastest-growing and most deprived of the Asian ethnic minorities. In 2001 in London the prevalence of problematic heroin use was already proportionately far higher among young Bangladeshi men than among their white counterparts: 4 per cent of the 16–24 age group as compared to 1 per cent of white men of that age.⁸² In Tower Hamlets in 2001, 79 per cent of under-25 heroin users were Bangladeshi, though they only accounted for 18 per cent of the population. The 2001 study reported very little drug use among Bangladeshi women, but more recent research has suggested that this may be changing and that there is a largely hidden population of female drug users engaging in high-risk behaviour but prevented by cultural constraints and the fear of stigma from seeking treatment.⁸³

Class

The use of drugs is not constrained by socio-economic group. With the prices of most drugs having dropped both in absolute

⁷⁸ BBC website 17 June 2006.

⁷⁹ Ethnicity and Health Unit, University of Central Lancashire, Memorandum 23 submitted to the House of Commons Home Affairs Select Committee. September 2001.

⁸⁰ See, for example, the work of the Orexis drugs service in North Lewisham which caters primarily to drug users from Vietnamese and Somali communities. <http://www.orexis.org.uk/Research.htm#agency>

⁸¹ A Ross et al, 'Drug issues affecting Chinese, Indian and Pakistani people living in Greater Glasgow', *Drugs: education, prevention and policy*, Vol.11, No.1, 2004.

⁸² R White, 'Heroin use, ethnicity and the environment: the case of the London Bangladeshi community', *Addiction*, 96, 2001.

⁸³ G Cottew et al, 'Illicit drug use among Bangladeshi women living in the UK: an exploratory qualitative study of a hidden population in East London', *Drugs: education, prevention and policy*, Vol.12, No.3, June 2005.

terms and in relation to other consumer goods over the last ten years, ecstasy is found on street corners in council estates as well as at parties in wealthy suburbs. Cocaine is becoming a street drug as much as a middle-class accessory. The British Crime Survey in 2005 revealed for the first time that cocaine users are more likely to be semi-skilled or skilled manual workers than professionals.

The substances that people use

Polydrug use

The picture of drug use in Britain is complex and is blurred further by a growing tendency for people to take combinations of drugs in what is known as 'polydrug use'. People increasingly use more than one drug and often six or more, including tobacco and alcohol; some people will use as many as 20. The objective is to use one drug to enhance the effect of another or to mitigate its after-effects: for example, smoking heroin to come down after ecstasy use. 'Speedballing' – injecting crack and heroin together – is a particularly dangerous variant of polydrug use, as the crack has the effect of making the user want to inject heroin more frequently, increasing the risk of overdose and infection and the incentive to commit crime.

As far as individual drugs go, it is possible to generalise roughly as to who is taking what.

Heroin

Heroin and other opiates are still taken by a relatively small number of users – less than 1 per cent of the adult population – but they account for a large proportion of problematic use. In recent years it would seem that the incidence of injected heroin use has remained roughly stable but that the smoking of heroin has risen. (A small but significant number of immigrants, mostly Iranian, smoke opium.) A 2004 study in 12 London boroughs showed that 3.7 per cent of the population between 15 and 44 had used opiates and that 2.1 per cent were problematic users, with 1.2 per cent of them injecting users.⁸⁴

Cocaine

Cocaine in its powder form, as it gets cheaper, would seem to be crossing age barriers as well as class barriers. The typical cocaine user was previously thought to be single and between 25 and 30. Evidence now suggests that increasing numbers of 16–19 year olds are trying cocaine, possibly reacting to the intense and negative media campaigning around ecstasy and seeing cocaine as a safer, more predictable alternative.⁸⁵ People between 20 and 24 have become the highest users, according to the 2006 British Crime Survey report. In addition, there

⁸⁴ M Hickman et al, 'Injecting drug use in Brighton, Liverpool, and London: best estimates of prevalence and coverage of public health indicators', *Journal of Epidemiological Community Health*, 58, 2004.

⁸⁵ A Boys et al, "'Rich Man's Speed": a qualitative study of young cocaine users', *Drugs: education, prevention and policy*, Vol. 9 No. 2, 2002.

was a rise between 2004 and 2005 in the number of users between 35 and 44. The Chair of Edinburgh's Alcohol and Drug Action Team, former deputy Chief Constable Tom Wood, warned in October 2006 that cocaine is rapidly becoming more of a problem in the city than heroin, mostly on the club scene.

Crack

Crack has traditionally had the image of a drug of deprivation, the cheap and somewhat squalid poor relation of powder cocaine. It is true that in England and Wales, among groups of people officially labelled 'vulnerable' – young people in care, for example, or on the streets – there are twice as many crack users as heroin users.⁸⁶ Crack use is also more common among sex workers, and it has been heavily marketed by dealers to problematic heroin users.⁸⁷ But treatment providers have been seeing the growth of a less obvious and more heterogeneous group of crack users, according to one drugs worker:

Now half of crack users we see have a job...middle-aged businessmen, career minded men, women in their early 30s with histories of recreational ecstasy and cannabis use... In Manchester crack use is now less of a "deep dark secret" for some and appears to be taking on something of a positive macho image in some social circles – the very same social circles which five years ago took great pleasure in baiting and beating the local "rock heads".⁸⁸

Ecstasy

Ecstasy has now been a clubbers' drug of choice for almost twenty years. According to a 2003 United Nations report, the appeal of taking ecstasy, apart from the physical and psychological effects, is that it is cheap, convenient and something one does with friends:

Taking the drugs usually does not require needles, syringes or heating paraphernalia; in most cases, there is little risk of blood-borne diseases. Pill-popping is seen as efficient, with effects that can be calibrated to suit individual preferences. Low prices make the cost of a pill trip about the same as that of two or three pints of beer.⁸⁹

More recent reports suggest that it is now also 'replacing cans of lager and cider as the street corner drug of choice for children on council estates trying to fend off the bleakness and boredom in their lives'.⁹⁰

Cannabis

Cannabis tends to be used more like tobacco and coffee than like other drugs. It also tends to be used by a wider variety of users

⁸⁶ Home Office Findings, 'Drug use among vulnerable young people: findings from the 2003 Crime and Justice Survey', 2005.

⁸⁷ Greater London Alcohol and Drug Alliance/GLADA, 'An evidence base for the London crack cocaine strategy', 2004.

⁸⁸ Tim Bottomley, Manager of the Piper Project in Manchester, 'Cracking the market', *Druglink*, Nov/Dec 2004.

⁸⁹ United Nations, *Ecstasy and Amphetamines: Global Survey 2003*.

⁹⁰ M Daly, 'Ecstasy: the next generation', *Druglink*, May-June 2005.

than any other drug. It is the drug most commonly used by the youngest group of drug users, but it is also used by an increasing number of older people – not only habitual smokers from the 1960s but also first-time users using cannabis for medicinal reasons. The average strength of cannabis imported into Britain has remained relatively constant, but a far higher proportion of cannabis is now cultivated domestically, using intensive hydroponic techniques, and this kind of cannabis is much stronger. (Different varieties of seeds are used and given feed supplements under special lighting that can artificially lengthen day length; the resulting plants are also likely to be fresher when they reach the consumer, with no degradation of the THC content in storage.) Domestic production largely accounts for the increases in cannabis potency that have been raising health concerns in recent years.⁹¹

⁹¹ EMCDDA Insights No 6, *An overview of cannabis potency in Europe*, 2004.

⁹² EMCDDA Thematic Papers, 'Hallucinogenic mushrooms: an emerging trend case study', 2006.

⁹³ When magic mushrooms were placed in Class A by the Drugs Act 2005, as discussed in Chapter 19 below.

⁹⁴ J Bashford et al, Department of Health Black and Minority Ethnic Drug Misuse Needs Assessment Project, Community Engagement, Report 2: The Findings, May 2003.

Magic mushrooms

Magic mushrooms (most usually the liberty cap or *Psilocybe semilanceata*) are used for their hallucinogenic effects by clubbers and others interested in the various drug-assisted methods of expanding consciousness. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) reports that 'according to consumer market analysts there is a mega-trend for people to actively seek out more intense experiences and [to] be more prepared to experiment with new products than in the past', and this trend has enlarged the market for mushrooms.⁹² Until 2005 magic mushrooms were relatively easy to obtain, fresh from the field or from markets, or in their dried form from 'head' shops (specialist shops selling drug paraphernalia, T-shirts, posters and so on) or over the Internet.⁹³

Khat

Khat, a shrub whose leaves contain the mild stimulant cathinone, is chewed in some refugee communities in the UK, mostly Somali. Its effects are similar to a mild amphetamine, generating energy and making people more relaxed, talkative and friendly. There has been some recent concern that chewing khat is causing problems in Britain that do not occur in its native countries. In Somalia khat is used by adult men in moderate quantities in a social setting, at the *mafrish* or meeting-place. In Britain it is increasingly being used in far greater quantities by young men and boys with nothing else to do, and Somali women have complained that khat chewing is creating a community of under-achievers. Certainly excessive khat chewing can cause depression and lethargy, which interact with the other problems to be found in refugee communities. Eighteen per cent of the largest sample of black and minority ethnic drug users so far surveyed in Britain reported using khat.⁹⁴ The government decided in 2006 not to

make khat illegal, primarily on the grounds that use was confined to a relatively small group of people and that there was little evidence of any links with crime.

Volatile substances

Volatile substances such as glue, lighter fuel and aerosols are abused most often by younger children who have less access to other drugs. They are used particularly frequently by the most marginalized: looked-after children, persistent offenders, the homeless and those truanting or excluded from school. The mean age of first use is around 12, and at least as many girls as boys use them.⁹⁵ They have killed more than 1,000 people in the last twenty years.

Benzodiazepines

Benzodiazepines, tranquillisers such as diazepam and temazepam, are legally prescribed in very large quantities. GPs in England wrote 12.7 million prescriptions for benzodiazepines during 2002. Surveys suggest that in any one year one in seven British adults will take them and one in 40 will take them all year round. Twice as many women as men use them. Benzodiazepines are quite often prescribed with a disregard for the strict guidelines first issued by the Department of Health in 1988, which recommend limiting their use to a maximum of four weeks. More than a million adults in Britain are believed to be dependent on them.⁹⁶ Benzodiazepines are also widely used illegally as part of a pattern of polydrug abuse, to extend the effects of other drugs or palliate withdrawal from them. Illegal supplies on the street are largely diverted from doctors' prescriptions. When they are involved in drug-related deaths it is most usually in combination with alcohol, but they are also often involved in deaths from heroin and methadone overdose.

Over-the-counter medicines

Products such as painkillers, decongestants, sedative antihistamines, laxatives, kaolin and morphine and cough medicines, mostly containing opioids, are abused by taking far more than the recommended dose or combining them with alcohol.⁹⁷ (Three bottles of codeine linctus are equivalent to one quarter gram of street heroin.) The most problematic such drug is currently thought to be Nytol, marketed as a sleeping pill, abused more frequently since controls on benzodiazepines were tightened.⁹⁸ Opiate-based prescription medicines are also abused off-prescription, often when heroin and methadone users are unable to obtain their regular drug. Eleven per cent of people reporting for treatment for recent illicit drug use in Scotland in 2003/4 had used dihydrocodeine, an opioid narcotic pain killer

⁹⁵ D Best et al, 'Adolescent Psychological Health Problems and Delinquency among Volatile Substance Users in a School Sample in South London', *Drugs: education, prevention and policy*, Vol. 11, No. 6, December 2004.

⁹⁶ Drugscope website, http://www.drugscope.org.uk/druginfo/drugsearch/ds_results.asp?file=%5Cwip%5C11%5C1%5C1%5Cbenzodiazepines.htm

⁹⁷ G Akram, 'Over-the-counter medication: an emerging and neglected drug abuse?', *Journal of Substance Use* (2000) 5.

⁹⁸ In 2006 the police shut down a number of unlicensed websites allegedly selling prescription-only drugs illegally, including sleeping pills and steroids. The Medicines and Healthcare Products Regulatory Agency is currently investigating over 100 internet-related cases. *Drugs and Alcohol Today*, November 2006.

prescribed for severe pain or coughs. The worst affected areas are reported to be London, Strathclyde and Aberdeen.

What are the trends?

Official statistics suggest – though, as we have argued above, these statistics are open to challenge – that over the period from 1998 to 2005/6, there was a decrease in the number of people in England and Wales between 16 and 59 saying that they had used drugs in the last year. This was largely due to a decrease in the use of cannabis, reflected in other European countries where cannabis use has been established for a considerable time: it is in countries where cannabis has not been used for so long that its consumption is more obviously rising.⁹⁹

Over the same period the use of Class A drugs went up, largely because of an increase in the use of powder cocaine between 1998–2000. After this surge, the use of Class A drugs overall and cocaine in particular remained stable between 2000 and 2003/4, decreasing slightly between 2003/4 and 2004/5. However, the use of powder cocaine rose between 2005 and 2006, from approximately 600,000 to around 750,000 people.

According to these statistics, younger people take more drugs than older people but the overall trend in drug use for younger people would seem to be slightly downwards, whereas for older people it is rising slightly. For people between 25 and 59, overall drug use has remained stable between 1998 and 2006 and for those between 30 and 44 the use of Class A drugs has gone up. In contrast, in the group most likely to take drugs, those between 16 and 24, there has been a gradual decline in the overall use of drugs over the last five years, with a rise in cocaine use balanced out in the overall calculation by a decline in cannabis use. Among younger people still, children between 11 and 15, drug use has gone up markedly in the last ten years, though it seems to have stabilized recently.

The independent drugs information service Drugscope conducts an annual snapshot survey of street drug prices, usually a good indicator of trends in drug use. (While dips in price indicate primarily that the supply of drugs into Britain has gone up, the inference is that supply has risen to meet growing demand.) The 2006 snapshot would seem to confirm that, despite recurring media speculations about explosions, surges and floods of drug misuse of various kinds, the prices of drugs and therefore, most probably, the prevalence of drug use have remained relatively stable in recent years.

However, the Drugscope survey did identify some new trends. One is the rise of ‘speedballing’, which has become so common in some places that the combination of heroin and crack is treated as a drug in its own right. In Liverpool dealers are offering a free rock of crack for every two £10 bags of heroin bought, while in Ipswich buying a bag of ‘brown’ [heroin] and ‘white’ [cocaine] together yields a £10 discount on what would usually be a £30 purchase.

Tastes for other drugs ebb and flow. The number of people using heroin appears not to be rising significantly. Cocaine, on the other hand, would appear to be becoming the principal drug of choice for stimulant users, with the use of powder cocaine approaching the levels that have become common in the United States. Petra Maxwell of Drugscope remarks:

Every year we hear of increasingly large hauls of cocaine. You would expect the price to go up, but the size of the hauls seems to be an indication of the growing size of the market rather than how much we are making a dent in it.

Crack use has not reached the epidemic proportions that were predicted after its use rose sharply in the United States, and it is still concentrated largely in a few major cities, but it is rising and the sharpest rises are to be found outside the principal centres. Ecstasy may be reaching a wider (and younger) range of consumers, but its core market may be declining slightly as a much wider range of drugs becomes available for clubbers: GHB, Viagra, the psychedelic 2C-1, mescaline and a vast array of obscure designer drugs available over the Internet. MDMA, the base ingredient of ecstasy, is also available in powder and crystal forms, far purer and stronger than in the most common ecstasy tablets.

Ketamine is another alternative for clubbers, emerging in the 2006 Drugscope survey for the first time as one of the main drugs on sale in Britain. Originally designed for use as a veterinary anaesthetic, it was found as a drug of choice in places like Newmarket in Suffolk, a centre for racing and training horses. LSD, on the other hand, dropped out of the Drugscope list in 2006 for the first time (although the British Crime Survey reported a rise in its use among 16–24 year olds between 2004 and 2005). Amphetamine use, too, is said to be declining, though Britain still has the highest rate of use in Europe, and the Drugscope survey found no evidence yet of the promised eruption in the use of methamphetamine or ‘crystal meth’. Psilocybe mushrooms had been becoming increasingly popular on the music and dance scene, a development that some observers

linked to a parallel interest in natural and organic products. Since their inclusion as a Class A drug in 2005, however (see Chapter 19 below), it has become much harder to obtain them (though this has had the perverse effect of prompting retailers to market legal but potentially more dangerous alternatives like the fly agaric mushroom). Official statistics claim that cannabis use has decreased slightly in recent years, a claim substantiated by a recent study which suggested that clubbers may be using less cannabis and more alcohol.¹⁰⁰ There has been an increase, however, in heavier cannabis use among much younger people, which is quite often a predictor of later problematic drug use.

¹⁰⁰ J McCambridge et al, 'Has there been a decline in the prevalence of cannabis use among British nightclubbers? Five-year survey data', *Drugs: education, prevention and policy*, Vol. 12, No. 2, April 2005.

While it may be true that Britain has a relatively high proportion of Class A drug users compared with other European countries, it is also true that a very large number of people in Britain use Class A drugs without becoming addicted or habituated. According to the British Crime Survey, around four and a half million people have ever used Class A drugs. This is more than ten times the current estimated number of problematic drug users. Even looking only at those people who are recorded as having used Class A drugs in the last month, in 2005 these more regular users only totalled slightly more than 500,000, still easily outnumbering the estimated number of problem drug users.

The overall picture of drug use in the UK is thus a complex one, blurred by figures that almost certainly underestimate its prevalence. Patterns of drug use do not lend themselves accurately to sound-bite descriptions. Crude stereotypes of 'the drug user' tend to obscure the wide variety of people who use drugs and every generalization is subject to a number of important qualifications. Nevertheless, it is clear that several million British people have used illegal drugs at some point in their lives and that illegal drug use crosses the barriers of age, class and geography.

In terms of specific substances, heroin and other opiates are taken by relatively few people, less than one per cent, but users of these drugs account for a large proportion of problematic users. Cannabis, on the other hand, tends to be used more like tobacco and coffee than like other drugs, and it is used by a wider variety of users. However, even though the predicted epidemics of crack and methamphetamine on the American scale have not occurred and the overall level of cannabis consumption is down, there is no room for complacency. The current estimate of the number of problematic users – 327,466 – shows an increase of more than 50,000 over the previous estimate, produced little more than five years ago. Evidence suggests that people are starting to use cannabis younger and that there has been an

increase in heavy cannabis use and the availability of stronger varieties of cannabis. Cocaine use, too, is on the increase while more risky polydrug use, including the use of recreational drugs with alcohol, is rising.

The enduring prevalence of drug use is another fact of life that policy makers have to acknowledge. However, policy also has to take account of the fact that different drugs have different effects on different people in different contexts. It is to the effects of drugs that the next chapter turns.

5 Drugs' effects

The effects that drugs may have, both intended and unintended, depend to a large extent on the individuals who use them, on the drugs that they use and on how they use them. Those who support the prohibition of drugs tend to make little distinction between 'use' and 'misuse'; to them, all use is misuse. For their part, those who favour the liberalization of drug laws insist that the word 'misuse', with its derogatory connotations of damage and wrongdoing, is simply inappropriate in a wide variety of situations. As the Misuse of Drugs Act 1971 makes clear, any of the substances listed as 'controlled drugs' may legitimately be possessed and supplied under certain conditions by specified groups of people – doctors, dentists, vets and pharmacists – and taken as medicines to achieve effects that are acknowledged to be positively beneficial. But are there in addition types of non-medical drug use that are relatively harmless?

Types of use and user

Drug users themselves may be divided into several broad categories (though it is worth noting that the same person may fall into several different categories at different times, according to which drugs they are using and how they are using them):

- people who use drugs very occasionally and do neither themselves nor anyone else any significant harm;
- people who use drugs frequently and do neither themselves nor anyone else any significant harm;
- people who use drugs and do themselves harm;
- people who use drugs and do themselves and their families harm;
- people who use drugs and do harm to themselves and their communities;
- people who use drugs and commit crimes in order to pay for their drugs;
- people who commit crimes and use drugs, without necessarily committing the crimes *because* they use drugs.

People in the first two of these categories – those who do neither themselves nor anyone else any harm – are largely invisible to people who do not fall into either category, and for that reason it is virtually impossible to estimate their numbers accurately. However, if we compare the number of people whom surveys suggest have used drugs during a twelve-month period (around 3.5 million in 2005)¹⁰¹ with the number of people who were in drugs treatment during roughly the same period (around 132,000)¹⁰² or who appeared in court charged with drugs offences (178,500),¹⁰³ or even those officially designated by the Home Office as ‘problematic’ (around 327,500)¹⁰⁴, the difference is huge, even allowing for those who need treatment but are not getting it or those who are committing offences that are in fact related to drug use but are not characterized as ‘drugs offences’.¹⁰⁵

In other words, by any known measure the number of people who are not harming themselves or others as a result of using drugs exceeds by a wide margin the number of people whose drug use actually causes harm. Much drug use is relatively harmless. This fact helps to explain, though it does not entirely explain, why so many people use drugs and in some cases go on using them.

The National Treatment Agency, responsible for overseeing the care provided to individuals who do suffer serious harm, stated in a formal submission to the Commons Home Affairs Select Committee that these may be a small minority: ‘Most people use drugs because they enjoy them, and for the vast majority of users this experience remains pleasurable and under their control.’¹⁰⁶ The agency’s statement recognized, first, that drug use is for many people enjoyable and, secondly, that for many people it is controllable – that is, manageable. Of course, it goes without saying that a large part of such drug use is concerned only with the occasional use of cannabis or ecstasy. It also goes without saying that in the case of other psychoactive substances the notion of manageable use is widely accepted. The millions of pharmaceutical drugs prescribed every year are dispensed on the basis of manageable use, and it is generally agreed that the majority of people can regulate their alcohol use and that most people classify themselves, and would be classified by others, as purely social drinkers. Many in the substance misuse field believe that this notion of ‘manageable use’ could be extended to include at least some of the drugs that are currently illegal.

In an influential book *Drug, Set and Setting*, Harvard psychiatrist Norman Zinberg argues that there exists a wide range of drug-using patterns, some of them far more harmful than others, and that there are also many ways of influencing these patterns

¹⁰¹ Home Office Statistical Bulletin 15/06, *Drug Misuse Declared: Findings from the 2005/06 British Crime Survey*.

¹⁰² The National Drug Treatment Monitoring Service reported a total of 131,718 people in treatment in England in December 2005. <http://www.ndtms.net/NatEnglandPerformanceReport.aspx?AllAgesOrYP=AllAges&Archive=05And0>

¹⁰³ A Walker et al, *Crime in England and Wales 2005/06*, Home Office Statistical Bulletin 12/06, 2006.

¹⁰⁴ ed. N Singleton, R Murray, L Tinsley, *Measuring different aspects of problem drug use: methodological developments*, Home Office Online report 16/06, 2006.

¹⁰⁵ Although a large proportion of crimes such as shoplifting, burglary and theft from cars may be related to drug use – the 2003 Strategy Unit report already cited estimated that ‘drug-motivated’ offences account for around 56 per cent of the total number of criminal acts – a relatively small number of problematic drug users account for the majority of these crimes.

¹⁰⁶ Paul Hayes, Memorandum 46 submitted to House of Commons Home Affairs Select Committee, October 2001.

to make them less harmful.¹⁰⁷ Zinberg maintains that the harmfulness of drug use depends on three factors:

- *drug*: the pharmacological action of the drug itself (how much the user takes and how he or she ingests it);
- *set*: the attitude of the user, including their personality,
- *setting*: the influence of the physical and social setting in which drug use occurs.

His proposition is that too much emphasis tends to be placed on the power of the drug and the weakness of the user. If the user can control the setting, the power of the drug to do harm may be controlled. If the user can control the rest of their life, they may well be able to control their use of drugs. It is when the rest of their lives are out of control that their drug use may also become a problem.

Following Zinberg, we would accept that the use of drugs is not in itself a sign of a loss of control. It is widely acknowledged that the recreational use of cannabis, ecstasy and amphetamines has to some extent become ‘normalized’ among young people: not normalized in the sense of being the behaviour of the majority because even occasional drug users are still outnumbered by non-users, with regular users in a still smaller minority, but normalized in the sense of falling within the range of behaviours that are considered normal by young people.¹⁰⁸ Even those who do not themselves take drugs know people who do and are aware of the existence of a drug culture. Behaviours are unlikely to become absorbed into the social mainstream in this way if they are completely out-of-control behaviours.

For many young people, using drugs is simply another of the many forms of consumption that are on offer, one that they can use as a means of defining their own identities, exercising their own choices and even establishing their own routines.¹⁰⁹ They are also aware of the potential risks. Research increasingly suggests that clubbers do not take ecstasy, for example, because they believe it is safe.¹¹⁰ On the contrary, they take it knowing that in some circumstances it can be harmful but believing they can control those circumstances. Choosing carefully whom to buy the drugs from and who to take them with, limiting the amount they spend and the doses they take, eating beforehand, drinking reasonable quantities of water – this is the kind of advice offered by a range of websites and other resources aimed at recreational drug users, and there is evidence that a significant proportion take such precautions.¹¹¹ ‘Young people are very clever about treating their bodies as chemistry sets,’ comments Conor McNicholas, editor of *New Musical Express*. ‘If they are taking ecstasy they will probably take Vitamin C beforehand, or take multivitamins

¹⁰⁷ Yale University Press, 1984.

¹⁰⁸ See, for example, the National Treatment Agency memorandum to the House of Commons Home Affairs Select Committee, September 2001: recreational drug use (occasional use of cannabis and ecstasy) has ‘become normalised amongst young people. That isn’t to say that all young people use drugs, about half never will, but... recreational drug use is now regarded as part of a normal repertoire of behaviours.’

¹⁰⁹ K Moore and S Miles, ‘Living the high life: the role of drug taking in young people’s lives’, *Drugs and Alcohol Today*, 5/2, August 2005, pp29-31.

¹¹⁰ K McElrath and K McEvoy, ‘Negative Experiences on Ecstasy: the role of drug, set and setting’, in ed. W Palacio, *Cocktails and Dreams: perspectives on drug and alcohol use*, (Pearson, 2004).

¹¹¹ e.g. ‘Responsibilities of the recreational drug user’, on <http://www.addictionalternatives.com/philosophy/recuse.htm> See also F Measham et al., *Dancing on Drugs: risk, health and hedonism in the British club scene*, Free Association Books, 2001.

to account for drug use. They will take... over-the-counter health supplements such as 5-HTP to counter some of the depression they might get during the week.¹¹²

Some commentators argue that it is not just weekend club drug use that can be tailored in this way to fit with the demands of a conventional working life. A range of studies from the Netherlands, where the social use of cannabis in 'coffee houses' is tolerated, suggests that many adult cannabis users work out for themselves precisely when, where, how much and how often they can use cannabis so that it does not dislocate their daily routines.¹¹³ Cocaine use too can be controlled within a secure social setting.¹¹⁴ What keeps many heavy users from falling into abuse is their personal stake in conventional life: jobs, families, friends, and so forth.¹¹⁵ Where the lives of cocaine users begin to come apart, the problem may in the end be found to be with their lives rather than with the cocaine. 'In my view,' observes Peter Cohen, 'daily and regular use, under certain circumstances also called addiction, is far less of a danger to people than social exclusion.'¹¹⁶

Even heroin use, it is now being claimed, can sometimes be kept within bounds. Some people – again, usually people who are in other ways secure, with family support, employment, housing and money – may take heroin for long periods without becoming dependent, may become dependent without their dependency disrupting their lives, or may succeed in moving from chaotic use to controlled use.¹¹⁷ Heroin users who are not dependent will limit how often they take it while those who are dependent will control how much they take. A report from a team at Glasgow Caledonian University in 2005 caused a flurry in the media by asserting that some heroin users who have never been in treatment can lead normal, productive and fulfilling lives, achieving educational qualifications and holding down jobs, without long-term health or social problems attributable specifically to heroin. The team's study of 126 long-term heroin users (7 years on average) revealed that more than half were in a stable relationship, a third had children and most had settled accommodation and were in employment or further education. Most had taken other drugs – all had used cannabis, almost all had used ecstasy, amphetamines, LSD and cocaine – but the majority did not inject anything and those who did avoided sharing equipment. Most rated their dependence on heroin as lower than their dependence on tobacco or alcohol. Such problems as they did experience were due as much to alcohol as to the drug or to the combination of drugs and alcohol.¹¹⁸ The implication

¹¹² Evidence to House of Commons Home Affairs Select Committee, November 2001.

¹¹³ e.g. P Cohen and H Kaal, 'The irrelevance of drug policy: patterns and careers of experienced cannabis use in the populations of Amsterdam, San Francisco and Bremen', CEDRO 2001.

¹¹⁴ e.g. N Zinberg, W Harding and M Winkler, 'A study of social regulatory mechanisms in controlled illicit drug users', *Journal of Drug Issues*, 7/2, 1977.

¹¹⁵ D Waldorf, C Reinman and S Murphy, *Cocaine changes: the experience of using and quitting*, Temple University, 1992.

¹¹⁶ Peter Cohen, 'The social and health consequences of cocaine use', presentation held at the Nationale Designerdrogen- und Kokainkonferenz, 3-4 June 2004, CEDRO, 2004.

¹¹⁷ H Warburton, P Turnbull and M Hough, *Occasional and controlled heroin use: not a problem?*, Joseph Rowntree Foundation, 2005.

¹¹⁸ D Shewan and P Dalgarno, 'Evidence for controlled heroin use? Low levels of negative health and social outcomes among non-treatment heroin users in Glasgow', *British Journal of Health Psychology*, 10, 2005.

is that the use of heroin, like other drugs, is as influenced by social and psychological factors as by the pharmacology of the drug and that dependence is as much a cognitive state as a physiological one.¹¹⁹

¹¹⁹ G Hayes, 'Evidence for controlled heroin use', *Drugs and Alcohol Today* 5/1 May 2005.

The impression often given in the media is that the chemical properties of particular drugs will inevitably have the same effects on everyone who uses them and are more likely than not to lead to addictive and destructive patterns of use. Even for heroin, it would seem, this is not true.

Nevertheless, while there are undoubtedly many instances of relatively 'harm-less' drug use, just as there are many instances of harmless alcohol use, there is no such thing as risk-free use of either drugs or alcohol – or tobacco, come to that. Every such substance has the capacity to cause harm if used in certain ways and in certain circumstances, and these harms can be significant for individual users, for their families and for the communities in which they live. Drugs are not inevitably harmful, but they frequently are, and the harms they cause can be immense. We now turn to address these harms.

The effects that drug use can have on individual users

Deaths

While the number of drug-related deaths in the population as a whole is relatively small, particularly in comparison with deaths related to tobacco and alcohol, in young adults between the ages of 15 and 34 drug-related deaths are the third most common cause of death after traffic accidents and suicide. One of the targets of the government's drugs strategy was to reduce drug-related deaths by 20 per cent between 1999 and 2004. The total has dropped but by only 9 per cent, largely due to an increase in 2004 that reversed the downward trend of the previous three years. While there has been some success in limiting the number of opiate-related deaths by bringing more problematic users into treatment, there has been a rise in the number of deaths related to cocaine.

In England and Wales in 2004 there were 1,679 deaths where only one drug was listed on the death certificate. There was a larger number of deaths where more than one drug was involved, making it impossible to attribute the cause of death precisely. Of the 1,679 deaths, 483 were due to heroin and morphine, most of them caused by overdoses, often after people came out of prison or left treatment prematurely with a reduced tolerance; 93 were caused by methadone poisoning, including some children who had found and swallowed prescribed

methadone in the home; 39 deaths were due to cocaine, a significant number of them in police custody suites, from swallowing powder cocaine or crack in order to avoid being charged with possession of the drugs; 46 were ascribed to amphetamines of all types and 25 to ecstasy. There were no deaths related to cannabis alone, though eight were related to cannabis in combination with alcohol.¹²⁰

In Scotland in 2005 there were 336 drug-related deaths. The majority of those who died (61 per cent) were known or suspected drug abusers. Heroin/morphine was recorded in 58 per cent of the deaths, alcohol in 34 per cent, diazepam in 27 per cent and methadone in 21 per cent.¹²¹ There was also a noticeable rise in the number of deaths involving cocaine.

Calculations such as these are always based on official statistics. Recent research has suggested, however, that the number of drug-related deaths could in fact be at least double the total suggested by official figures.¹²² Looking at the causes of death among a sample of known drug users, the study found that fewer than half would have been classified as drug-related deaths under the government's definition, which mainly considers drug toxicity and drug-related mental and behavioural disorder. A significant proportion of the remaining deaths, however, were caused by bacterial or viral infections, liver or heart disease or intentional self-harm, all likely to be associated with drug use.

In addition to killing people, the majority of currently illegal drugs can cause non-lethal but sometimes serious physical and psychological harms.

Physical effects

Heroin

Broadly speaking, heroin is the most physically dangerous of drugs, largely because it is the most physically addictive. Heavy physical dependence causes people to run more risks in obtaining and taking heroin and also to endure unpleasant withdrawal symptoms: sweats, cramps, nausea, running nose, pain and emotional trauma.

Heroin is also the drug most often injected, and injection itself carries a wide range of serious health hazards. Most obvious is the risk of contracting blood-borne viruses. Sharing syringes, or the spoons, cups, water or filters used in preparing street heroin for injection, can all transmit HIV, Hepatitis B and Hepatitis C. In addition, the *Lifeline* 'Guide

¹²⁰ <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=11695> National Statistics, *Deaths related to drug poisoning, England and Wales*, 'Table 1. Number of deaths by drug-related poisoning by underlying cause, England and Wales'.

¹²¹ Drug Misuse Information Scotland, *Drug Misuse Statistics Scotland 2006*, 2006.

¹²² A Khundakar et al, NDTMS Themed Report, 'Deaths of those in contact with drug treatment services in the North West of England for the reporting period 2003/4 and 2004/5', Centre for Public Health at Liverpool John Moores University, 2007.

for injecting drug users' warns against, among other things, injecting into an artery or the jugular vein, which may result in bleeding to death or loss of a limb, repeatedly injecting in the same place, which risks damaging or collapsing veins, injecting into the finger, because there are tiny arteries near the surface and injecting into the groin, as the femoral vein is very near the femoral artery and, if that is pierced, the injector could bleed to death.

¹²³ <http://www.guardian.co.uk/drugs/Story/0,,1598996,00.html>

Cocaine

Cocaine in its powder form has a far more glamorous image and one of its attractions in recent years appears to have been the assumption that it is safer than ecstasy, whose risks were heavily publicized after the death of policeman's daughter Leah Betts in 1995, apparently from the consumption of a single tablet. The intoxication that cocaine produces is shorter-lasting and easier to control. However, the come-down can be unpleasant and debilitating, and the risk of heart attack is claimed to rise 24-fold in the hour immediately following the use of cocaine. One addiction specialist reported that a third of people under 40 coming into the Accident and Emergency department of a large London hospital with chest pains had been using cocaine. (The proportion rose to 50 per cent at weekends.)¹²³ Some regular users may well become run down through not sleeping or eating well, and they will be more vulnerable to infections. Cocaine is both caustic and corrosive when injected or inhaled. Snorting cocaine can cause a stiffening of the facial muscles and nasal bleeding, and heavy users may damage nasal membranes or even suffer perforation of the nasal septum, but inhaling in general remains less dangerous than injecting.

Crack

Crack is a more harmful form of cocaine. It causes the brain to release the neurotransmitters adrenaline, serotonin and dopamine. Adrenaline governs the body's 'fight or flight' mechanism, while serotonin and dopamine are mechanisms to reinforce pleasurable feelings and enhance mood. The amounts of these neurotransmitters released by smoking crack are huge, putting considerable strain on the body's systems: breathing, blood pressure, heart rate and body temperature. This strain can lead to heart failure, breathing difficulties and chest infections. The crack "high" is immensely pleasurable but very brief, and the "crash" is correspondingly steep and unpleasant, often causing fatigue, depression, anxiety, aching, paranoia or panic. People resort to repeated and compulsive use to postpone the crash but find their tolerance growing, which means that they need to take higher and higher doses, at first to achieve the original high, but then simply to avoid the crash.

Some will also use other drugs – alcohol, benzodiazepines, heroin – to deal with the side-effects of the crash when it comes. Crack has a reputation for making its users aggressive, manic and violent. It is also more closely associated with risky sexual behaviour: the exchange of sex for drugs or sex with intravenous drug users.¹²⁴

Ecstasy

Ecstasy in its chemical composition is considered by some scientists to be relatively safe, in its short-term effects at least.¹²⁵ However, it is often sold in impure forms and used in risky ways and dangerous contexts. What is sold as ecstasy may contain amphetamine, ephedrine, ketamine or other adulterants, and the mixture can occasionally be lethal. Ecstasy also tends to have diminishing returns and users will often binge and take an excessive number of tablets in the attempt to recapture the original euphoria. Very often they will also take other drugs on top of it, either to enhance or prolong its stimulant effects (cocaine and amphetamines) or to come down gently from them (alcohol, benzodiazepines, cannabis and even heroin).

Ecstasy does have a range of immediate physical effects, stemming from its rapid release of serotonin. They can include rapid heart rate, high blood pressure, teeth grinding and shivering. After taking ecstasy users may feel very tired and low and need a long period of sleep to recover. Some of the more serious harm, however, is associated not with the drug itself but with the way in which it is used as part of a night's dancing, which in hot and crowded conditions can lead to heatstroke, collapse and convulsions. On the other hand, drinking far too much water in an effort to avoid dehydration leads to hyponatremia, a very low plasma sodium level caused by diluting the blood with water, while at the same time MDMA causes the secretion of an anti-diuretic hormone that inhibits urination. This combination produces headaches, nausea, confusion and the risk of cerebral oedema or swelling of the brain, which can be fatal.

Methamphetamine and amphetamine

These substances speed up the central nervous system by triggering the release of chemicals including dopamine and serotonin. Methamphetamine, in particular, is highly addictive, especially when injected or smoked in crystal form ('crystal meth'). Powerful stimulants, amphetamine and methamphetamine have the short-term effects of high blood pressure, cardiac arrhythmia and jitteriness and longer-term effects that may include compulsive scratching, kidney damage and weight loss. The 'come-down' and withdrawal symptoms for methamphetamine are steep and severe,

¹²⁴ C Lejuez et al, 'Differences in impulsivity and sexual risk behaviour among inner-city crack/cocaine users and heroin users', *Drug and Alcohol Dependence*, 77 (2005). As usual, it is not clear which comes first; is it a genetic predisposition to impulsivity that impels you to take crack, or does crack make you more impulsive?

¹²⁵ Neuroscientist David Nutt, for example (a long-standing member of the government's Advisory Council on the Misuse of Drugs), told the House of Commons Home Affairs Select Committee in 2001: 'I personally think that ecstasy is relatively safe in the short term. The long-term risk is to my mind unknown at present, although as each year goes by I get relatively more sanguine about the risk rather than less.' <http://www.publications.parliament.uk/pa/cm200102/cmselect/cmhaff/318/1112703.htm>

akin to those related to crack cocaine, and may similarly make users prone to sharp mood swings and violence.

GHB

Gammahydroxybutyrate or GHB is derived from gamma butyrolactone and sodium hydroxide (i.e. the main ingredients of floor stripper and drain cleaner). It can induce both unconsciousness and vomiting, a deadly combination. The difference between a dose that will achieve the desired effects and one that will do damage is small and hard to gauge, as much GHB is made at home by amateur chemists. It can induce dependence, and withdrawal may lead to convulsions and coma.

Ketamine

Ketamine, as a dissociative anaesthetic originally designed for veterinary use, is very strong and can be particularly damaging if the user is not feeling physically and emotionally well. Ketamine can suppress breathing and heart function and is extremely dangerous in combination with alcohol. Because of its anaesthetic effect, users are more likely to fall and hurt themselves without realizing it; they can also be temporarily paralysed and vulnerable to rape or robbery or to vomiting while unconscious. While taking the drug, users lose much of their episodic memory (the store of events from the past); semantic memory is also impaired (affecting coherent speech) as is working memory (reducing the capacity to make decisions or plan ahead). Episodic memory can be affected for some time after use; high doses of ketamine can cause complete amnesia of anything that takes place while the user is under its influence, making it suitable for use as a date rape drug. Because these side-effects can be so damaging, only about one in four people usually progresses beyond experimental use, but in those whom it suits ketamine can cause strong psychological dependence and lead to bingeing.

Benzodiazepines

Benzodiazepines are legally prescribed tranquillisers (including Valium and Mogadon) that are widely used off-prescription in combination with illegal drugs. They are safe and effective for short-term use, but when taken for long periods they may produce a wide range of unpleasant symptoms – including both increased aggression and stupor – and also serious dependency, for which there is no easy treatment. Withdrawal symptoms include severe headaches, ‘formication’ or a feeling of insects under the skin, nightmares and nausea.

Cannabis

Cannabis has effects that are less pronounced and more variable than those of many other drugs, partly because there are so many different types and partly because users tend to interpret the effects in different ways:

Novice users who do not know what to expect may find the experience of using cannabis particularly distressing, especially if strong variants are involved. On the other hand many people report that nothing much happened when they first smoked cannabis.¹²⁶

A recent survey of long-term users reported:

The mean scores [of those users who were surveyed] indicate moderately positive perceptions of the effects of cannabis on psychological health, neutral impact on physical health, slightly positive impact on sex, moderately negative impact on memory when stoned, slightly negative impact on memory when not stoned, and moderately positive impact on life in general.¹²⁷

Some researchers, however, question the allegedly neutral impact of cannabis on physical health. For example, recent research suggests a link between heavy cannabis use and osteoporosis.¹²⁸ Also, in Britain unlike in the US, cannabis is most often smoked with tobacco and therefore shares many of tobacco's harmful effects. Users inhale less frequently but more deeply, and the smoke is very hot. Frequent inhalation of cannabis smoke, which has high concentrations of tar and toxins, can exacerbate bronchitis and cause cancer of the lung and oesophagus. The use of cannabis also tends to encourage smokers to keep smoking.

Cannabis dependence has itself now been established as a real phenomenon, having been contested for many years. The Advisory Council on the Misuse of Drugs reported in 2002:

Repeated cannabis use does lead to a significant proportion of regular users becoming dependent although the severity of their dependence is generally not such as to lead to criminal behaviour... Studies amongst cannabis dependent users have revealed that when they stop they experience a real physical withdrawal syndrome characterized by decreased appetite, weight loss, lethargy, irritability, mood changes and insomnia.¹²⁹

Poppers

'Poppers', (amyl, butyl and isobutyl nitrite) are chemicals that were first used for angina, as they have the effect of dilating blood vessels and loosening soft muscle tissue. They were packaged in small glass capsules that were cracked open to release vapour, hence the name 'popper'. They now come in small bottles with

¹²⁶ 'Cannabis: a briefing paper for drug education practitioners', Drug and Alcohol Education and Prevention Team, 2005.

¹²⁷ N Coggans et al, 'Long-term heavy cannabis use: implications for health education' in *Drugs: education, prevention and policy*, August 2004.

¹²⁸ *Guardian*, May 23, 2005.

¹²⁹ ACMD, *The classification of cannabis under the Misuse of Drugs Act 1971*, Home Office 2002. The Advisory Council on the Misuse of Drugs is an independent expert body that was set up under the Misuse of Drugs Act 1971 to advise the government on issues relating to dangerous or otherwise harmful drugs. It is administered from the Home Office. The role of the ACMD is discussed at greater length in Chapter 19.

screw or plug tops and can be inhaled straight from the bottle or on a cloth or anything else absorbent. Technically the supply of poppers is illegal except on prescription. In practice they are sold in clubs, joke shops, sex shops, gay bars and ‘head’ shops (which supply drugs paraphernalia), at dance events and on the Internet. They are used to loosen inhibitions, boost other drugs and produce stimulation while dancing as well as to enhance sexual activity. There is an initial ‘rush’ to the head as blood vessels dilate, the heartbeat quickens and blood rushes to the brain. When taken in combination with Viagra, as they quite often are, poppers can reduce blood pressure to dangerous levels. Poppers are caustic. Drinking rather than sniffing them – and popper bottles look very like the bottles used for GHB, which you drink – can kill you.

¹³⁰ European Monitoring Centre for Drugs and Drug Addiction, ‘Co-morbidity – drug use and mental disorders’, *Drugs in Focus* 14, 2004.

Volatile substances

Substances such as glue, lighter fuel, dry cleaning fluids and aerosols are used in various ways. Vapours are sniffed, often from a paper or plastic bag, or sprayed directly into the throat. They slow breathing and heart rate and produce feelings similar to being drunk, with disorientation, loss of co-ordination, visual distortions and sometimes brief unconsciousness. Sniffing to the point of becoming unconscious risks death through choking on vomit. Suffocation is a risk if the plastic bag is placed over the head or if aerosol gases squirted directly into the mouth freeze the airways. The solvent vapours from cleaning fluids sensitise the heart to the effects of exertion and can lead to heart failure, especially if the user is running around.

Polydrug use

Polydrug use multiplies the risks associated with individual drugs. Some combinations are particularly hazardous and a significant proportion of deaths are the result of polydrug use or the combination of illegal drugs with alcohol. Heroin and methadone suppress respiration, as do alcohol and benzodiazepines such as Valium and diazepam, making their combination very dangerous. Cocaine and alcohol form cocaethylene, associated with increased risk of liver damage and early death. Combining alcohol with ecstasy considerably increases the risk of dehydration. The combination of GHB and alcohol can induce coma and death.

Psychological effects

There is considerable overlap between drug use and a wide range of mental disorders. About 30–50 per cent of psychiatric patients in Europe today use drugs.¹³⁰ The most common mental disorders associated with drug use are personality and anxiety disorders. American studies have also reported

high rates of the coexistence of drug misuse and post-traumatic stress disorder.

There is much argument as to whether drug use causes mental impairment or disorder or is itself a consequence of mental impairment or disorder. Some research suggests that mental disorder most often precedes drug use but that the prognosis for psychiatric problems worsens with continued drug use. Other studies suggest that the 'hijacking' of neurotransmitter systems in the brain by psychoactive substances may itself have direct, harmful and lasting effects on the brain.

Until now the argument has always been that evidence of cognitive impairment in drug users is inconclusive and that it may have been existing impairments that led the users to take drugs. However, the weight of evidence is beginning to suggest that in some cases the use of drugs produces impairments over and above any that may have existed before: impairments in decision-making, for example, or in memory function.¹³¹ Certainly, the Department of Health in this country continues to record growing numbers of mental health admissions related to drug use. For instance, the Department of Health figures for 2001 suggested that 447 such admissions, mostly for psychotic disorder, were associated with recreational drug use, accounting for 14,463 bed days.¹³²

Concerns over the impact of drug use on mental health have centred in recent years on ecstasy, cannabis and methamphetamine.

Ecstasy

Ecstasy has been charged with a range of psychological effects. Releasing emotions, beneficial in therapy, can be hazardous in uncontrolled conditions, and among the effects attributed to ecstasy are anxiety, hallucinations and a state of intoxication that mimics paranoid psychosis. A heavy weekend's use of ecstasy can result in lethargy and depression later on – the 'midweek blues' – which can seriously interfere with work and study. Because taking ecstasy is usually done in company, taking it with friends who are in bad moods or are having unpleasant experiences can make one's own experience more difficult. (Conversely, taking it with someone more knowledgeable who praises it can enhance its effects.)¹³³ There is increasing concern about the possible long-term effects of regular ecstasy use on memory and mood. The United Nations Office on Drugs and Crime has raised the spectre of 'a generation of ecstasy users suffering the effects of a decline in mental function and memory, i.e. Alzheimer-type symptoms earlier than would be expected with the normal

¹³¹ See e.g. Barry Everitt, Cambridge, 'The Neural Basis of Drug Addiction' – Foresight BSAD project, *Background note exploring some of the science underpinning the project*.

¹³² C Gregory et al, *The economic and social costs of Class A drug use in England and Wales, 2000*, Home Office Research Study 249, 2002.

¹³³ K McElrath and K McEvoy, 'Negative experiences on ecstasy: the role of drug, set and setting', in ed. W Palacio, *Cocktails and Dreams: perspectives on drug and alcohol use*, Pearson, 2004.

ageing process.’¹³⁴ Without suggesting that brain damage is inevitable, the Drugscope inventory of drugs comments that where brain damage does occur, it ‘does not depend on an extensive history of use... it is dose-dependent, and... it may not be completely reversible.’¹³⁵

Cannabis

Cannabis use has been shown to coexist to some extent with psychological harm. There is considerable scientific disagreement as to precisely what the relationship between the two might be. A recent review by the Beckley Foundation of the current evidence summed up the debate:

There are four main views on the nature of the association between cannabis and later mental disorders. Firstly that the link may be due to socio-demographic, economic or genetic factors common to both cannabis use and the disorder. Secondly, the self-medication hypothesis suggests that patients with mental health problems may be using cannabis and other drugs as a form of self-treatment for their condition. Thirdly that cannabis directly causes new cases of the mental disorder. Finally, the vulnerability hypothesis proposes that the use of cannabis can increase the risk of mental health problems for some at-risk people.¹³⁶

Cannabis intensifies moods, can heighten anxiety and even cause paranoia while it is being used. It has also been accused of precipitating ‘amotivational syndrome’, a chronic lack of motivation and bouts of apathy. For some heavy users, problems with memory and attention may last for weeks after they have stopped using the drug, but the same can be said of heavy drinkers and there is as yet no conclusive proof that the use of cannabis during adolescence affects social or cognitive development. Evidence that cannabis use can cause mental illness in and of itself is hotly disputed. But there would seem to be a general consensus that it can trigger mental illness in those who are already prone to it and worsen some existing schizophrenic disorders. ‘Taken as a whole,’ the Beckley Foundation review concludes,

the available epidemiological evidence suggests that cannabis can exacerbate the symptoms of schizophrenia. The best available evidence from the existing range of prospective epidemiological studies indicates that cannabis can precipitate schizophrenia in people who are already vulnerable for individual or family reasons. Those with a psychosis vulnerability may also be at an increased risk of experiencing psychotic symptoms, particularly if their cannabis use is regular.

The evidence for an association between cannabis use and depression or anxiety is mixed, with longitudinal research

¹³⁴ United Nations, ‘Ecstasy and Amphetamines: Global Survey 2003’.

¹³⁵ http://www.drugscope.org.uk/druginfol/drugsearch/ds_results.asp?file=%5Cwip%5C11%5C1%5C1%5Cecstasy.html

¹³⁶ N Hunt et al, *Cannabis and mental health: responses to the emerging evidence*, Beckley Foundation, Report 8, April 2006.

suggesting that cannabis is a moderate risk factor for later depression but that the relationship between cannabis and anxiety is likely to be the result of other mediating factors such as childhood and family factors.

¹³⁷ Singer Stephan Jenkins, quoted in D Sheff, "My Addicted Son," *New York Times Magazine*, February 6, 2005, p. 44.

Methamphetamine

Methamphetamine, if used regularly, can cause psychological as well as physical dependence. Many heavy users alternate between periods of high energy and depression, followed by delusions, panic attacks, paranoia and a feeling of being 'wired', with violent mood swings that may make them very aggressive. One heavy user has described the process: 'Methamphetamine makes you feel "bright and shiny". It also makes you paranoid, incoherent and both destructive and pathetically and relentlessly self-destructive. Then you will do unconscionable things in order to feel bright and shiny again.'¹³⁷

Against this background of the undeniable damage that drugs can do, and have done, we should reiterate that they do not do this damage every time they are used. They damage some people and not others. Some drugs, and some types of drug use, are very much more dangerous than others. As we shall argue below in Chapter 7, considerably more people are harmed by alcohol and tobacco than by currently illegal drugs. More people are killed every year by sniffing glue than by snorting cocaine. Very many more people are killed in traffic accidents than by drug overdoses. It is necessary to be aware of the physical and psychological harms that individual drugs can inflict, but also to keep these harms, and our reaction to them, in proportion.

The effects that drug use can have on families

More attention has generally been paid to the effects of drugs on individual users than to the impact that users' behaviour may have on those around them – partners, parents, children, brothers and sisters, friends and neighbours – and there seems to have been little systematic exploration of the overall web of interconnected consequences. Drug abuse, in other words, is a problem that is more often than not treated in silos. Drugs workers focus primarily on drug users, while social workers may have more interest in their children. Teachers are principally concerned with the child to be educated, whether it is the child or its parents who have the drugs problem. GPs have the opportunity, but rarely the occasion, to consider the health needs of both drug users and their families. Few people have concentrated on the needs of other family members, parents or siblings, and not enough help is available to them.

Some drug users become rude, unpredictable, withdrawn, dishonest, embarrassing, expensive and violent, and daily life can be turned upside down, with mealtimes disrupted, younger children not picked up from school and familiar household necessities suddenly missing because they have been stolen and sold. When the problem first emerges, most families will attempt to handle it themselves, usually by trying to persuade the user to stop. Some parents may choose to avoid the problem by throwing out the offending child or refusing to let them come home, but the majority are deliberately non-confrontational, caring for the user, giving them money, even buying drugs for them. A father of one said: 'I actually went out and bought 20 bags of heroin for her. I just wanted to keep her in the house. I drove home with 20 bags of heroin in the boot of my car.'¹³⁸

Watching what is happening to the drug user, other members of the family can feel confused, ashamed, angry, guilty, uncertain, fearful, unsupported, depressed, even suicidal and completely unable to help. Relationships of mutual trust within the family can be destroyed. Parents not uncommonly feel their lives have been taken over by the user's problem. They are unable to go on holiday or travel on business, or even leave the house, for fear of what may happen while they are gone. They may feel they dislike or even hate their child and hope they would die or disappear.¹³⁹

'Your heart grows cold and hard.'¹⁴⁰

'After the initial shock I really started to feel angry. I began to hate my child for doing this to us.'

'There was times when I could have killed him myself, that's how bad it is to you.'

'You know they are lying. They just tell you things and you believe them. It is so horrible, your baby telling you these things.'

'It's crazy – you go to get the iron and it's gone. He's sold it for a fiver to get drugs.'

'I had people turning up on my doorstep saying that [my daughter] had sold them my belongings. Initially I let them take them, then started saying no and had my windows put through as a result.'

'You feel like a leper. You feel like everybody is normal but you're not, because you're going through a very traumatic time. You're going through more of a traumatic time than the drug addict is because they are out of it anyway, they don't know – and you have to see all that's going on.'

These acute stresses can be very damaging to other relationships within the family. Parents may disagree on how to treat the user.

¹³⁸ Most of the first person quotations in the following paragraphs are taken from two publications: J Butler and L Bauld, 'The parents' experience: coping with drug use in the family', in *Drugs: education, prevention and policy*, Vol. 12, No. 1, Feb. 2005, and M Barnard, *Drugs in the family: the impact on parents and siblings*, Joseph Rowntree Foundation, 2005.

¹³⁹ David Clark, 'Family misfortune', *Drink and Drugs News*, 29 November 2004.

¹⁴⁰ Home Office report, 'Information resources for 'family' members who are supporting drug users', 2003.

Although research has indicated that boys, in particular, would like more communication from their fathers about drugs and are influenced by their behaviour, fathers are more likely to be angry and to try to distance themselves from the problem, being aggressive towards the user and abusive to other family members. This situation can be particularly difficult for a stepfather, who may resent having the problem without having the acknowledged authority to deal with it. The user's mother is more likely to be the one who gets involved, which in itself can cause difficulties. 'My marriage has nearly broken up. I'm actually addicted to helping my daughters. I'm more addicted than them.' Quite often she will turn to her own mother for help, but not all parents can rely on their extended families. 'I have lost contact with other family members. You feel lower than they are. They won't have my daughter in their homes in case she steals from them.'

Amidst all this, siblings may well be forgotten. 'It was just everything about ma sister and I wis just left aside a bit.' (brother) Even worse, if they are not ignored, they may be used as an 'abuse board' by parents unwilling to vent their feelings on the child who is vulnerable. A sister or a brother may be the user's main source of support and may feel caught between them and their parents. Alternatively, they may be very unhappy at being forcibly distanced from an older brother or sister who has become indifferent, self-centred, argumentative and unreliable. Younger children are also at significantly higher risk of developing drugs problems themselves, either from being exposed to drug use and following the example of an admired older brother or sister, or from wanting to compete with them, or because the older child deliberately introduces them to drugs.

When it is the parent that is the drug user, children are at even greater risk. The 2003 report *Hidden Harm* by the Advisory Council on the Misuse of Drugs estimated that there are about 300,000 children of problematic drug users, representing some 3 per cent of all children under 16 in the UK. (The percentage is higher in Scotland.) These children are more likely than most to have parents who are very young and very deprived as well as being drug users, and they may be subject to poverty, neglect and abuse. They may be exposed to violence in the home, or simply a greater carelessness about dropped cigarettes, electrical appliances left on and windows and doors left open. There may be methadone in the fridge and drug paraphernalia left around. They have a higher chance of witnessing criminal behaviour such as drug dealing, shoplifting and robbery, and they may move around more frequently. School attendance may be disrupted and may in any case be made a misery

by the stigma of having a parent who takes drugs. In one study of Scottish families, the child of a woman addicted to dihydrocodeine commented, ‘I’d just rather she drank... Because people wouldnae call her a junkie.’¹⁴¹ One drug-using mother observed,

I always used to say these people that leave their kids in the house on their own, they’re the bad parents. But I used to be a good parent ’cause I used to take ma kids with me to score and we’d stand out in the rain for three hours waiting on somebody coming back with drugs. But I was still a good parent ’cause I had ma children standing beside me. It didnae matter that it was 11 o’clock at night and they were soaking and they were hungry and they were tired and I think that’s all the lies that ye’ve got to lie to yourself to be able to get through life with.¹⁴²

The children of drug users are liable to have more psychiatric, behavioural and developmental disorders and are more likely themselves to use drugs.¹⁴³ They may have feelings of shame, loneliness and abandonment. In the words of the *Hidden Harm* report, ‘They often expressed a deep sense of absence and isolation that was conveyed in the often used phrase that their parents were not “there for them”.’¹⁴⁴ Heavy cannabis use can be as destructive in this respect as some harder drug use. Drink may take parents away on benders; drugs make them absent at home. Many of these children, particularly boys, are reluctant to discuss their problems with outsiders, however sympathetic, and would rather use distraction strategies or blank things out. ‘Children mainly use informal support, and are most likely to talk to parents (more often mothers) or friends, siblings, extended family or pets.’¹⁴⁵

The effects that drug use can have on communities

Patterns of prevalence suggest that the kind of drug use that causes problems takes root where people are socially excluded and where there is a concentration of residents with psychological and personal problems. Drug dealing will flourish where people can earn more money – or think they can earn more money – selling drugs than by any legal method, where local attitudes and values sometimes support illegality and where drug dealers have street status with some young people. Local energy to tackle drug problems can be eroded by crime and a dilapidated environment.¹⁴⁶ This makes some neighbourhoods more vulnerable to drug misuse than others: ‘sink’ or fringe estates, areas with poor transport, areas with a high proportion of rented housing (social and private), areas of low skills and high unemployment with many people on income support. This does not mean

¹⁴¹ A Bancroft et al., *Parental drug and alcohol misuse: resilience and transition among young people*, Joseph Rowntree Foundation, 2004.

¹⁴² Marina Barnard, ‘Between a rock and a hard place: the role of relatives in protecting children from the effects of parental drug problems’, in *Child and family social work*, 8, 2003.

¹⁴³ E Gilvarry and I Crome, ‘Implications of parental substance misuse’ in ed. I Crome et al, *Young People and Substance Misuse*, Gaskell, Royal College of Psychiatry, 2004.

¹⁴⁴ ACMD, *Hidden Harm*, 2003.

¹⁴⁵ ‘Understanding what children say about living with domestic violence, parental substance misuse or parental health problems’, *Findings*, Joseph Rowntree Foundation, May 2004.

¹⁴⁶ R Lupton et al, ‘A rock and a hard place: drug markets in deprived neighbourhoods’, Home Office Research Study 240, 2002.

that drug misuse is confined to inner cities; it may be found in country or coastal villages, commuter 'new' towns and middle-class suburbs. The seaside resort of Great Yarmouth, for example, with the second highest deprivation rate in the East of England, has a thriving drugs trade largely controlled by gangs from Merseyside.¹⁴⁷ The town suffers from high seasonal unemployment and has a good deal of temporary accommodation catering for the transient populations that offer good cover for both dealers and users. Yarmouth was reported in 2004 to have an emerging problem with sex workers working on the streets, and with the drug dealing, car crime and criminal damage that 'are likely to be features of the life of sex workers at street level'.¹⁴⁸ More people die in Great Yarmouth than anywhere else in Norfolk from drug-related causes.

Besides the disrupted lives of individual drug takers, the main impacts of a serious drug problem in a neighbourhood may include an increase in acquisitive crimes such as theft, street robbery, car break-ins and burglary, with dependent users stealing and shoplifting to fund their habits and ever younger children and young people drawn into 'running' and minor dealing. There is, in consequence, also likely to be a heightened fear of crime – both of drug dealing and of the crimes committed to fund drug use – and of the fires and other damage that may be caused by drug factories. In 2005 the London Fire Brigade reported some 50 fires caused by dangerous makeshift electrical connections set up to heat cannabis growing operations.¹⁴⁹

A serious drug problem may sometimes lead to an increase in violent incidents. This violence is rarely drug-crazed aggression directed at other people in the community, though it may create a general atmosphere of intimidation, but is more usually confined to dealers and users themselves. In 2002 an altercation between rival Turkish and Kurdish heroin importers in a social club in Green Lanes, Haringey turned into a street battle with sticks, knives and guns in which 21 men were injured and a bystander was killed. A recent report from the Home Office concluded that:

Illegal drug markets appear to ... represent the single most important theme in relation to the illegal use of firearms, characterized by systemic violence that appears to increase towards the street (retail) end of the market. Firearms possession was reported in relation to robberies of drug dealers (that appear to be increasing), territorial disputes, personal protection and sanctioning of drug market participants.¹⁵⁰

The presence of an active drugs market is likely to lead to higher levels of anti-social behaviour such as excessive noise.

¹⁴⁷ 'Tide of misery by seaside as big city drugs gangs move in', *Guardian*, 5 September 2004. <http://www.guardian.co.uk/crime/article/0,2763,1297550,00.html>

¹⁴⁸ Great Yarmouth Borough Crime and Disorder Reduction Partnership, *Great Yarmouth Crime and Disorder and Drugs Audit*, 2004.

¹⁴⁹ 'Police target cannabis factories', *Independent*, 25 September 2006.

¹⁵⁰ G Hales et al, *Gun crime: the market in and use of illegal firearms*, Home Office Research Study 298, 2006.

According to the Home Office, ‘some users may be active at different timeframes to their neighbours – amphetamine users, for example, can cause difficulties in this respect.’¹⁵¹ The first-ever daily count of anti-social behaviour identified 2,920 incidents due to drug/substance misuse and drug dealing nationally.¹⁵² Under Section 20 of the Drugs Act 2005, the police now have the power to apply for ‘intervention orders’. These, in the words of the Home Office, will have the effect of forcing drug addicts known for their anti-social behaviour to get free drug treatment:

Police can apply for intervention orders whenever they believe that drug abuse is contributing to a person’s anti-social activities, such as aggressive begging, or playing music or televisions consistently loudly, and intimidating neighbours and passers-by. These civil orders issued by a court can compel the recipient to undergo drug treatment, or face a fine of up to £2,500... This ‘tough love’ approach is designed to meet two goals – ensuring a decent quality of life for the law-abiding majority, and encouraging those with drug addictions to get the help they need.¹⁵³

The development of a drug market in an area is often associated with a rise in prostitution, which is more and more frequently related both to drug use and to supply, partly because the same crime networks are involved in both activities and the same premises may be used for both.¹⁵⁴ Girls may be given drugs to induce them to prostitute themselves and are then paid in drugs to establish a habit that keeps them in prostitution. The link between prostitution and drug addiction was graphically underlined at the end of 2006, when five prostitutes were murdered by a serial killer in Ipswich. Although women were advised by the police to keep off the streets while the killer was still at large, some sex workers continued to go out at night in order to finance addictions to crack and heroin.

At the same time, there may also be an increase in the number of people begging, as many problematic drug users beg to fund their habit, and an increase in the number of people sleeping rough, as many providers of supported or private sector housing will effectively bar drug users. Public spaces may become unusable, with the spread of drug litter and its attendant health risks. All of this will depress house prices, create unpopular housing areas, undermine regeneration or even disqualify an area from getting it, and it may accelerate the spiral of decline, imprinting neighbourhoods with an image they find hard to shake off. The St Paul’s area of Bristol, for example, has had an unenviable reputation as the city’s ‘front line’ for drug dealing, which projects like St Paul’s Unlimited have to work hard to combat.

¹⁵¹ www.drugs.gov.uk Communities toolkit – ‘Drugs and estate and housing management’.

¹⁵² http://www.homeoffice.gov.uk/docs2/ASB_Day_Count_Summary.pdf

¹⁵³ Home Office website, ‘Stopping drug-related anti-social behaviour’, <http://www.homeoffice.gov.uk/about-us/news/drug-related-anti-social>

¹⁵⁴ www.drugs.gov.uk Communities toolkit – ‘Drugs, sex work and sex markets’.

Drugs and crime

It is important to mention at this point that the relationship between drugs and crime is more complex than a simple progression from drug use to offending. Very frequently the criminal behaviour exists first and it is the crime that provides the money that makes the drug use possible. 'Most drug-misusing offenders were offenders before their drug misuse became problematic,' observes Paul Hayes of the National Treatment Agency. 'What appears to happen from the research evidence, therefore, is not that honest men and women become criminals, but that part time amateur criminals become full time professionals... Drug dependency can therefore be seen as amplifying the criminality of existing offenders rather than initiating criminal involvement.'¹⁵⁵

Drugs and crime are unquestionably connected at a number of levels. Drug users are more likely than non-users to be criminals and a large majority of offenders have consumed at least one drug recently. But not all drug types are associated with all crime types and some drug types are not associated with crime at all: for instance, there is little evidence of any link between crime and the recreational use of cannabis or ecstasy. The association between drugs and crime is multi-faceted and traffic between the two may be moving in both directions. Research indicates that much offending tends to begin *after* the use of recreational drugs (which are not generally associated with e.g. acquisitive crime) but *before* the use of 'hard' drugs. In other words, there is no clear-cut temporal progression from drug use to offending, as it seems that most people who are likely to be involved in crime are already offending by the time they begin serious drug misuse. This supports the argument that the link between drugs and crime may not be a straightforward causal one but may simply be forged by factors that underlie them both, such as deprivation and social exclusion.¹⁵⁶

The monetary costs of drug use

The results of any attempt to calculate the costs to the economy of a phenomenon such as drug use will be strongly influenced by the study design and the methodological assumptions made. Any findings will be correspondingly open to attack by those who question the particular methodological assumptions as well as the basic premises on which such calculations often rest. The Strategy Unit drugs report in 2003, for example, was looking at drug misuse primarily from the perspective of reducing what it defined as 'drug-related crime' when it put the estimated total costs of drug misuse in the United Kingdom at £24 billion per year. The Foresight report on *Brain Science, Addiction and Drugs* in 2005, which had a heavier emphasis on the health impact

¹⁵⁵ Memorandum to the House of Commons Home Affairs Select Committee, op.cit. The evidence on the relationship between drugs and crime is extensive, complicated and often contradictory, but many studies of patterns of crime and drug use among people passing through the criminal justice system have suggested that criminal behaviour often pre-dates drug use. See for example M Hough et al, 'Drugs and crime: what are the links?', a review paper submitted on behalf of *Drugscope* to the House of Commons Home Affairs Select Committee in 2001, <http://www.drugscope.org.uk/druginfol/evidence-select/drugscime.htm> M Edmunds et al, 'Doing Justice to Treatment: referring offenders to drug services', Drug Prevention Advisory Service Paper 2, Home Office, 1999; D Deitch et al, 'The relationship between crime and drugs: what we have learned in recent decades', *Journal of Psychoactive Drugs*, 32(4), 2000.

¹⁵⁶ T Bennett and K Holloway, *Understanding drugs, alcohol and crime*, Oxford University Press, 2005.

of psychoactive substances, projected that the total costs may have risen by 2025 to £35 billion.

Although it too is subject to the reservations above, one analysis of the costs of problematic drug use is widely cited both by those in charge of the National Drug Strategy and by critics of the strategy. This analysis is a research study conducted for the Home Office by academics from the University of York led by Professor Christine Godfrey, entitled ‘The economic and social costs of Class A drug use in England and Wales, 2000’.¹⁵⁷ The study points out that two separate sets of costs must be taken into account: the costs that flow from the harms done by drug use to individuals and society and the costs of the strategies adopted to counter these harms. The factors that should be included in calculating such costs are listed as follows.

Costs to the individual

- 1 the costs related to premature death;
- 2 the costs of drug-related illness;
- 3 loss of earnings through criminality and imprisonment, sickness, temporary or permanent unemployment; and
- 4 the costs of reduced educational attainment as translated into reduced future earnings.

Costs to society

- 1 the costs in terms of lost output and lower Gross Domestic Product as a result of sickness absence, theft in the workplace, the need to increase security, and expensive schemes for drug testing in the workplace;
- 2 the costs to communities of environmental damage, drug litter and lowered house prices;
- 3 the costs of caring for the children and other dependants of drug users;¹⁵⁸
- 4 the other costs of social care and social security benefits;
- 5 the costs of health care (other than drug treatment) for drug users, including GP care, Accident and Emergency, ambulance services, hospital days, mental health services, death costs, plus specialist services such as the care of babies born to drug using parents or treatment for HIV and hepatitis;¹⁵⁹
- 6 the costs of health care for people affected by the drug misuse of others – drugs users’ families, for example, or people suffering stress through an increased fear of crime;¹⁶⁰ and
- 7 the costs of crime related to drug use, discussed below.

The most recent update to the original study by Professor Godfrey produced an overall economic and social cost for Class A drugs in England and Wales in 2003/04 of around £15.4 billion.¹⁶¹

¹⁵⁷ Home Office Research Study 249, 2002. The later Drug Harm Index on which the Home Office relies as an indicator of its own performance is more widely challenged.

¹⁵⁸ These costs were estimated by the Godfrey report at £63 million in England and Wales in 2000.

¹⁵⁹ Godfrey estimated £4.3 million spent in 2000 on babies born with drug-related problems. For HIV, Godfrey produced a figure of £888,753 for each new case presenting in 2002, incorporating figures for the predicted loss of 20 years’ life, valued at a total of £714,229, plus 15 years of treatment at £15,000 per year.

¹⁶⁰ Godfrey estimated the average yearly loss of health for people in Britain as a result of fear of crime at £19.50 per head.

¹⁶¹ ed. N Singleton, R Murray, L Tinsley, *Measuring different aspects of problem drug use: methodological developments*, Home Office Online report 16/06, 2006.

The largest single set of social costs are those which official figures attach to 'drug-related crime'. It is not always clear whether 'drug-related crime' in this context refers to criminal offences in breach of drug laws, to crimes of violence and corruption surrounding the operation of drug markets, to crimes committed under the influence of drugs, or to acquisitive crimes committed to fund drug use. More often than not, those who are attempting to calculate the costs of 'drug-related crime' simply lump all these costs together, taking advantage of the ambiguities in the relationship between drugs and crime (discussed above) to present the figures in the most drastic possible light.

The 2003 Strategy Unit report on drugs, for example, referred to 'drug-motivated crime' and focused under this heading on acquisitive crime committed to fund drug use, as well as drug driving (which caused more than 200 deaths in 2002), mugging (around 238,000 crimes per year) and murder (130 per year). The report asserted that drug-motivated crime had risen over the previous seven years while other types of crime had remained stable or fallen, and it attributed 85 per cent of shoplifting, 80 per cent of domestic burglary, 71 per cent of non-domestic burglary, 55 per cent of theft from cars and 54 per cent of robbery to drug misuse. It estimated that drug-motivated offences accounted for around 56 per cent of the total number of criminal acts and a third of the total cost of crime – £19 billion – with £16 billion of this attributable to heroin and crack users. The Godfrey report stated that in 2000 Class A drug-related crime accounted for more than £10 billion worth of crime, 88 per cent of the total cost.

As for the costs of the strategy, the government Spending Review for 2000 carried out a cross-departmental review of public spending plans on illegal drugs. The planned expenditures for 2003/4 were as follows:

	£million
Drug treatment	401
Protecting young people (education)	120
Safeguarding communities	95
Reducing availability (criminal justice)	380
	996

These figures were substantially increased in the Spending Reviews for 2002 and 2004, following the updating of the UK government's drug strategy in 2002. The government's projected direct annual expenditure on the drug strategy for 2004/5 and 2005/6 was as follows:

2004/5	£million
Drug treatment	512
Protecting young people	155
Safeguarding communities	297
Reducing supply	380
	1,344

2005/6	£million
Drug treatment	573
Protecting young people	163
Safeguarding communities	367
Reducing supply	380
	1,483 ¹⁶²

The estimated amounts of money would not appear to have been delivered in practice, in the case of drug treatment at least, according to figures presented to the House of Commons in October 2006 by the Secretary of State for Health.¹⁶³ The planned expenditure for treatment in England and Wales in 2003/4 was £410 million; the actual expenditure (combining the Pooled Treatment Budget from central government and local funding from local authorities, Primary Care Trusts, police and probation services) was £436 million, exceeding the estimate by £26 million. However, in 2004/5 actual expenditure (£457 million) may have fallen short of projected expenditure (£512 million) by £55 million and in 2005/6 actual expenditure (£508 million) may have fallen short of projected expenditure (£573 million) by even more, £65 million.¹⁶⁴

What is missing from all these accounts is a detailed analysis of the cost-effectiveness of the drug strategy itself. Basic calculations have been published of the ratios between the costs of drug interventions and their savings in terms of health and social costs. But Christine Godfrey, co-author of the key study of the economic and social costs of drug use mentioned above, has argued that a really robust and thorough-going cost-benefit analysis should be a priority for government.¹⁶⁵ Failure to complete this analysis makes it impossible for policy makers to consider alternatives to existing policy by comparing the costs of the current strategy with the estimated future costs of other options, whether these be decriminalization, legalization or zero-tolerance.¹⁶⁶ We agree with Professor Godfrey.

¹⁶² Home Office website, 'Government direct annual expenditure on the Drug Strategy', <http://www.drugs.gov.uk/drug-strategy/funding/?version=1>

¹⁶³ Caroline Flint, Parliamentary Written Answer, 23 October 2006.

¹⁶⁴ In the 2004/5 and 2005/6 figures for actual expenditure, the local government expenditures were estimated and incorporated local funding increases based on a 2 per cent inflation increase. The Pooled Treatment Budget has increased year on year during this period from £253 million in 2004/5 to £300 million in 2005/6, £385 million in 2006/7 and £ 398 million in 2007/8. In the Scottish Executive's Draft Budget for 2007/08, £39 million is allocated for tackling anti-social behaviour and promoting community safety and £32 million for tackling drug misuse.

¹⁶⁵ At the 2005 conference of the Society for the Study of Addictions, York, November 2005.

¹⁶⁶ See e.g. J Miron, 'The Budgetary Implications of Marijuana Prohibition', Marijuana Policy Project, 2005.

6 Why people use drugs

The previous chapters have examined the prevalence of drug use in the United Kingdom and some of its consequences. An analysis of drugs policy in its widest context must also explore a third piece of the jigsaw: why people use illegal drugs. Most people working in the drugs field would be very reluctant to respond to this question, on the basis that there are almost as many different answers as there are drug users. This chapter offers only a few broad but important generalizations.

Why do people use drugs at all?

Many people undoubtedly use drugs out of curiosity and the wish to experiment. They take drugs in the belief that they will improve their lives in some way. In 2005 the university magazine *Student* surveyed Edinburgh students on their life styles. Those reporting drug use were asked whether they considered drugs to be a positive force on their lives. Of those who replied to the question, 42 per cent considered cannabis to be a positive force, 48 percent felt the same about cocaine, 54 percent about magic mushrooms, while 75 per cent responded that they considered ecstasy to be a positive force in their lives.¹⁶⁷

‘Mankind has always sought doors in the wall of reality.’¹⁶⁸

For some users, drugs may be a means of spiritual enlightenment. Supporters of psychedelic drugs in particular – such as magic mushrooms and LSD – argue that they provide spiritual insight and an expansion of consciousness.¹⁶⁹ Researchers in neurotheology – the neurology of religious experience – at Johns Hopkins University argue that magic mushrooms can produce mystical experiences with life-changing effects.¹⁷⁰

Others use drugs for therapeutic reasons. MDMA, the chemical from which ecstasy is derived, began to be used in the 1970s as a means of enhancing communication in psychotherapy. According to Ann Shulgin, wife of the chemist Alexander Shulgin who introduced it to a circle of psychotherapists for use in this way, MDMA is a drug which, used under carefully controlled conditions, allows personal insight without fear or loss of control. It has been used extensively in marital therapy and in therapy for post-traumatic stress, enabling people to examine experiences and assimilate them rather than repressing threatening memories. Even when ecstasy, a cruder form of MDMA, is used purely for entertainment, one of its main attractions is that its use is a collective activity; it is seen as a way of creating, reinforcing and expressing friendship, dissolving the individual into a wider group experience. ‘It makes you feel

¹⁶⁷ S Friedman, ‘Your highness’, *Student*, 04-05(13).

¹⁶⁸ M Gossop, *Living with drugs*, Ashgate, 2000, p.205.

¹⁶⁹ Blackman, op.cit.

¹⁷⁰ ‘Hallucinogen research inspires neurotheology’, *The Lancet Neurology*, Volume 5, Issue 9, September 2006, Page 732. http://www.maps.org/pipermail/maps_forum/2006-August/007295.html

special, like you're out clubbing with the whole club.'¹⁷¹ People who are drunk on alcohol often feel the same way – and certainly behave as though they do.

¹⁷¹ K Moore and S Miles, 'Living the high life: the role of drug taking in young people's lives', *Drugs and Alcohol Today*, 5/2, August 2005, p.30.

Drug experiences, their defenders claim, are special. They are an antidote to boredom, a route to adventure and risk taking, sometimes the only one that people feel is open to them. Some drugs are endowed with glamour, others bestow feelings of power and competence. Some really do enhance performance at a time when there is increasing pressure, on young people in particular, to excel and be happy. What propels many, perhaps most casual drug users at the outset is the combination of curiosity and the immediate availability of drugs. Without doubt, some drug use is supply-led. Determined dealers can and do create demand. The rapid expansion of heroin use in the 1980s, for example, seems to have been triggered by a sudden increase in supply, and the current rise in the practice of 'speedballing', injecting heroin and crack together, is undoubtedly dealer-driven. In a 2003 survey, around 75 per cent of pupils who reported having taken Class A drugs said that they had been given them free on the first occasion.¹⁷²

¹⁷² National Statistics, *Drug use, smoking & drinking among young people in England in 2003*, 2004.

¹⁷³ *Guardian*, 2 August 2005.

One of the most common explanations that users give for having started to take drugs is that they thought it would help them fit in with other people. Drug taking creates communities, sometimes illusory but sometimes real, and it seems to offer a solution to feeling different, excluded or unwanted, within a family or at school. The more people feel shut out, the further they are likely to go in order to fit in. Drug taking for many people is not a positive action but a reaction. Drugs are an escape: from monotony and stress but also from loneliness and unhappiness. Some drug workers see this kind of use as 'self-medication'.

Psychoactive substances have long been used by human beings in all cultures as a means of relieving pain. They play a significant role in modern medicine. They are used legally as anaesthetics and anodynes and therapeutically for mental disorders. They can also have beneficial effects on physical health. Cannabis, for example, can be used as an anti-emetic to treat the side-effects of chemotherapy, as an appetite stimulant for people suffering from AIDS-related illnesses, as an analgesic for types of nerve damage (for example, in diabetes) and for the relief of several of the symptoms of multiple sclerosis. According to sufferers, magic mushrooms relieve the symptoms of cluster headaches.¹⁷³ By the same token, moderate alcohol consumption, especially of red wine, has been claimed to protect against heart disease.

There is even renewed discussion of some potential beneficial effects of nicotine.¹⁷⁴ Injected subcutaneously, for example, it has been used to improve concentration in sufferers from Alzheimer's disease. More generally, very large numbers of people use prescription drugs, alcohol and tobacco not specifically as a medicine but as a means of coping with the pressures of everyday life.

Why do people use drugs in ways that cause problems?

If it is possible to use drugs in a controlled way, why do some people use them in ways that cause problems?

Problems in connection with drugs can happen to anyone. There is no one section of the population with a specific vulnerability to drug-related harm, the equivalent of high blood pressure or brittle bones.¹⁷⁵ Some individuals, however, may be more likely than others to go beyond controlled drug use into problematic use, for reasons that may be physical, psychological or social.

Just as there are genetic and other physiological reasons for misusing alcohol in dangerous ways, there are similar reasons for using drugs in dangerous ways. It is possible to speak of a genetic predisposition to misusing drugs.¹⁷⁶ This does not mean that people's genetic structure somehow forces or requires them to use drugs. However, once they have started using drugs, genetic influences, in combination with pressures in their environment and particular personality traits, may make them more likely to move from occasional or regular use to dependence. Neuroscientists working on the Foresight inquiry into *Brain Science, Addiction and Drugs* reported that between 40 and 60 per cent of the overall vulnerability to addiction is thought to have genetic components. In trying to identify the genetics of drug use, human studies have concentrated on genes associated with dopaminergic function. Broadly speaking, subjects with fewer dopamine receptors in the brain get more pleasure from drugs, leading to the theory that such people have a greater incentive to abuse and not just use them.¹⁷⁷

As for the influence of individual personality, most authorities reject the concept of a single 'addictive personality', a notion that has historically been tinged with shades of weakness and culpability. However, there are various personality traits that are more likely to lead people into using drugs dangerously: among them a disposition towards novelty seeking and risk taking, impulsiveness, difficulty in dealing with frustration, rebelliousness and lack of self-esteem.

¹⁷⁴ Professor Robin Room, Science Review, 'Social policy and psychoactive substances', Foresight *Brain Science, Addiction and Drugs*, 2005.

¹⁷⁵ See, for example, the evidence given by Professor John Strang to the 2006 Science and Technology Committee enquiry into the use of scientific evidence by government.

¹⁷⁶ This has the obviously significant consequence that some disposition to misusing drugs may be hereditary. See e.g. A Agrawal and M Lynskey, 'The genetic epidemiology of cannabis use, abuse and dependence', *Addiction*, Vol. 101, June 2006.

¹⁷⁷ T Robbins et al, Science Review 'Neuroscience and drugs of addiction', Foresight *Brain Science, Addiction and Drugs*, 2005.

Factors outside the individuals themselves will also help determine whether and how people take drugs. The most obvious environmental influence is the exposure to psychoactive substances in the womb. ‘It is well established that prenatal exposure to cocaine, heroin, marijuana, nicotine or alcohol can have profound effects on cognitive and motor function in adolescence and adulthood, and there is some suggestion that this exposure influences propensity to addiction.’¹⁷⁸ More recently, however, it has been suggested that other less direct environmental influences can increase the likelihood of drug abuse in later life – childhood sexual or physical abuse, for example. ‘The prevailing view is that these stressors influence the development of neural systems that underlie the expression of behavioural and endocrine responses to stress and reward.’¹⁷⁹ The important point here is the suggestion that abuse or neglect may result in physical change as well as emotional distress, strengthening the argument that problematic drug use lies at least partly beyond the scope of the drug user’s will.

Drug use in general is not confined to particular sections of society. When the British Crime Survey for 2003/4 drew up a list of risk factors for drug use, some of them actually related to privilege rather than deprivation. The variables with the closest associations with drug use were: being single (excluding being a widow or widower), being divorced or cohabiting, being young, visiting pubs or wine bars three times a week or more, being male and going to nightclubs. Other factors included earning £30,000 or more and living in an upwardly mobile neighbourhood. Nor is problematic drug use confined any more strictly to a particular sector of society. There are problematic drug users who had secure childhoods and have comfortable lives. A large proportion of these single, upwardly mobile nightclubbers use drugs occasionally, recreationally and without major harms, but some unquestionably fall under the heading of ‘problematic drug user’.

Nevertheless, problematic use is far more common among people who are poor, whose family has broken down or who never had a stable family structure in the first place.¹⁸⁰ The same is true of individuals who are struggling at school, in neighbourhoods where there are high levels of crime and low levels of public service and where there is no real community or other sources of social support. One Scottish study revealed that between 1999 and 2001 there was a yearly average of 460 admissions to hospital for drug conditions per 100,000 population in the 10 per cent of the most deprived areas of Scotland, compared with only 20 per 100,000 in the 10 per cent of least deprived areas.¹⁸¹ A survey in June 2003

¹⁷⁸ Ibid.

¹⁷⁹ Ibid.

¹⁸⁰ H Beckett et al, ‘Understanding problem drug use among young people accessing drug services: a multivariate approach using statistical modelling techniques’, Home Office Online Report 15/04, 2004.

¹⁸¹ Cited by Mike McCarron, ‘Drugs: which policies work?’, *RSA Journal*, February 2006.

of 92 per cent of all the people in Scotland's prisons, of whom some 80 per cent were known to use drugs, uncovered an average imprisonment rate of 953 per 100,000 population for the 27 most deprived council wards in the country, compared with a Scottish average of 237 per 100,000.

Drug use has thus been found to coincide with a range of indicators of poverty, deprivation, exclusion and family problems and as a response to pain, stress, uncertainty, loneliness, frustration and boredom. Various groups of young people have been categorized by the Home Office as particularly vulnerable to problematic drug use. In one study, centred on the Crime and Justice Survey, four groups of vulnerable young people accounted for a disproportionate share of Class A drug use.¹⁸² First were those who had ever been in care – that is, had spent time between the ages of 10 and 16 in a foster family, care home, children's home or young people's unit. Those leaving care had high levels of self-reported drug use compared with the general population: 34 per cent smoked cannabis daily, and no fewer than 10 per cent had used cocaine within the last month.¹⁸³ Second came those who had ever been homeless (for a period of at least a month, sleeping rough, in a temporary hostel or in bed and breakfast accommodation). The third group comprised truants and those excluded from school. In the 2003 youth survey, 'pupils who had ever played truant were considerably more likely than those who had not to have taken drugs in the last month (38 per cent compared with 7 per cent)', and the same was true for exclusion – though it is not clear which comes first, drug-taking or truancy. One study suggests that the correlation is closer for girls than boys.¹⁸⁴ The Crime and Justice Survey 2003 suggests that truants had the highest level of drug use of all the most vulnerable groups of young people. The fourth group comprised serious or frequent offenders, defined as those who had admitted either one serious offence such as vehicle theft, burglary, robbery or drug dealing, or six lesser offences, in the past year.

The same patterns and relationships are obvious in all age groups. Social disadvantages of all kinds overlap with problematic drug use in a vicious circle of cause and effect.

Homelessness

One in three problem drug users is homeless or in need of housing support, and a large proportion of homeless people are drug users.¹⁸⁵ Drug use can be both the reason for homelessness in the first place and a barrier to rehousing. In a 2002 survey, more than four out of five homeless people had used drugs in the

¹⁸² In e.g. J Becker and S Roe, 'Drug use among vulnerable groups of young people: findings from the 2003 Crime and Justice Survey', *Findings 254*, Home Office, 2005.

¹⁸³ J Ward et al, 'One problem among many: drug use among care leavers in transition to independent living', Home Office research study 260, 2002.

¹⁸⁴ C Goulden et al., 'At the margins: drug use by vulnerable young people in the 1998/99 Youth Lifestyles Survey', Home Office Research Study 228.

¹⁸⁵ Audit Commission, *Drugs Misuse 2004*.

last month, and 50 per cent had taken heroin.¹⁸⁶ Rough sleepers are two and a half times more likely to have used LSD and almost four times more likely to have taken magic mushrooms than people who have never been homeless.¹⁸⁷ ‘There is a hierarchy of drug use which is related to people’s state of homelessness... The further someone goes from permanent housing, the closer they get to problematic drug use.’¹⁸⁸

Displacement

Refugee communities are targets for drug dealers. Young people within them are vulnerable to future drug use as they are commonly experiencing depression, loneliness, isolation, racially motivated crime and bullying, inadequate housing (including being placed in hostels with problematic drug or alcohol users) and barriers to education.¹⁸⁹ Older people may continue to use traditional substances like khat or paan but without the social controls that applied in their home country.

Unemployment

According to the 2003/04 British Crime Survey, unemployed respondents had higher rates of drug use in the previous year than employed or economically inactive people.

Childhood abuse

In one 2005 study, nearly two-thirds of female drug users contacting treatment services in Scotland had been physically abused and more than one-third sexually abused by a family member or family friend.¹⁹⁰ Other studies have associated childhood abuse with polydrug use, HIV-related risk behaviour and poorer outcomes of drugs treatment.

The ‘gateway’ theory of problematic drug use

The simplest theory of why people progress from relatively unproblematic drug use to problematic use is the gateway theory and it is perhaps the most controversial, because in one form or another it underlies all of these policies that seek to prohibit the use of all drugs, including the least harmful, on the basis that ‘one thing leads to another’.

This ‘gateway’ theory, to be explained in a moment, is to be distinguished from the ‘stepping stone’ theory, which few people now seriously propound. The ‘stepping stone’ theory proposes that those who use cannabis will inexorably progress to using ‘harder’ drugs and from these inevitably to heroin, through some alleged pharmacological properties of the drugs themselves: because cannabis use unleashes chemicals in the brain that cause a desire for new drugs or because cannabis users, becoming

¹⁸⁶ J Fountain and S Howes, *Home and Dry? Homelessness and substance use in London*, Crisis, 2002.

¹⁸⁷ C Godfrey et al, *The economic and social costs of Class A drug use in England and Wales, 2000*, Home Office Research Study 249, 2002.

¹⁸⁸ O Baker, ‘Yes...but it all depends what you mean by homeless’, *Druglink*, Sept/Oct 2002. The 2003/4 British Crime Survey points out: ‘Private renters had the highest levels of drug use... while owner occupiers had the lowest levels. People living in flats and maisonettes reported a higher prevalence compared with those living in houses.’

¹⁸⁹ Centre for Ethnicity and Health, University of Central Lancashire, ‘Young refugees and asylum seekers in Greater London: vulnerability to problematic drug use’, GLADA 2004.

¹⁹⁰ N McKeganey et al., ‘Physical and sexual abuse among drug users contacting drug treatment services in Scotland’, *Drugs: education, prevention and policy*, Vol. 12/3, June 2005.

accustomed to the mild intoxication of cannabis, begin to crave a more intense high. No chemical or physiological basis, however, has yet been found for this theory.

The gateway theory is quite different. It does not suggest a progression of this kind. It simply uses the metaphor of a series of gateways as an analytical tool for looking at how people move between the use of one substance and another, which substances may well include alcohol and tobacco.¹⁹¹ It suggests that drug-using careers follow a generally predictable course, starting with alcohol and tobacco and moving on to various different illicit drugs. But there is no set order for this progression. The person going through the first gate into the first field – the gate from alcohol to cannabis, say – is faced with new gates leading to further fields.

The point at issue is the degree to which going through the first gate makes going through other gates more likely. Some believe that the progression is almost inevitable. Others consider that the progression is certainly more likely but not inevitable. Surveys repeatedly find that the odds of having used cannabis recently are much higher among young people who have drunk alcohol recently than among those who have never drunk, and the odds of having used a Class A drug are higher still among those who have used cannabis, particularly among those who have used cannabis regularly and those who started using it early. However, it is also true that the vast majority of people who have used cannabis have never used heroin and many have never used any other drug at all. A significant proportion of cannabis users do not drink. Similarly, an increasing number of people use heroin without ever having used any ‘softer’ drug.¹⁹²

It could be that many people do indeed start by using cannabis and progress to using other drugs, not because of anything inherent in cannabis but more likely because of something inherent in *them*. ‘There are a number of risk factors and life pathways that predispose young people to use cannabis and ...they overlap with the life pathways that predispose young people to use other illicit drugs. Cannabis happens to be the most easily available to those predisposed to use illicit drugs so it is used before other drugs.’

Availability, in some people’s opinion, may actually be the key. Rather than the chemical properties of substances or the psychology or social background of users, it may be strictly practical considerations of access and availability that determine whether, when and how someone moves from the use of one

¹⁹¹ *Drugscope* submission to the House of Commons Home Affairs Select Committee in 2001, drawn extensively from a technical paper by John Witton, National Addiction Centre and Sarah Mars, London School of Hygiene and Tropical Medicine.

¹⁹² See, for example, David Blunkett’s evidence to the House of Commons Home Affairs Select Committee, Session 2001–02, on ‘The Work of the Home Office’, Minutes of Evidence, HC 302, Q. 11: ‘The evidence that we have at the moment, particularly with the increased use of crack and cocaine amongst young people whilst there has been an overall general drop in terms of drug use, would indicate that there is a movement direct to the Class A drugs.’

drug to the use of another. Those who sell cannabis often have a wide range of other products on offer and a variety of marketing ploys with which to promote them. This fact is used by those who wish to tighten controls on cannabis: ‘If buying cannabis makes it easy to buy other drugs, then we should make it impossible to buy cannabis’ (i.e. shut the first gate). However, it is also used by those who wish to loosen controls: ‘Since zero-tolerance of cannabis use is impracticable, we should make it possible to buy cannabis without going to dealers who also sell cocaine and heroin’ – in other words, open the gate to cannabis in the attempt to make cannabis use a dead end with no obvious passage to more harmful forms of drug taking.¹⁹³

These alternative explanations of why people progress from non-problematic to problematic drug use – which might loosely be termed the ‘inevitable-progression’, ‘increased-probability’ and ‘consumer-market’ theories – are different types of theory. They also have very different implications for policy, as anyone attempting to base a strategy on a ‘gateway’ theory must acknowledge.

7 Legal and illegal drugs

It should be obvious from the previous chapter that people use illegal drugs for many of the same reasons and in many of the same ways as they use legal drugs such as alcohol and tobacco. The use of these substances is, however, regarded and regulated very differently by the law. To get a bearing on what drugs policy should look like, it is crucial to view the use of drugs that are currently illegal in the context of our experience with the best-known legal drugs, alcohol and tobacco.

The boundaries between different kinds of psychoactive substance are blurred. All drugs act according to the same general principles. All have multiple effects and their effects vary with dose. All can be dangerous and all are subject to some degree of legal control. The principal difference is the fact that the use of one group of drugs has been sanctioned by culture and habit in Britain while the use of the other has not.

How different substances are regulated in the United Kingdom

Drugs

‘The Government believes that all controlled drugs, including cannabis, are harmful and that no one should take them.’¹⁹⁴ Production, distribution and sale are all prohibited, and in most

¹⁹³ Peter Lilley MP made this argument the centrepiece of his pamphlet, *Common Sense on Cannabis: the Conservative Case for Change*, Social Market Foundation, 2001.

¹⁹⁴ Government response to ACMD report on cannabis classification, ‘Background to Cannabis Reclassification’ <http://www.drugs.gov.uk/drugs-laws/cannabis-reclassifications/background>

cases these prohibitions are strictly enforced. The possession of drugs is technically prohibited, but the prohibitions are enforced with varying degrees of discretion. The use of drugs per se is not treated as an offence in itself though it is used as a trigger for compulsory treatment when associated with other offences. (The laws relating to the control of drugs are discussed in more detail at in Chapter 18 below.)

Alcohol

The aim of alcohol policy is not primarily to forbid the use of alcohol or even to reduce the numbers of people who consume it but to prevent the crime, disorder and other harms related to its use, to preserve public safety, to prevent public nuisance and to protect children from harm. The production, sale, possession and consumption of alcohol are all restricted in various ways. There are, for example, controls on the strength of alcohol that may be produced. There are restrictions, through the Licensing Acts, on who may sell alcohol and on where and when they may sell it as well as on who may buy it (no one under 18) and how much they may buy. One of the purposes of the high taxes on alcohol is to discourage excessive consumption of it as well as to offset the costs associated with excessive consumption where it does occur.

Further restrictions are imposed by local bye-laws governing where, when and how much people may consume. Some local authorities, for example, have created alcohol-free zones, and alcohol may not be permitted in football grounds or on football trains; the police have the power to confiscate alcohol from people under 18 if they are drinking in a public place. There are also restrictions on how people may legally behave after drinking: driving having drunk more than the prescribed limit, creating disorder in a public place or endangering one's own or other people's safety at work. There is a growing emphasis in policy throughout the United Kingdom on 'responsible drinking', with the introduction of measures to restrict 'Happy Hours', for example, and heavily discounted bulk buys.

The advertising and promotion of alcohol are permitted but only under certain conditions. Alcohol advertising is governed by a combination of legislation and self-regulation to ensure that drink brands are not promoted as having the power to improve social or sexual success, or to make the drinker popular and attractive. Advertising messages must also avoid encouraging irresponsible or dangerous behaviour, such as drinking at work or when driving. Advertising must not be targeted at people under 18. Nevertheless, hundreds of millions of pounds are spent

on advertising and marketing alcohol every year, the rules are quite often circumvented, and Alcohol Concern believes there is a need for an independent regulatory body responsible for all aspects of alcohol marketing.¹⁹⁵

Tobacco

The World Health Organization (WHO) Framework Convention on Tobacco Control is the first global health treaty negotiated under the auspices of the WHO. It commits countries to implementing a range of control measures such as a ban on advertising and the protection of people from second-hand smoke. In the United Kingdom the possession of tobacco is not restricted, but production, sale and consumption are all controlled to varying degrees. Controls are imposed on the strength of tobacco products and the additives they contain. There are restrictions on who may buy them (no one under 16, and the government is considering raising this age to 18) and also on when and where they may be sold. There are also restrictions on where they may be consumed: not on garage forecourts, for example, or where food is prepared. In Scotland it is already illegal to smoke in any workplace or enclosed public place. In England a bill to ban smoking in virtually all workplaces was approved by parliament in 2006 and is expected to come into force in the summer of 2007. Tobacco products are heavily taxed to raise prices and discourage consumption, and health warnings on packaging are compulsory. The Department of Health is considering the use of graphic images as well as written messages within a thick black border. Tobacco advertising is banned altogether.

The question is whether these differences in the stringency with which alcohol, tobacco and drugs are controlled are directly linked to their relative harmfulness. Critics of current policy would point out that far more people drink and smoke than use drugs. Tobacco causes far more deaths than either alcohol or drugs, and alcohol causes twice as many deaths as drugs. There are thirty times more binge drinkers than problematic drug users. Nicotine is more addictive than heroin. Drug-related crime costs more than alcohol-related crime, but alcohol is involved in more crimes of violence. If alcohol were included in the current classification system, it would probably be on the border between Class A and Class B. If tobacco were included, it would probably be on the border between Class B and Class C.¹⁹⁶

¹⁹⁵ 'Advertising Alcohol' factsheet, http://www.alcoholconcern.org.uk/files/20040506_085240_Advertising%20factsheet%20April%202004.pdf#search=%22alcohol%20advertising%22

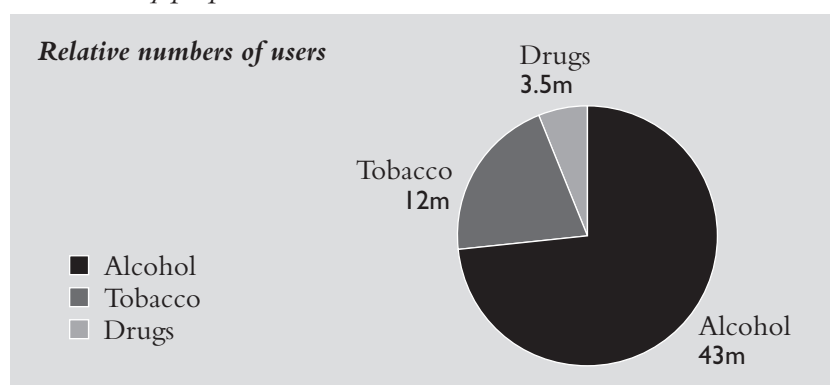
¹⁹⁶ Runciman Report, *Drugs and the Law. Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, Police Foundation, 1999, para.40.

The comparative harms of alcohol, tobacco and illegal drugs

We consider that the comparative harm caused by each drug must be a starting point for determining policy towards it. Of course, 'harm' is a multi-faceted concept. We have found it instructive to ask precisely the same questions for each class of psychoactive substance (alcohol, tobacco and illegal drugs) and of each individual illegal drug:

- How many people use them?
- How many problematic users are there?
- What are the main health-related harms?
- How many deaths do they cause?
- What are the other costs?
- How much crime is related to their use and what kinds of crime?

1 How many people use them?



In the United Kingdom as a whole, 90 per cent of the adult population uses alcohol, around 25 per cent of the population smoke, and slightly over 11 per cent have used illegal drugs in the last year.¹⁹⁷

2 How many problematic users are there?

In England and Wales, somewhere between 250,000 and 350,000 users of illegal drugs are deemed to be 'problematic'. In contrast, 8.2 million people are considered to have an 'alcohol use disorder', and 1.1 million people are considered to be dependent on alcohol (approximately 3.6 per cent of the entire population).¹⁹⁸ Eleven million from time to time indulge in binge drinking. A BUPA Wellness survey in October 2005 found that as many as a quarter of all adults in Britain, and 47 per cent of 18 to 24-year-old men, are binge drinkers, i.e. drink at least double the recommended daily limit of 3/4 or 2/3 units per day. Binge drinking accounts for 40 per cent of all the occasions on which men drink and 22 per cent of those when women drink.¹⁹⁹ A Department of Health survey in 2004 suggested that 21 per cent of all men and 34 per cent of men between 16 and 24 drink

¹⁹⁷ Health Development Agency, 'Prevention and reduction of alcohol misuse: evidence briefing summary', March 2005. ASH, 'Basic Facts 1: Smoking statistics', <http://www.ash.org.uk/> Home Office Statistical Bulletin 04/05, *Drug Misuse Declared: Findings from the 2004/05 British Crime Survey*.

¹⁹⁸ Alcohol Needs Assessment Research Project, *The 2004 National Alcohol Needs Assessment for England*.

¹⁹⁹ Health Development Agency, op.cit.

more than 8 units in a day at least once a week. The number of women in Britain drinking more than the recommended levels has increased sharply, more than in any other EU country. Alcohol use among children between 11 and 15 has risen steadily over the last ten years. Around 25 per cent of this whole age group and 50 per cent of 15-year-olds drink regularly. In 2004–5 almost 4,000 children between 11 and 15 were admitted to hospital because of alcohol-related problems: mental and behavioural disorders, liver disease or alcohol poisoning.²⁰⁰

²⁰⁰ Caroline Flint, Parliamentary Answer, 8 November 2006.

²⁰¹ Alcohol Concern, *Children of Problem Drinking Parents*, 2003.

In addition, between 780,000 and 1.3 million children are affected by parental alcohol problems, three or four times as many as are affected by parental drug use. Alcohol misuse has been identified as a factor in over 50 per cent of all child protection cases.²⁰¹ Children living with problem-drinking parents are likely to suffer from their parents' inconsistency, emotional detachment and neglect. The social care charity Turning Point in 2006 published a major report entitled *Bottling It Up: the effects of alcohol misuse on children, parents and families*. 'Family life,' they warned, 'can become characterized by chaos and a lack of routine, and in some cases unpredictable behaviour associated with mental health problems and violence.' Children with problem-drinking parents are more likely to become ill from poor hygiene, to have accidents from being left unsupervised, to miss school through having to care for their parents and to lack friends because they are ashamed to bring anyone home. They are likely to feel angry, frustrated, anxious, sad and depressed and are more likely than other children to have psychological problems and psychiatric disorders. They are also more prone to eating disorders, more likely to experiment with drugs and alcohol at an earlier age and more likely to progress to problematic use. Not least, they are more likely to drink more heavily, more often and alone.

Though there is no formal definition of a 'problematic' smoker, some number of smokers could nevertheless be deemed to have (and to cause) problems by virtue of the health-related harms they cause themselves and the harm and annoyance they cause others. The most obvious 'problem' smoker might be said to be one who smokes heavily and who has tried and repeatedly failed to stop.

3 What are the main health-related harms?

Health-related harms are well documented for psychoactive substances. According to the World Health Organization, illegal drugs account for 2.6 per cent of the total burden of Disability-Adjusted Life Years in the UK. Alcohol accounts

for 5.2 per cent of the total burden, and tobacco accounts for 14.2 per cent.²⁰² In a list of the top ten risk factors for deaths in the UK, tobacco is rated No.1 and illicit drug use No.10, below, as it happens, low fruit and vegetable intake. Disorders relating to alcohol use feature among the seven principal risk factors for ill health across Europe. In a table of the proportions of Disability-Adjusted Life Years that can be attributed to the leading fifteen known risk factors, tobacco comes second, alcohol third and illegal drugs eighth (above air pollution but below physical inactivity).

Some of the most serious health-related harms are common to more than one psychoactive substance. The respiratory depression caused by heroin, the raised blood pressure caused by cocaine, the depression caused by ecstasy and the memory loss and paranoia sometimes associated with cannabis are all also associated with drinking. Alcohol is also as likely as, say, cocaine or ecstasy to be associated with high-risk sexual behaviour. Like heavy use of cocaine, heavy drinking can produce psychotic episodes. In 2004 the number of hospital admissions 'with a primary diagnosis of a mental or behavioural disorder and relating to drug misuse' were 710 for cannabis, 3,110 for heroin and 10,910 for alcohol.²⁰³ Other harms are associated primarily with injected drugs, notably HIV, hepatitis and septicaemia.

Relative degrees of addictiveness are debated, but it is generally agreed that nicotine is the most addictive of psychoactive substances, ahead of heroin and crack cocaine. In 2000 the Tobacco Advisory Group of the Royal College of Physicians assessed nicotine as creating the greatest degree of dependence in the user. 'Tobacco dependence is a serious form of drug addiction which... is second to no other.'²⁰⁴ In addition, the group ranked the physical symptoms of withdrawal from alcohol as more severe than those for withdrawal from cocaine.

4 How many deaths do they cause?

Tobacco causes far more deaths than either alcohol or illegal drugs. The World Health Organisation has estimated that by 2015 it will cause ten per cent of all deaths: some 6.4 million deaths across the globe, half as many again as HIV/AIDS.²⁰⁵ In Britain, too, tobacco is a major killer. For example, in Scotland in 2004, death rates were as follows:²⁰⁶

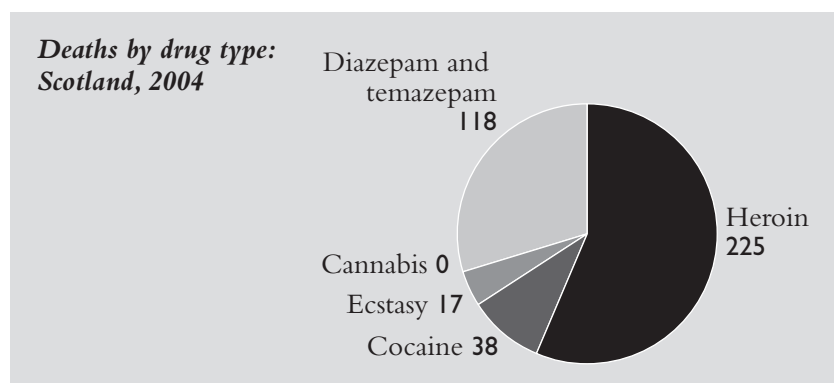
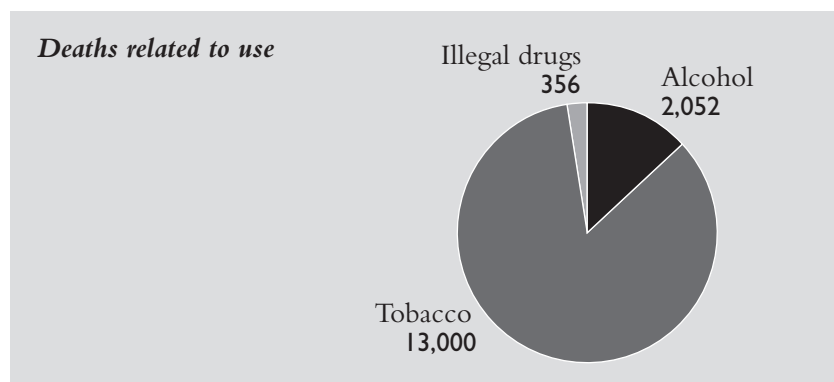
²⁰² WHO, *The European Health Report 2005*.

²⁰³ NHS Health and Social Care Information Centre, 'Hospital Episode Statistics', cited by Rosie Winterton, Minister of State for Health Services, in answer to a parliamentary question on 30 January 2006.

²⁰⁴ *Nicotine addiction in Britain*, Royal College of Physicians, 2000.

²⁰⁵ *Public Library of Science Medicine*, November 2006.

²⁰⁶ Statistics for drugs taken from General Register Office for Scotland, *Drug-related Deaths in Scotland in 2004* <http://www.gro-scotland.gov.uk/press/news2005/drug-related-deaths-in-scotland-in-2004.html> Statistics for tobacco taken from Scottish Executive, *Health in Scotland 2004, 2005*, and for alcohol from Office of National Statistics, *Alcohol Information Scotland*, 18 July 2006.



In 2004 there were around 106,000 deaths related to smoking in Britain. It is estimated that half of all persistent smokers will die of related diseases. Seventeen per cent of deaths from heart disease are associated with smoking. In addition, a further 600 deaths a year are due to second-hand smoke in the workplace, far more than are due to any industrial injury. Second-hand smoke increases the risk of lung cancer by 20–30 per cent and coronaries by 25–35 per cent, as well as increasing the risk of asthma and cot death in children.

In 2004 there were 8,389 alcohol-related deaths in the UK (according to a new harmonized definition of alcohol-related deaths that has been recently agreed across the UK).²⁰⁷ This number represents a rise from 6.9 per 100,000 of the population in 1991 to no less than 13.0 per 100,000 in 2004. Two thirds of the dead are men. Men aged between 35 and 54 had a death rate of 38.3 per 100,000, more than three times the rate of men from 15 to 34 and almost twice the rate of men aged 55–74. The rate of deaths for women showed a similar pattern with most deaths in the 35–54 age group: again, the number of deaths doubled between 1991 and 2004.

Alcohol misuse is closely associated with deaths from cirrhosis of the liver and is also known to play a part in strokes, cancers of the oesophagus and the liver and possibly also cancers of the breast and rectum. Alcohol misuse has recently been causally linked to the rise in mouth cancer that caused 1,600 deaths

in the UK in 2004. Heavy use is linked to around 20 per cent of suicides (around 1,000 suicides a year) and 65 per cent of suicide attempts. Some 700 people were killed in drunk driving or other accidents in 2004, including 100 pedestrians killed on the roads at night who were found to have been drinking.

In England and Wales in 2004 there were 2,598 deaths 'from drug-related poisoning' where the word 'drugs' includes prescribed drugs and over-the counter medicines such as paracetamol.²⁰⁸ The figures gathered by the Office of National Statistics reveal that heroin, methadone, cocaine, amphetamines (including ecstasy) and GHB accounted for 663 of these deaths. Seventy-three per cent of drug-related deaths are of people under 45. A high proportion of deaths from illegal drug use are the result of overdose, the large majority from heroin and methadone. There are more deaths from the abuse of benzodiazepines such as temazepam and Valium than from cocaine, ecstasy and cannabis put together.

It is worth asking why we are more shocked by drug-related deaths than deaths from other types of substance abuse. The answer may be because many drug deaths are more conspicuously premature, involving people in their twenties and thirties (or even in the most widely publicized cases, their teens). Dying of drink or tobacco tends to be a more protracted process. But, in addition, it seems clear that the demonization of illegal drugs discussed in Chapter 2 provides a large part of the explanation. The death of a teenager through drug misuse shocks. The death of the same teenager as a result of a drink-driving accident comes as less of a shock – except, of course, to his or her parents and friends.

Illegal drugs, however, are no longer as special in this regard as they were. Recent figures have shown that 'an average of two young men and one young woman now die every day in England and Wales from the effects of alcohol. And the trend of people dying younger from alcohol-related causes is predicted to continue.'²⁰⁹ In particular, deaths among young women have increased sharply, tripling over twenty years. Around 1,000 young people under 15 are admitted to hospital every year for acute alcohol poisoning. Binge drinking is bringing down the average age of liver failure, and in both sexes deaths from acute intoxication, which can be rapid, have doubled in the last 20 years.²¹⁰ It is also relevant that, although drink-driving is found in all age groups, it is most common amongst young men between 17 and 24, who are thus likely to account for a majority of drink-driving deaths.²¹¹ The fact is that our sense of shock is almost certainly

²⁰⁸ <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=11695> National Statistics, *Deaths related to drug poisoning, England and Wales*, 'Table 1. Number of deaths by drug-related poisoning by underlying cause, England and Wales'.

²⁰⁹ <http://www.communitycare.co.uk/Articles/Article.aspx?iArticleID=44602&PrinterFriendly=true>

²¹⁰ Parliamentary Office of Science and Technology, Postnote No 244, July 2005, 'Binge Drinking and Public Health'.

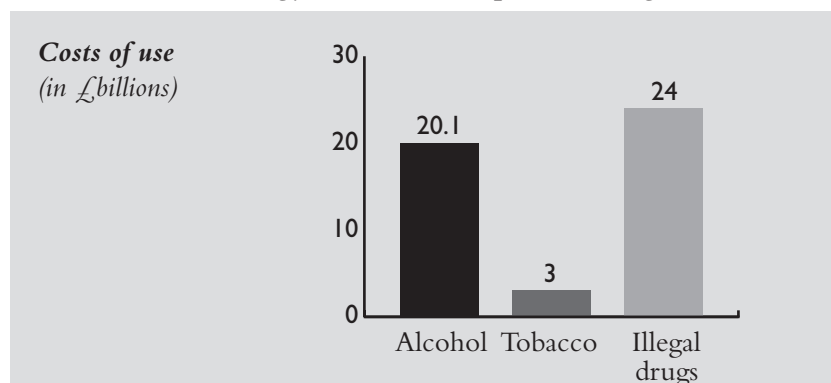
²¹¹ According to Kent County Council's study on 'Drug Driving', small-scale surveys suggest that 18 per cent of driver/rider fatalities had some form of illegal drug in their system and 6 per cent had some form of prescribed drug.

related less to the number of cases than to the amount and the intensity of the publicity given to a few dramatic drug-related deaths, especially the deaths of young women.²¹²

5 What are the other costs?

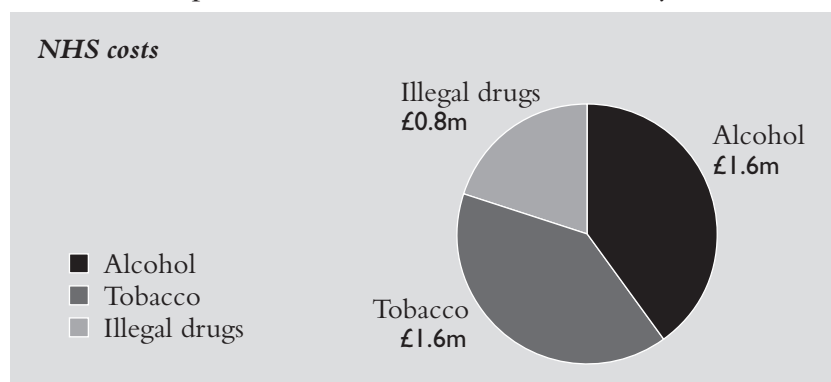
The harms from alcohol, tobacco and illegal drugs are not measured in terms of health alone. Economists have put rough figures on the comparative financial costs of their use and misuse.

The financial costs of illegal drug use to the nation have been discussed above in Chapter 5. The total figure of £24 billion is taken from the Strategy Unit’s 2003 report on drugs.



In the diagram above the costs of alcohol and illegal drugs to the economy are calculated on the basis of health damage, crime, loss of productivity and social problems.²¹³ The relatively low costs of tobacco are presumably due to the relatively low impact of tobacco-related crime (the principal crime associated with tobacco being smuggling).²¹⁴

But when health costs are separated out, as in the diagram below, the relative ‘expensiveness’ of tobacco is more clearly revealed.²¹⁵



As regards alcohol, it has been estimated that 33 per cent of all inpatient care, up to 35 per cent of all Accident and Emergency attendance and ambulance costs, up to 150,000 hospital admissions and 1 in 26 NHS bed days and up to 17 million lost working days (representing a loss of productivity of up to £6.4 billion) are attributable to that particular drug.²¹⁶

²¹² Shane Blackman (*Chilling Out: the cultural politics of substance consumption, youth and drug policy*, Open University Press, 2004, p.170) calls this the ‘public gallery of dead young women’, referring to the relentless publicising of the deaths of Leah Betts, Julia Dawes, Lorna Spinks and Rachel Whiteear as a means of promoting a political and prohibitionist agenda by treating drug misuse as a symptom of general moral decline and social malaise.

²¹³ Figures taken from Strategy Unit, *National Alcohol Harm Reduction Strategy*, Interim Analysis, 2003.

²¹⁴ Figure taken from ASH Factsheet No. 17, ‘Tobacco smuggling’, August 2004.

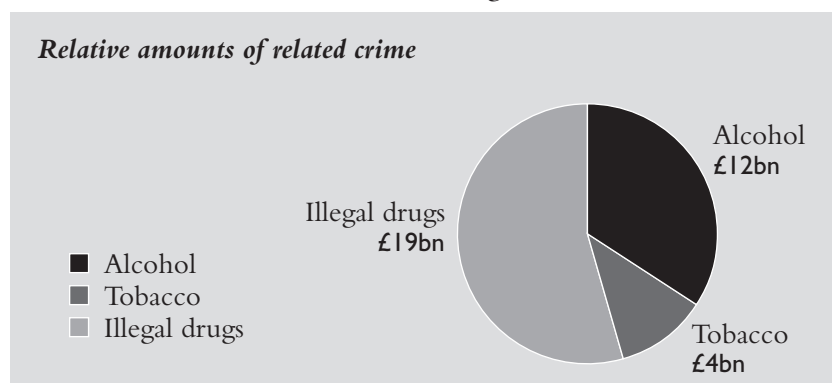
²¹⁵ Figures based on an answer to a parliamentary question on 7 April 2005 by Melanie Johnson, Parliamentary Under-Secretary of State for Public Health. ‘Smoking costs the national health service between £1.4 billion and £1.7 billion a year in England, as set out in the White Paper, *Choosing Health...*’ The interim analytical report prepared by the strategy unit to support the production of the alcohol harm reduction strategy for England estimated the cost annually to the health service due to alcohol related harm as between £1.4 and £1.7 billion... Problem drug users are estimated to cost the NHS between £283 million and £509 million per year, in addition to the specific addiction treatment they are receiving.’ The figure of £0.8 billion for drugs is achieved by taking a mid-point of £400 million between her two estimates and adding the Pooled Treatment Budget for 2006/7 rounded up from £384.6 million to £400 million.

²¹⁶ Strategy Unit, *National Alcohol Harm Reduction Strategy*, op.cit.

The socioeconomic costs of prescription drug abuse have not been quantified in the same way, but this kind of ‘hidden’ drug misuse is likely to be a frequent factor in job loss, decreased productivity and generic health costs.²¹⁷

6 How much crime is related to their use?

The ‘crime harms’ associated with alcohol, tobacco and drugs cannot, of course, be directly compared when the possession of one, and only one, of these types of substance is a crime in itself. Nevertheless, there are some interesting distinctions to be made.²¹⁸



Different kinds of crime are related to the use of the different substances. For example, the majority of drug-related crimes are acquisitive, though drugs are also implicated in some violent crime, particularly in gang wars over the supply of illegal drugs. Illegal drugs are also thought to contribute to an increasing number of driving offences. (French researchers estimated in April 2005 that 2.5 per cent of fatal crashes are due to cannabis use.)²¹⁹

In contrast, though alcohol is a factor in 33 per cent of all burglaries and results in around 85,000 cases of drunk-driving a year and around 600 road deaths, it is more commonly linked with violent crime, with some 1.2 million incidents reported each year.²²⁰ It is estimated that 40 per cent of all violent crime is alcohol-related, 78 per cent of assaults and 88 per cent of criminal damage, accounting for more than 1 million crimes a year.²²¹ ‘As many as one in ten assaults treated in UK Accident & Emergency departments are caused by offenders using glasses and bottles as weapons.’²²² The Drinkaware Trust’s 2006 survey ‘Out of Order’ found that 32 per cent of 18–30 year old men felt more aggressive after drinking a lot of alcohol.²²³ (In London the figure was 47 per cent.) A commentator on the cannabis magazine *The Red Eye Express* pointed out that when people get drunk, they go out looking for a fight. ‘You get nice and stoned, you go out looking for Mars bars.’²²⁴

Between a third and a half of all domestic violence (some 360,000 incidents a year) is alcohol-related.²²⁵ In addition,

²¹⁷ <http://www.benzo.org.uk/manual/bzcha01.htm>

²¹⁸ The statistics for illegal drugs are taken from the 2003 Strategy Unit report, which defines crime as ‘drug-motivated’ crime – acquisitive crime to fund drug use, drug-driving and other crimes committed under the influence of drugs – but excludes the crimes of possession and supply.

²¹⁹ <http://news.bbc.co.uk/1/hi/health/4486308.stm>

²²⁰ According to *Drink-Driving News*, October 2005, drink-driving deaths in the UK rose from 580 in 2003 to 590 in 2004. <http://www.80mg.org.uk/ddnews05.html#OCT> Strategy Unit drugs report, 2003.

²²¹ <http://www.crime-reduction.gov.uk/toolkits/ar020101.htm>

²²² Parliamentary Office of Science and Technology, Postnote No 244, July 2005, ‘Binge Drinking and Public Health’.

²²³ The Drinkaware Trust, established in 2006, is the educational arm of alcohol industry body The Portman Group.

²²⁴ D McCandless, ‘High Society’, *Independent*, 5 September 2005.

²²⁵ The 2004/5 British Crime Survey suggested that in 53 per cent of incidents of domestic violence the offender was thought to be under the influence of alcohol, as compared with 11 per cent under the influence of drugs.

drinking, either by the perpetrator or the victim, is a factor in 30 per cent of sexual offences. Various authorities claim that alcohol is still by far the most effective date-rape drug. However, the number of women convicted of drink-related offences is also rising.

²²⁶ Kerb crawling is not yet illegal in Scotland, but the bill is currently being debated.

The controls imposed on the use of tobacco are mainly directed at reducing health harms. Where alcohol is concerned, it is not use itself so much as the crimes associated with use that are the prime target of legislation and other controls. This is also true in the case of gambling and prostitution, activities that are not prohibited but that operate within a framework of controls designed to minimise their links with crime. Gambling itself is not illegal. It is controlled by the Gambling Act 2005 whose aims are to prevent it being a source of crime or disorder or being used to support crime, to ensure that it is conducted in a fair and open way and to protect children and vulnerable people from being harmed or exploited by it. Similarly, prostitution is not in itself illegal but activities related to it are controlled where they are a threat to public order, cause public offence or support crime. Thus soliciting in the street, kerb crawling and controlling prostitutes for gain are all illegal.²²⁶

From the figures above, it would appear that in relation to the relative amounts of harm that they cause to individuals and to their costs to society at large, alcohol and tobacco are under-controlled and some drugs are over-controlled. We will argue later for a policy that starts to address this imbalance by bringing alcohol, tobacco and other drugs within a single regulatory framework, one capable of treating each substance in accordance with the amount of harm that it causes.

Part II Drugs policy at the moment

8 The evolution of drugs policy

Drugs policy in Britain has historically had two facets: a health-centred approach to the health harms resulting from drug misuse and a drive against drug-related offending through the criminal justice system. Each approach has always been seen as important but has at different times been given different priorities. At present, for all the money that has recently gone into providing treatment, the criminal-justice approach is firmly in the ascendant.

When drug misuse first started to be conceived of as a problem for British society in the mid-19th century, it was defined as a threat to health and therefore as a medical issue. By the turn of the 20th century the newly emerged medical profession was asserting its authority to define and treat addiction as a disease, and the Pharmaceutical Society was claiming the right to be the sole legal supplier of drugs.

However, drug use in the meantime had also begun to be framed as a criminal justice problem. At the outbreak of war in 1914, British policy on drugs became the responsibility of the Privy Council Office as, in the absence of a Ministry of Health (not created until 1919), no other department was willing to take on the responsibility. Two years later, in the middle of the First World War, an interdepartmental meeting in June 1916 agreed that the problems of drugs misuse were most appropriately viewed as ‘police matters’. They reached this conclusion in the wake of public concerns over the rumoured use of cocaine by troops and munitions workers. The regulations promulgated under the Defence of the Realm Act of 1914 that we referred to in Chapter 2 introduced a definition of ‘harmful’ substances (primarily cocaine and opium) and criminalized their unauthorized supply and possession. The new definition brought drugs within the sphere of the Home Office because it was the department responsible for the Defence of the Realm Act, and made it, in effect, the lead ministry in terms of policy, though doctors still retained practical control in terms of treatment.

In the early 1920s the penal approach to drugs control gained ground in the UK. A clause in the Treaty of Versailles of 1919 had required signatories to legislate for their internal drugs problems. The Dangerous Drugs Act 1920 authorized the ‘Secretary of State’ – in practice the Home Secretary – to regulate the manufacture, sale, distribution and possession

of dangerous drugs. The drugs to which the Act applied could be extended in future by an Order in Council when such drugs were considered ‘likely to be productive, if improperly used, of ill effects... analogous to those produced by morphine or cocaine’. The Dangerous Drugs Regulations of 1921 provided for a licensing and regulatory framework to implement the provisions of the Dangerous Drugs Act, limiting the supply, prescription and possession of dangerous drugs to doctors, dentists or vets. This was the first statutory expression of special privileges given to doctors in relation to dangerous drugs.

Two years later the Dangerous Drugs Amendment Act 1923 imposed heavier penalties for drug offences and gave the police increased powers of search. The heavier penalties and new powers were partly in response to a changed public – or at least press – mood. The ‘vice’ conception of drug use dominated the newspaper reports of the period, with stories of “peddlers” and “dope fiends”.²²⁷ There was concern about high-profile celebrity deaths and drugs were increasingly associated with foreigners.

The stringency of the Dangerous Drugs Amendment Act was also partly driven by the Home Office’s desire to follow the model of America’s 1914 Harrison Act, which treated drugs as a criminal issue and restricted the powers of doctors to prescribe them. However, the new British Act left the medical profession more freedom of action than did the Harrison Act, allowing any doctor to dispense opiates ‘so far as may be necessary for the exercise of his profession’. A regulation proposed by the Home Office in 1922 that doctors should not be permitted to prescribe a controlled drug for their own use was withdrawn following objections from the British Medical Association. The Home Office nevertheless remained broadly opposed to the prescribing of ‘maintenance’ doses of dangerous addictive drugs on the grounds that ‘abrupt withdrawal from drug dependence was possible and that any other form of treatment was improper’.²²⁸

To set out what constituted legitimate prescribing practice, the new Ministry of Health set up a committee under Sir Humphrey Rolleston, President of the Royal College of Physicians. The committee’s report in 1926 not surprisingly found in favour of retaining significant medical input into the problem of substance misuse. The Dangerous Drugs Regulations of the same year reasserted the ‘disease’ model of addiction and confirmed that prescribing heroin and morphine to addicts was a legitimate medical treatment. These regulations established what was subsequently labelled the ‘British system’ under which addicts could receive a regular supply of heroin or morphine in order

²²⁷ G Stimson and E Oppenheimer, *Heroin addiction: treatment and control in Britain*, Tavistock, 1982.

²²⁸ Contemporary document cited in an historical overview of drug policy carried out in the course of the Shipman Inquiry. *Shipman Inquiry, Fourth Report – The Regulation of Controlled Drugs in the Community*, 2004, p.46.

to maintain or gradually to reduce their use without their doctors being liable to prosecution. 'The legacy of Rolleston was to create a dual approach to substance use and misuse,' one observer has written:

On the one hand the police retained the power to prosecute unauthorized use, supply and possession, thus criminalizing drug users not authorized by the medical profession.

On the other hand, the medical professions retained the right to diagnose, define and treat addiction. In this way a dual approach developed, with substance misusers being defined as either criminal or sick depending on the arm of the British system with which they came into contact.²²⁹

The Rolleston Report had declared that drug use was a problem to be solved and not a sin to be punished, and between the 1920s and the early 1950s the dominant approach to the problem was indeed a medical approach, with doctors prescribing to a small number of individual addicts, many of them doctors themselves.²³⁰ But such prescribing always took place within the existing criminal framework; and in the late 1950s and early 1960s the situation changed. Instead of the largely middle-class, middle-aged and professional therapeutic opium users of the interwar years, there emerged, as we saw in Chapter 2, a far larger group of much younger users taking drugs – primarily cannabis and amphetamines – for pleasure.

These developments prompted a wave of legislation to deal with the rising numbers of users and the wider range of drugs used in new cultural settings. In 1964 the Dangerous Drugs Act made the cultivation of cannabis illegal, and the Drugs (Prevention of Misuse) Act 1964 brought amphetamines within controls. As for opiates and cocaine, there had for some years been concern that a small number of doctors had been prescribing irresponsibly, with the result that excess quantities of heroin and morphine had been leaking onto the illegal market. In 1965 the second report of the Brain Committee recommended that this leakage should, if possible, be brought under control.²³¹ The report led to the passage of the Dangerous Drugs Act 1967. Regulations under the new Act stipulated that doctors now had to be specially licensed by the Home Secretary in order to prescribe heroin or cocaine and that the names of addicts had to be notified to the Chief Medical Officer at the Home Office (not, notice, to any official of the Ministry of Health).

Under the 1967 Act specialist drug dependency units or clinics were established to handle prescribing. Originally offering injectable heroin on a maintenance basis, they increasingly came

²²⁹ Adrian Barton, *Illicit Drugs: use and control*, Routledge, 2003.

²³⁰ V Berridge, *Opium and the People: opiate use and drug control policy in nineteenth and early twentieth century England*, Free Association Books, 1999, p.269.

²³¹ Set up initially in 1958 by the Department of Health and Social Security at the instigation of the Home Office, to re-examine the Rolleston Committee's decision to allow doctors to prescribe heroin and morphine to drug addicts.

to offer oral methadone on a reducing basis. In general, according to Professor Gerry Stimson, drugs treatment was taken out of the hands of the GP at this point and given, for the most part, to psychiatrists. ‘This “psychiatrization” of the problem fitted well with the growth of psychiatry as a specialism in the 1960s.’²³² Doctors were still the experts on medical problems caused by the use of drugs, but from now on there would be more and more use of the criminal law to achieve, among other things, public health gains.

The Misuse of Drugs Act 1971 and the National Drug Strategy

In 1971 the Misuse of Drugs Act established the approach to drugs and the misuse of drugs that still prevails. The Act introduced a classification system for illegal drugs (only), in a hierarchy that was intended, at least, to be drawn up by reference to the harms, largely medical, that each substance causes. The Act also enshrined in law a clear distinction between the supply and the possession of drugs, and it set up the Advisory Council on the Misuse of Drugs as a source of independent advice on the risk of harmful effects ‘sufficient to constitute a social problem’ that might be caused by the misuse of drugs.²³³ The term ‘controlled drugs’ now replaced ‘dangerous drugs’ in all relevant domestic legislation.

Although much of the 1971 Act was couched in medical language, the 1980s were largely dominated by an enforcement approach in response to a sharp rise in drug-related crime (partly as a result of the restrictions on GPs’ ability to prescribe) and also in response to a very rapid spread in the use of drugs. At one end of the spectrum, there was a marked growth in injecting heroin use. At the other, there emerged a new culture of recreational drug use, with the rise of ‘dance’ drugs – mostly ecstasy and amphetamines – involving a much wider range of people than in the past. The amounts of imported drugs rose steeply, and policy increasingly focused on supply reduction.

At the same time public health concerns over HIV/AIDS and a serious AIDS epidemic among injecting drug users in Scotland obliged policy makers to take seriously the need to reduce the medical harms caused by drugs. That an important role in drugs policy was still claimed for doctors was evidenced by a series of directives from the Department of Health, most notably *Treatment and Rehabilitation* in 1982 and the 1984 *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse* (to be followed in 1991 with *Drug Misuse and Dependence Guidelines on Clinical Management*, updated in 1999). Through these directives the Department of Health exerted pressure

²³² G Stimson and R Lart, ‘The relationship between the state and local practice in the development of national policy on drugs between 1920 and 1990’, in ed. J Strang and M Gossop, *Heroin addiction and the British System*, Vol.1, 2005.

²³³ The composition and role of the Advisory Council on the Misuse of Drugs is discussed in some detail in Chapter 19 below.

on doctors to involve themselves in treating and controlling problematic drug use.

²³⁴ Barton, *op.cit.*

By this time the drugs policy community could be seen as composed of two sometimes competing elements.²³⁴ Supply and dealing were the undisputed territory of the criminal justice system, but where drug use was concerned both law and medicine were laying claim to the same constituency of drug users. The Home Office retained overall control of policy, which was developed within a criminal justice framework; but the medical profession continued to stake its claims to have some input. In the 1980s, in the absence of a comprehensive government drugs strategy, there was little cooperation: the police and customs worked to enforce the law, and doctors treated those users who happened to come to their attention. But the need for collaboration was becoming increasingly obvious. In 1994 a Department of Health report entitled *Across the Divide* called for joint working. The following year the Major government set up the Central Drugs Coordination Unit and a ministerial sub-committee of the Cabinet on the misuse of drugs. They were headed by the Lord President of the Council, thus locating the Central Drugs Coordination Unit in the Privy Council Office.

The Unit was the first body to attempt to coordinate drugs policy under national leadership. Its 1995 strategy document, *Tackling Drugs Together*, defined drug misuse as a major social problem, giving it a prominence that it has never since lost. *Tackling Drugs Together* looked at the drugs problem through the prism of law and order but also acknowledged the importance of reducing demand through treatment, as well as through education and prevention; and it gave explicit recognition to the concept of harm reduction. By creating a broader definition of 'harm', to include harms to the community as well as harms to the individual, it created a policy umbrella under which the law-and-order and medical approaches could combine, even if the resources were still going primarily into the criminal justice system and into efforts at supply reduction.

This combined approach was largely continued by the Blair government in the ten-year drugs strategy that it launched in the 1998 document *Tackling Drugs to Build a Better Britain*. The latter was issued from the Cabinet Office, which now incorporated the Central Drugs Coordination Unit, headed by Britain's first drugs 'czar', former Chief Constable Keith Hellawell. The strategy's most prominent feature was its central focus on drug-related crime and its insistence that health services

and the criminal justice system should combine to combat it. One source has characterized the document as calling for ‘a strange strategic alliance ...between law enforcement and the call for greater access to treatment... Treatment was thus re-conceptualized as an intervention which might lead to reduction of criminal behaviour.’²³⁵

The ground had been prepared for an alliance of this sort by the 1991 Criminal Justice Act which gave courts the power to impose drugs treatment – ‘coerced treatment’ – as part of a sentence. In the absence of clear guidelines to sentencers or information on the availability of treatment, the courts had so far rarely used this power, but the post-1997 government liked it and in the 1998 Crime and Disorder Act introduced Drugs Treatment and Testing Orders (DTTOs) as a further step towards coerced treatment. DTTOs (since replaced by Drug Rehabilitation Requirements that work in a similar way)²³⁶ require a high degree of collaboration between law-enforcement and health agencies. They require police to catch offenders, drug workers to assess their need for treatment and then to provide it, probation officers to ensure compliance with the Order and courts to monitor progress. Nevertheless, they are essentially criminal-justice led. (In a further development of this linkage between treatment and the criminal justice system, the Criminal Justice Interventions Programme, later renamed the Drug Interventions Programme, would be introduced in 2003.)

The government’s criminal justice approach to drugs, as part of its general emphasis on law and order, was made even clearer in June 2001 when, as part of a major reorganization of departmental responsibilities, the Central Drugs Coordination Unit (now known as the Anti-Drugs Coordination Unit) was relocated to the Home Office. The announcement from the Prime Minister’s Office read:

The Prime Minister has made a number of major changes to the machinery of government. Taken together, they will ensure a much sharper focus on the Government's priorities ...The Home Office will be streamlined, losing a number of functions which are not central to its work, to allow it to focus on tackling crime, reform of the criminal justice system and asylum. As part of this, the UK Anti-Drugs Co-ordination Unit will transfer into the Home Office from the Cabinet Office.

A little later, the drugs czar was sidelined, being given only a part-time advisory role, and the Home Office openly assumed the lead in the drugs strategy.²³⁷ A similar move was made in Scotland in 2005 when lead responsibility for drugs policy was

²³⁵ J Strang and M Gossop, ‘The “British System” of drug policy: extraordinary individual freedom, but to what end?’ in ed. J Strang and M Gossop, *Heroin addiction and the British System*, Vol. 2, Routledge, 2005, p.215.

²³⁶ DTTOs are still available in Scotland and there are currently no plans to legislate for their removal. The closest equivalent in Scotland to Drug Rehabilitation Requirements is the attaching of Specific Conditions to probation orders, requiring offenders to attend drug treatment or education programmes.

²³⁷ Keith Hellawell resigned a year later in protest at the downgrading of cannabis to Class C and the relaunching of the drugs strategy, which he described as ‘a re-spinning of the issue to appear as if something has been done’. *Guardian*, 10 July 2002.

transferred from the Health Department to the Justice Department. In Wales, however, responsibility rests with the Minister for Social Justice and Regeneration and in Northern Ireland with the Department of Health, Social Services and Public Safety.

²³⁸ The Directorate was renamed the Crime and Drug Strategy Directorate in 2006.

The evolution of British drugs policy in the twentieth century is a story of constant efforts by successive governments to use the law, the criminal justice system and the medical profession to prevent the use of controlled drugs and limit the harm that they do. Drugs policy has rarely been a subject of party-political contestation. Both Conservative and Labour parties have adopted an approach that treats drug use as first and foremost a matter for the criminal justice system, with prevention and treatment as subsidiary concerns.

Despite this consistent emphasis on crime, however, the international drugs trade has advanced and developed faster than all the efforts at enforcement and it has proved necessary to introduce new legislation at regular intervals, with the governments of both major parties showing themselves ready to add to the growing body of drugs laws. On the face of it, the large volume of new legislation and the frequent reorganizations of the government agencies dealing with drugs suggest that governments themselves have not believed that existing approaches were proving particularly successful.

9 The objectives of policy

Current drugs policy displays many of the tensions of the past. The demands of the criminal justice system compete, in funding terms at least, with the demands of public health and the demands of social care are often overlooked. The principal objective of policy makers, in our view, should be the search for a better equilibrium between these demands, one which acknowledges that they could more profitably seen as complementary.

Between 2001 and 2006 the National Drug Strategy was taken forward in England by the Drug Strategy Directorate in the Home Office.²³⁸ The most recent version of the strategy is the *Updated Drug Strategy 2002*. Its overall objective is ‘reducing the harm that drugs cause to society – communities, individuals and their families’. This objective is anchored in a philosophy of prohibition. The opening paragraph of the summary of the Strategy states: ‘We have no intention of legalising any illicit drug. All controlled drugs are dangerous and nobody should take them.’

Scotland, Wales and Northern Ireland are bound by the Misuse of Drugs Act 1971, but within that common legal framework most aspects of drugs policy – notably health and criminal justice – are devolved to their respective administrations. Each has put in place a drug or substance misuse strategy tailored to the particular circumstances of the country. The Scottish and Welsh strategies place particular emphasis on the need for joint working: *Tackling Drugs in Scotland: Action in Partnership* and *Tackling Substance Misuse in Wales: A Partnership Approach*. Northern Ireland had a five-year strategy along much the same lines – *Drugs Strategy for Northern Ireland* – which ran from 1999 to 2004. It has recently been updated in the *New Strategic Direction for Alcohol and Drugs 2006-2011*.

²³⁹ The Drug Harm Index is a matrix developed for the Home Office within which the harms that individuals and society suffer due to drug-related crime, the health impacts arising from drug abuse, and the impact of drug use and dealing on communities are calculated.

The drug strategy's main objectives

The four strands of the English drug strategy as currently set out on the Home Office's 'Tackling Drugs, Changing Lives' website are:

- reducing the supply of illegal drugs;
- preventing young people from becoming drug misusers;
- reducing drug-related crime; and
- reducing the use of drugs through increased participation in treatment programmes.

These strands coincide broadly with the three objectives set out in the Public Service Agreement addressed specifically towards 'Action on Illegal Drugs' in 2000. The first target for 'action on illegal drugs' was to *reduce the harm* caused by illegal drugs (as measured by the Drug Harm Index encompassing measures of the availability of Class A drugs and drug related crime) including substantially increasing the number of drug misusing offenders entering treatment through the criminal justice system.²³⁹ The second target was to *increase the participation* of problem drug users in drug treatment programmes by 100 per cent by 2008 and increase year on year the proportion of users successfully sustaining or completing treatment programmes. The third target was to *reduce the use of* Class A drugs and the frequent use of any illicit drug among all young people under the age of 25, especially the most vulnerable young people.

Drugs and the Public Service Agreements

Public Service Agreements (PSAs) were introduced in 1998 as part of the Comprehensive Spending Review process and will be reviewed as part of the 2007 Comprehensive Spending Review. They represent public commitments by government departments to the Treasury to meet certain targets in the delivery of public services in return for 'additional investment'. Each Agreement

specifies an overall aim, a set of objectives and a set of targets and sets out explicitly which minister is accountable for the delivery of the targets. The 2000 Comprehensive Spending Review set out Public Service Agreements for every government department and added some extra agreements to address ‘cross-cutting issues’ of which illegal drugs was one.

The objectives of the English drug strategy have until now been generally reflected in the strategies of the devolved administrations and have remained broadly the same since the strategy was first formulated in 1998. There have, however, been some interesting changes in emphasis. In the original version of the English strategy, for example, there was a strand related specifically to minimizing the impact of drug misuse on communities. That has now disappeared.²⁴⁰ The *New Strategic Direction* set out by Northern Ireland also shows signs of rather different policy priorities, (to be discussed below, for example at pp.118 and 188.)

The strengths of current policy

Britain’s drug strategy over the past dozen years – since the Major government’s 1995 document *Tackling Drugs Together* – is remarkable for having actually been a coordinated effort deserving of the name ‘strategy’. Mike Trace, at one stage deputy drugs czar in the Blair government and one of the Labour strategy’s architects, explains:

Until the mid-1990s nobody had made a serious attempt to bring together all the complex strands of how drugs affect a western society and bring together all the issues of how you link up your education work to your treatment work, how you link up your social inclusion policy to your drugs policy, how you link the supply-side efforts with the demand-side efforts... The UK drug strategy of 1998 was the most sophisticated attempt to bring all those strands together, identify what the overarching objectives were and bring all of that morass of activities together into a government programme... My claims for its value are mainly in terms of giving people a structure by which to consider some very complex issues rather than its outcome success.²⁴¹

The drug strategy has achieved a considerable amount. It has embodied an important distinction between different types of drug use by explicitly focusing on problematic use of Class A drugs, (even if, as we shall see, the law itself does not adequately distinguish the relative harmfulness of drugs within the present classification). Over the years the strategy has also made growing, if discreet, acknowledgement of the importance of minimizing harm from drug use as well as preventing or ending it. It has

²⁴⁰ The four original aims as set out in *Tackling Drugs to Build a Better Britain* (1998) were:

- ‘to help young people resist drug misuse in order to achieve their full potential in society;
- to protect our communities from drug-related anti-social and criminal behaviour;
- to enable people with drug problems to overcome them and live healthy and crime-free lives;
- to stifle the availability of illegal drugs on our streets.’

²⁴¹ Evidence to the House of Commons Home Affairs Select Committee, 11 December 2001.

introduced drugs education into the school curriculum. Since 2001, it has funnelled unprecedented amounts of money into drugs services. The drugs treatment workforce has been almost doubled and the number of drug users in treatment has increased – by more than 50 per cent, according to the Home Office – with shorter waiting times for the remainder. Drugs have become a much higher governmental priority.

Raising the profile of drugs issues has had the invaluable effects of seizing the attention of the public, focusing the efforts of policy makers and making it possible in consequence to channel funding into the area of drugs treatment. However, isolating a single ‘drugs strategy’ may inadvertently have helped to foster the impression that there is a single ‘drugs problem’, and this is misleading.

The drug strategy’s weaknesses

Problematic drug use is a health problem, because problematic users do serious damage to their own health. Drug use that is currently non-problematic can become so. The association between drug use and acquisitive crime inevitably means that drugs constitute a criminal justice problem. Not least, problematic drug use points to problems in the fields of education, housing, employment and social care. A strategy that confronts all these various problems as though they constituted a single problem – and that is based on a wholly unrealistic rhetoric – is bound to be flawed.

More specifically, the current strategy suffers from defects of presentation, balance and priorities. Four weaknesses stand out. First, the strategy’s objectives are not clearly or candidly stated. The logic of the harms-prevention strand of its approach conflicts with the logic of a largely prohibitionist rhetoric.

Second, the strategy gives undue emphasis to the relationship of drug use to crime at the expense of the relationship of drug use to health. The strategy is cast first and foremost as a campaign against crime. It acknowledges the health damage and the misery endured by people who have problems with drugs but, both implicitly and explicitly, it treats these as being of less importance than the damage done to others by drug-related crimes and other anti-social behaviour. The strategy identifies its objective as ‘reducing the harm that drugs cause’, but its view of harm is a hierarchical one, with the harms caused by crime coming at the top. The overall ethos of the current drugs strategy is one of law enforcement and crime prevention rather than one concerned at least as much with education,

public health, the health of individuals, social support and social cohesion.

The tendency to accord priority to the imperatives of the criminal justice system is most obvious in the Drug Interventions Programme. (The Drug Interventions Programme – DIP – is discussed at greater length at pp.148–157 below.) The primary aim of the programme is to reduce drug-related crime by coercing into treatment Class A drug users who have committed offences like theft and burglary. It has the effect of securing treatment for offenders far more quickly than for drug users who have committed no crime other than possessing the drug itself. To some extent, the health strand of drugs policy has been hijacked by the criminal justice strand, with the criminal justice system used to force an entry into the treatment system.

Third, the prioritizing of the criminal justice strand of the strategy and the positioning of the Home Office as the agency leading the drugs strategy have created a climate in which it is almost impossible to focus, in addition, on reducing other drug-related harms without looking soft and unconcerned with crime. The constant association of drugs with crime creates a stigma that clings to all drug users, even those who have not committed other crimes, and it undercuts efforts to minimise the harms that problematic users do to themselves. It continues the demonization of individual drugs and the individual drug user rather than projecting drug use as a problem to be solved in communities and by communities.

Fourth, the drugs strategy does not include alcohol or tobacco. As we have already begun to argue, this undermines its credibility and its effectiveness.

To summarise, current drugs policy lacks integrity in both senses of the word: honesty and cohesion. There is a gap between the prohibitionist rhetoric produced for public consumption – ‘All controlled drugs are dangerous and no one should take them’ – and, within the detail of the strategy, indications of a subtler and more realistic approach, aimed at reducing harm. It is as if the government is trying to do good by stealth but, precisely because it feels it has to do good by stealth, it is not doing as much good as it could. Unable to acknowledge all of its objectives, it is condemned to pursue policies that certainly appear, and sometimes are, confused and contradictory.

Drugs policy needs internal consistency, with equal weight being given to health imperatives and criminal justice imperatives and

to the needs of drug-using offenders and non-offenders alike. Drugs policy must have some distinct identity of its own, with the problems related specifically to drugs recognized for what they are. But at the same time drugs policy needs to be part of a greater whole. Many of the worst problems surrounding drug use grow out of, and contribute to, other social problems – deprivation, family breakdown, unemployment, educational failure and social exclusion. To such social problems, the current strategy, with its emphasis on the criminal justice system, offers neither quick fixes nor slow ones.

²⁴² Details here are drawn largely from Serious Organised Crime Agency, *The United Kingdom Threat Assessment of Serious Organised Crime 2006/7*, 2006.

10 Reducing the supply of drugs

Previous chapters have focused on drugs policy as a whole, its evolution and its overall aims. We turn now to consider its individual objectives. How successful is each strand of policy? What are the weaknesses in its implementation? And how might it be improved?

In this chapter we examine the issue of reducing the availability of illegal drugs: the sources of illegal drugs, the nature of our efforts to stem the flow and the reasons why these efforts have been largely unsuccessful. We go on to suggest or endorse changes of focus in the campaign against drugs supply that might produce better results.

The drugs supplied to Britain²⁴²

Heroin

The heroin supplied to Britain is produced almost entirely in Afghanistan. Some comes by air, but the main trafficking route is overland via Iran to Turkey where much of Europe's supply is processed. The consignments then come through the Balkans overland to Europe. Heroin very often passes through the Netherlands, where many of the principal brokers are concentrated: in 2005 almost half the heroin seized in or en route to the UK had come through the Netherlands, though some also comes through Belgium and France. Most enters Britain through ports in the South-East, hidden in legitimate loads or in special compartments in lorries.

Turkish traffickers continue to dominate the supply of heroin to the UK, both within the UK itself and further upstream, selling heroin in bulk to other criminals. However, various other ethnic groups are also heavily involved. Pakistani traffickers use direct trade and transport links with Britain to import heroin from Pakistan. Groups from various parts of Eastern Europe are also involved, as are a significant number of white British

criminals. These British gangs appear increasingly willing to bypass the London-based ethnic Turkish traffickers who have been their traditional suppliers. They establish direct links with warehousing operations in transit countries like France and the Netherlands and import directly from there.

Cocaine

Cocaine comes mostly from Colombia, with lesser amounts emanating from Peru and Bolivia. It often goes first by sea in bulk shipments to the Caribbean or West Africa (mostly Nigeria or Ghana) and then on to Europe by sea or using air couriers. The principal European destinations are Spain, the Netherlands (where many key brokers live) or, increasingly, Eastern Europe. Cocaine may reach Britain from Europe by air (as cargo or carried by couriers) or by road in container lorries off cross-channel ferries. A small proportion comes straight from South America, carried by air couriers or sent by fast parcels, in 'little and often' consignments designed to spread the risk of detection. Tourists are believed to be an increasingly significant source of supply.

All the indications are that Colombian traffickers continue to dominate cocaine supply to Europe, with representatives in most of the countries through which the consignments must pass. West Indian groups based in the Caribbean are also known to traffic 'little and often' amounts of cocaine powder by air courier from various Caribbean islands either direct to Britain or via mainland Europe. The UK cocaine market is supplied by criminals of various different ethnicities – Colombian, Spanish, Dutch, British and others – working together or separately to move cocaine in bulk through Europe to the UK. Once in Britain, much powder cocaine is channelled into the crack cocaine market. West Indian traffickers, many British-born, have a conspicuous role in this trade.

Cannabis

Cannabis resin comes mostly from Morocco by way of the Netherlands or from the Netherlands itself, as does a proportion of cannabis herb. An increasing amount of cannabis herb, believed to be around 60 per cent of the total, is now grown in Britain. There is significant involvement by Vietnamese gangs in the bulk production of cannabis as opposed to small-scale cultivation for personal use.

The UK synthetic drugs market is dominated by Dutch and Belgian criminals who produce the drugs and by white British traffickers based in Belgium, the Netherlands and Britain who arrange transport and distribution.

Ecstasy

Ecstasy consumed in Britain is almost all manufactured in the Netherlands or Belgium, relying on precursor chemicals made in China and obtained through Chinese criminal networks. (The drug is sometimes made into tablets here, but the chemicals are more commonly manufactured abroad.) Ecstasy is most usually brought in through the ports of Harwich, Felixstowe and Dover.

²⁴³ P Bean, *Drugs and Crime*, Willan, 2002.

²⁴⁴ Dorn and Murji, *op.cit.*

Amphetamines

Amphetamines too come largely from the Netherlands and Belgium, though these countries may be acting as an entrepôt for Poland and other Eastern European countries. Some amphetamines – no more than 20 per cent of the total supply – are produced in Britain, but exact figures are lacking.

The supply network

There are, very roughly, three levels of drugs supply: importers, wholesalers (who can be further sub-divided into different levels) and dealers, who also operate in tiers. However, people in the drugs trade move freely within the system: importers may act as their own initial wholesalers, big dealers may manage their own imports, street dealers may well be users.

Importers

Most observers agree that there is no overarching organization managing drugs trafficking into or within the UK. There may be several thousand people within Britain who are able to move significant quantities of drugs, with more than one hundred gangs in London alone operating as reasonably high-level dealers.²⁴³ These are best understood as networks or partnerships of independent traders or brokers. ‘There is not so much a national drugs market as a series of loosely interlinked local and regional markets.’²⁴⁴

Some importers are British, mostly known criminals, buying directly from producers or large-scale traffickers abroad. A larger proportion of importers would seem to be foreign nationals or British nationals originating from producing countries or transit countries like Pakistan and having close connections there. Much of the heroin supplied in the UK is distributed through the Turkish community in North London while cocaine goes through Colombians based in London. West African groups based in the South East appear to play an increasingly important role in the supply of cocaine and crack.

Wholesalers

The gap between the importation of drugs and their sale on the street is filled by a complicated web of connections, sometimes

referred to as the ‘middle market’, made up of wholesalers, brokers and larger dealers dealing on different scales. ‘Middle market brokers’ is the label given by the Home Office in the *Updated Drug Strategy 2002* to those dealing in quantities of drugs between 1 and 5 kilos.

Wholesalers tend to be older than street-level dealers and to have established criminal records. Many are ‘commodity’ suppliers, prepared to provide any profitable illegal commodity, including illegally smuggled people and guns.²⁴⁵ Some deal in all the main illicit substances; others specialise in the ‘dance drugs’ (amphetamine, ecstasy and occasionally cocaine). An increasing number have taken to supplying ‘speedballs’, mixed packages of heroin and crack cocaine. (Heroin users are targeted as potential customers for crack; the intense cravings produced by crack lead to an increased demand for heroin as well.)

Although wholesalers operate in most areas of Britain, a number of cities are significant centres for drug distribution. All types of Class A drugs are distributed from London, Liverpool and Birmingham to other areas of the UK. However, other smaller cities and towns are becoming more prominent and the overall picture is increasingly complex and diverse. Armed drugs gangs are expanding their operations from cities into provincial towns as dealers desert urban districts where markets have reached saturation point. Towns like Nuneaton, Rugby and Bolton have become targets for gangs from Birmingham and Manchester, boosting gun crime and turf wars there. Drug dealers from London are moving down the Thames Corridor into the Home Counties.²⁴⁶ Portsmouth was claimed to have been targeted by London dealers in 2005 with half-price heroin aimed at attracting a new customer base.²⁴⁷ Bristol is a regional hub for the importation and distribution of cocaine, ecstasy and heroin. Nottingham and Leeds are centres for crack. Wolverhampton has been associated with the crack trade in Scotland since the 1990s, when dealers from the West Midlands began to target Aberdeen and the neighbouring fishing towns of Peterhead and Fraserburgh on the ground that they were a safer and less violent market in which to operate. Police intelligence also suggests that prostitutes from Wolverhampton have followed the crack trade and established themselves in Aberdeen, where they boost both trades.²⁴⁸

Dealers

Wholesalers and larger dealers tend to remain well concealed, passing on most of the burden of risk involved in distribution and sales to smaller dealers further down the supply chain. Some

²⁴⁵ Geoffrey Pearson and Dick Hobbs, ‘Middle market drug distribution’, Home Office Research Study 227, 2001.

²⁴⁶ *Telegraph*, 11 June 2006.

²⁴⁷ BBC website, ‘Portsmouth reels from cut-price heroin’, 6 September 2005.

²⁴⁸ Scottish Advisory Committee on Drug Misuse, *Psychostimulant Working Group Report*, 2002. A recent report from the Children 1st Fraserburgh Families project suggests that the influx of crack cocaine has resulted in an increase in the number of pregnancies among substance misusing women, as crack commonly encourages risky sexual behaviour. *Communitycare.co.uk* website, 1 November 2006.

of these smaller dealers, who might be described as retailers, have a degree of protection in the form of fixed bases – legitimate businesses, houses or flats – from which they operate with the help of lookouts and couriers. This more discreet setting might suit, for example, many middle-class consumers of cocaine and cannabis. Still more vulnerable, as the only suppliers who are usually visible, are street-level dealers selling direct to the consumer, and even they may pass on the risk by using teams of runners, young people or trusted users, actually to hand over the drugs, distancing themselves from both the drugs and the customers.

In general, writes Al Morgan for Drugscope, drug dealing at this level is often discreet, dispersed and flexible:

The image of the neighbourhood drug dealer as a man with a hood and dark glasses hanging around outside the school gates is as outdated as that of soccer jobs with shaved heads and bover boots... [and] the traditional user-dealer working from home has largely been usurped by the 'deals-on-wheels or 'dial-a-deal' delivery service... This method is utilized by middle tier dealers often purchasing multi kilogram deals of heroin and cocaine, which is then simply converted into crack to maximise profits. The drugs are then retailed on the street in street-sized deals, usually £10 deals that provide maximum profit margins. It is not unusual for an average daily 'round' to generate in excess of £2000.²⁴⁹

One source divides street-level dealers broadly into appointment dealers, street dealers, network suppliers, user-sellers and social suppliers, depending on the ways in which they work and the people to whom they sell.²⁵⁰ Those operating strictly for profit, and not using drugs themselves, are known as 'bread-heads'.

Drug markets may be either 'closed' or 'open'. In closed markets, dealers sell only to people known to them or referred by other customers. Meetings are usually arranged by telephone. In open markets, operating on the street or in pubs, clubs, cafes or crack houses, dealers will sell to anyone. These open markets are the most damaging to a neighbourhood in terms of acquisitive crime, deal-related violence, a drug-related sex market and a general atmosphere of threat and squalor.

What is being done under current policy to reduce the supply of drugs?

Supply reduction agencies

Besides the police and customs services, various agencies are involved in trying to reduce the supply of drugs to Britain. At the strategic level, the task is overseen by the government's

²⁴⁹ 'Waiting for the man', *Druglink*, Jan/Feb 2005.

²⁵⁰ R Lewis, 'Flexible hierarchies and dynamic disorder – the trading and distribution of illicit heroin in Britain and Europe 1970-1990', in ed. J Strang and M Gossop, *Heroin Addiction and Drug Policy: The British System*, Oxford University Press, 1994.

Concerted Inter-agency Drug Action group (CIDA). Set up in 1999 to develop and coordinate activity to reduce the supply of Class A drugs to the UK, CIDA originally comprised all the agencies responsible for anti-drugs activity from the point of production to local supply: the National Criminal Intelligence Service, security and intelligence agencies, Home Office, Cabinet Office, Metropolitan Police Service, National Crime Squad, Scottish Drug Enforcement Agency, Association of Chief Police Officers, HM Customs and Excise, Foreign Office and Ministry of Defence.

²⁵¹ HM Customs and Excise, *Annual Report 2004*: 'HM Customs and Excise is ... the lead agency in support of the Financial Secretary's position as Minister accountable for the Availability leg of the strategy.'

Until 2006 CIDA was chaired by the Customs service, which regarded itself as being at the centre of delivering the supply reduction strategy and presumably accounted for the lion's share of the budget devoted to 'import investigation'.²⁵¹ About 45 per cent of the Customs department's entire law enforcement effort was devoted to detection, investigation and intelligence operations against Class A drugs. Many of these functions have now been taken over by the new Serious Organised Crime Agency (SOCA), whose Chief Executive has also assumed the chairmanship of CIDA.

The Serious Organised Crime Agency was formed in 2006 from the amalgamation of the National Crime Squad (NCS), National Criminal Intelligence Service (NCIS) and the part of the Immigration Service that tackles organized immigration crime, along with those parts of Customs and Excise that were dealing with drug trafficking and associated criminal finance. SOCA's objectives are to build understanding of serious organized crime and the most effective ways of combating it; to investigate and disrupt organized crime and support the other agencies involved in combating it; and to promote the seizure of criminal assets. Its operational efforts are being divided between combating drug trafficking, people trafficking, fraud and other organized crime, with by far the greatest proportion of its time – 40 per cent – to be spent fighting the trafficking of drugs, primarily those in Class A.

In Scotland, the Scottish Drug Enforcement Agency was established in 2000 under Section 36(1) of the Police (Scotland) Act 1967. The Director of the Agency is accountable to Scottish Ministers for financial resources. Scottish Ministers are answerable to the Scottish Parliament for these resources, and they are also responsible for monitoring the Agency's performance. The SDEA took on the new title of Scottish Crime and Drug Enforcement Agency in 2006, under the Police, Public Order and Criminal Justice (Scotland) Act 2006. There is a strong relationship between

the SCDEA and SOCA, designed to maximize operational effectiveness in responses to serious organized crime.²⁵²

In addition, the Assets Recovery Agency was set up in 2003 as a specialist body to coordinate the seizure of criminal assets by a range of organizations across the UK, including SOCA.²⁵³ Drug trafficking is one of the major sources of funding for organized crime and accounts for a significant proportion of criminal assets. The Assets Recovery Agency was established under the Proceeds of Crime Act 2002, which gave law enforcement agencies powers to confiscate the proceeds of crime and additionally created scope for civil actions to recover assets where criminal proceedings were not possible (i.e. where evidence was not sufficient for prosecution).²⁵⁴ The Agency has consisted of teams of financial investigators and lawyers whose job is both to recover assets themselves and to promote the use of financial investigation as an integral part of criminal investigation by other bodies.

Supply reduction tactics

Some supply reduction efforts are indirect, aimed at the sources of drug supply overseas. The government has committed £37 million, for example, to reducing heroin supplies to Britain by supporting the implementation of the Afghan government's drugs control strategy. Part of the rationale for British military intervention in the Helmand province of southern Afghanistan is to create the conditions in which Afghan counter-narcotics forces can eradicate poppy cultivation. Britain is training, mentoring and equipping these forces and has contributed £1.5 million to the Afghan Law and Order Trust Fund which supports salaries and purchases of equipment for the counter-narcotics police. The Department for International Development (DFID) is also supporting the development of alternative crops and alternative livelihoods as a means of encouraging small farmers to move out of opium production.²⁵⁵

Since 2001 the Foreign and Commonwealth Office has funded training for counter-narcotics agencies in Turkey, Iran, Pakistan, the Balkans and Jamaica. Under Operation Trident the British government signed a joint agreement with the Jamaican government in 2002 to intercept air passengers attempting to smuggle cocaine concealed in their bodies. Scanning equipment and better intelligence-gathering in Jamaica has dramatically reduced the number of Jamaican couriers detected at British airports. A similar agreement – Operation Westbridge – was negotiated with Ghana in October 2006.

²⁵² The SDEA was originally established on the basis of a collaborative agreement of the eight Scottish Chief Constables and Conveners of the Police Authorities and Joint Police Boards. The Police, Public Order and Criminal Justice (Scotland) Act 2006 places the newly-titled SCDEA on a clear statutory footing. From April 2007 the SCDEA will have the facility to recruit police officers directly. In addition to working to reduce the supply of illegal drugs, Enforcement Agency staff liaise with local DATs and the Scottish Executive and coordinate Choices for Life, an annual drug prevention and education event for children in the last year of primary school.

²⁵³ Though the Agency only had a limited role in Scotland.

²⁵⁴ The Assets Recovery Agency works to recover assets which are, or represent, property obtained through crime in England, Wales and Northern Ireland. This is done through the High Court. In Scotland, this power is exercised by the Civil Recovery Unit of the Crown Office.

²⁵⁵ Britain is also supporting the development of crops in Bolivia as alternatives to coca leaves. Lord Triesman, Parliamentary Answer, 10 July 2006.

At home, the job of tackling international traffickers and major importers of drugs has largely passed to the Serious Organised Crime Agency, leaving regional police forces to focus more closely on domestic drugs crime at the regional level – crime that may still be organized but will not necessarily involve international networks.

²⁵⁶ P Mason, 'Innovate to intercept: dealing with dealers', *Drugs and Alcohol Today*, 5/2, August 2005.

The 'middle market' is an area where until recently there was something of a hiatus in the action against drug supply. The attention of national agencies like the National Crime Squad had been focused on major importers while local police services concentrated primarily on street dealers. In the last five years, various programmes have been aimed at bridging this gap. Regional task forces have been set up to work across the borders of individual police services in the Midlands, Merseyside and South Wales in order to target wholesalers and middle-level dealers who may themselves be working across borders. Most recently, the Metropolitan Police has established its Middle Market Drug Project, a 70-strong rapid response unit bringing police and customs officers together to operate as a team under shared working conditions, without ranks or titles and with a deliberately entrepreneurial culture.²⁵⁶ The Project operates three shifts working round the clock and at weekends and has its own financial and administrative support, its own intelligence system and its own surveillance unit.

Action against street-level dealers may take many forms. At its most intensive it may involve street sweeping, concentrating a massive police presence on a specific area for a fixed period, possibly round the clock, scooping all suspects into the net with a wide use of stop-and-search and the issue of search warrants for suspected premises. In Operation Crackdown in January 2005, a three-month operation targeting Class A drug markets at the local level, 32 police forces worked together to close crack houses, disrupt drug markets, seize illegal guns and arrest dealers. They closed 170 crack houses, seized over 200 kilos of heroin and cocaine and over 86,000 ecstasy tablets, charged 1,471 dealers and seized over 400 guns and £3.2 million in cash assets. In September 2006 the Association of Chief Police Officers initiated a national clamp-down on cannabis farms, seizing crops and breaking supply chains of cultivators-cum-retailers across the country.

Smaller individual 'crackdowns' may be focused more closely on specific drugs, specific streets or specific features of drugs markets such as crack houses, clubs, pubs or raves. Crack houses may be kept under surveillance and closed down by raids and evictions. These particular activities have been made easier by the Anti-

Social Behaviour Act 2003. In Operation Cape, staged in Leeds in 2003, 65 ASBOs were issued simultaneously to clear a notorious housing estate of drug dealers. Drug markets may be disrupted by first disrupting sex markets, enforcing criminal controls and anti-social behaviour orders on sex workers who both supply drugs to punters and increase the demand for drugs themselves. Sometimes police may aim simply to disturb street dealers and markets, interrupting daily trading with street patrols, stop and search, closed circuit television and test purchases by undercover officers, making markets less secure for those operating within them and at the same time deterring the novice and casual user. The current ‘Street Level Up’ initiative, operating in selected areas across the country, seeks to link all of these activities by tracing the whole length of the drug supply chain in an area and then attacking it in a co-ordinated way, building up the intelligence picture from street dealer to retailer to wholesaler and importer and beyond.

²⁵⁷ Announcement by Drugs Minister Vernon Coaker; Home Office press release, 14 June 2006.

Raids, crackdowns, stop-and-search operations and ASBOs are supplemented with assets recovery proceedings. Asset seizure has not been the sole preserve of the Assets Recovery Agency. Under a cross-government initiative entitled Operation Payback, law enforcement agencies and prosecution authorities such as individual police services, Customs, the Crown Prosecution Service and the Courts Service have all been empowered to trace assets and initiate proceedings to recover them under the criminal law. Confiscation is linked directly to a criminal prosecution, is dealt with on conviction and assesses both the benefit derived from the criminal activity and the assets available to the offender from any source, which need not actually relate to the criminal activity. Assets recovery is in fact becoming an integral part of criminal investigation. In the Middle Market Drugs Project, for example, each section has its own financial unit and each operation has a parallel financial investigation.

The success of assets recovery has been greatly aided by an incentive scheme under which the agency bringing a case can retain a proportion of the proceeds if the prosecution succeeds. In 2005/6 some £96 million was seized through the assets recovery process, of which £26 million was distributed to police forces alone on the basis of their performance in pursuing the proceeds of crime. (Forces in West Yorkshire, Greater Manchester, Lancashire and South Wales each got over a million pounds, while the Metropolitan Police retained almost £8 million.)²⁵⁷

The procedure has been for cases to be brought to the Assets Recovery Agency by enforcement agencies where criminal

prosecutions have failed but where there is evidence of criminal conduct that is supported to the civil standard of proof, i.e. on the balance of probabilities. The Agency has then pursued civil recovery of the assets and has also been empowered to conduct full tax investigations of both individuals and companies.

²⁵⁸ Drugscope website, 'Drugsearch'.

²⁵⁹ E Bramley-Harker, *Sizing the market for illegal drugs*, Home Office RDS Occasional Paper 74, 2001.

Why efforts to reduce the supply of drugs have not succeeded

It is hard to assess the impact of strategies for limiting the supply of illegal drugs because most of the necessary indicators and measures are missing: precisely how big the illegal drugs market is, what it is worth or how it behaves.

The Office for National Statistics has tried to estimate the value of the British drugs market, using drugs seizures as a guide.²⁵⁸ Even making various assumptions about the size of the market – the number of users, the quantity of drugs consumed and their purity, and the proportion of drugs being seized at import – the estimate cannot be tied down any more closely than somewhere between £3.9 billion and £8.5 billion. The latest Home Office estimate of £6.6 billion is no more recent than for 1998.²⁵⁹

There is much debate and a lack of conclusive evidence as to whether drugs markets are 'rational' and behave like other markets. It is not clear, for example, how strongly drug users are influenced in their behaviour by the price of what they want. Nor is it clear exactly what determines prices. A wide range of factors may have an effect. Changing social attitudes, bad weather or political instability in producer countries might inflate prices by reducing supply and increasing demand. Declining production costs (due to high-yielding crops), declining labour costs (due to using juvenile dealers), declining 'insurance' payments (if risks were perceived to diminish) might all lower prices. A major drugs seizure might inflict a financial loss on a trafficking operation but, given the enormous scale of their profits, the traffickers may simply absorb the costs without passing them on to the consumer. For all these reasons, it is not possible simply to argue either that tougher enforcement will lead to higher prices or that lower prices signify a failure of enforcement policies.

If you are unable accurately to measure the overall size of the market, the amounts you have seized in relation to that market, the effect that seizures have on prices within the market or the costs of your own operations, it is very hard for you to gauge the impact that your programme is having. However, the day-to-day observations of the police and customs officers tasked with reducing drug supply are probably as accurate a guide as any

other, and their reflections tend to suggest that, if the ultimate objective is to raise drug prices and therefore reduce consumption while at the same time striving to wipe out dealing, efforts to reduce supply have been largely unsuccessful.

These efforts have certainly not succeeded in raising prices.²⁶⁰ The average street price of heroin has fallen consistently over the last five years, from £70 per gram in December 2000 to £54 in December 2005 and, according to the most recent Drugscope drug prices survey, to around £40–45 in September 2006. The average street price of cocaine powder was £65 per gram in 2000, £49 in December 2005 and, according to Drugscope, around £43 in September 2006. A ministerial written answer in the House of Commons on 9 September 2005 acknowledged that the street prices of drugs in general have fallen consistently over the last ten years.

According to the 2003 Strategy Unit report, commissioned by the Prime Minister to review the cost-effectiveness of drugs policy, attempts at supply reduction through seizures and arrests are never likely to be permanently effective, given the scale of the problem and the pressure of market forces. Drugs seizures have tended to be isolated actions, not well coordinated between agencies or geographical regions, and the amounts seized represent only a small fraction of the total supply. The Serious Organised Crime Agency itself concludes in its UK Threat Assessment for 2006 that ‘despite many tonnes of Class A drugs being prevented from reaching the UK, arrests and seizures have achieved short-term disruptions rather than a sustained reduction in the size of the UK drugs market’.²⁶¹

The Strategy Unit report argued that it would be necessary to seize some two-thirds of the drugs being imported into Britain in order to affect prices, and a United Nations study suggests a figure nearer to 75 per cent.²⁶² The current seizure rate is much lower than either of those figures (the Strategy Unit report estimated 20 per cent in 2003), and prices remain unaffected. Even if prices did go up, the Strategy Unit pointed out that consumption would not necessarily go down and the effect might be instead a corresponding rise in crime to fund the increasing cost of drug use. It is also suggested that higher prices might push people towards stronger drugs, in search of a better return on their money. In other words, a reduction in consumption would not automatically mean a reduction in drug-related harm.

The Strategy Unit considered that police work against drug dealing within Britain represents better value for money than

²⁶⁰ One exception might be the national clamp-down on cannabis farms in September 2006 which, in the short term at least, seems to have had the effect of slashing supply and doubling the costs of cannabis on the streets in many British cities. ‘Pot farm raids hit supply’, *Druglink*, Nov/Dec 2006.

²⁶¹ SOCA, *The United Kingdom Threat Assessment of Serious Organised Crime 2006/7*, 2006.

²⁶² Commission on Narcotic Drugs, ‘Illicit Drug Traffic and Supply’, including Reports from the Subsidiary Bodies, Report of the Secretariat, United Nations Economic and Social Council, 1 March 1996 (E/CN.7/1996/9).

efforts at interdiction abroad. However, even well-targeted police investigations and arrests of middle- and lower-level dealers may only hope to be effective in the short term. The London borough of Camden, embracing King's Cross, Bloomsbury and the West End, has one of the most serious drug problems in the country. In 1993 Operation Welwyn was launched by police and health agencies as an attack on prostitution and drug dealing in King's Cross. In the late 1990s Project Lilac was set up as a partnership between local authorities and police to tackle a very active open drug market in the West End covering parts of two authorities and four police divisions. However, in 2001 Camden Council reported to the House of Commons Home Affairs Select Committee:

Project Lilac has allowed us to focus £2 million of Targeted Policing Initiative funding on an area of approximately two square miles in the West End to pilot methods for permanently disrupting drug markets. Highly developed partnership working across agencies and across boroughs... has produced a greater understanding of the components of the drug market, some impact on the quality of life issues for West End communities, an impressive number of judicial disposals for drug supply crimes and no discernible impact on the market. Similarly Operation Welwyn in King's Cross, which has run for eight years, has found that test-purchase operations, which are both resource-intensive and dangerous, followed by mass arrest phases, have made no discernible difference to drug supply in the King's Cross area.²⁶³

In some areas, dealing drugs may be the only job opportunity open to some people, and it is likely to be the most profitable available to a great many more. Dealers are often portrayed in the media as outsiders preying on communities, but social research has found that they may well be an integral part of communities. One recent study of four contrasted drug-dealing neighbourhoods in England found that many sellers came from their local communities and had family and friends who had benefited from the money and cheap stolen goods associated with their drug dealing:

Some drug markets are closely linked with both the legal and illegal economies of their neighbourhoods. In the sites we studied we found that drug dealing was sometimes run by cohesive groups with local family ties and extensive local networks of friends.²⁶⁴

In areas such as this one, dealers are likely to be protected from the police by their communities. At the lower level, dealers themselves may well cooperate and share information about police tactics.²⁶⁵ Even where this is not the case, the quick profits to be made from low-level dealing will guarantee that when one

²⁶³ Memorandum 39 submitted by the London Borough of Camden to the House of Commons Home Affairs Select Committee, September 2001.

²⁶⁴ T May et al, *Understanding drug selling in communities: insider or outsider trading?*, Joseph Rowntree Foundation, 2005.

²⁶⁵ K Broadhurst et al, 'Research into the views and perceptions of drug dealers', PRCI, 2005

dealer is arrested his place will be filled almost at once by another and that when one crack house is closed the operation will open again nearby.

²⁶⁶ Steve Sampson, 'Remote control', *Druglink*, Jan–Feb 2005.

²⁶⁷ C Rydell & S Everingham, *Controlling cocaine: supply versus demand*, RAND, 1994.

In the wake of the drugs-related shooting of Charlene Ellis and Letitia Shakespeare in Aston, Birmingham on New Year's Day 2003, Operation Trap was put in place – a huge operation involving a £3million war chest, a gun amnesty, a £1,000 reward for information, patrols, roadblocks, armed vehicle checks and helicopter surveillance, armed response units, undercover spotters, 44 closed circuit television cameras, street posters and dawn raids. One hundred and fifty arrests were made with an estimated likelihood of around 50 prosecutions. Crime has fallen in the area, but police sources consider it likely that a large number of the dealers have simply moved indoors, to deal from their homes, or next door, to high crime areas outside the city.²⁶⁶

In this situation, tackling drugs solely by attempting to reduce their availability is very unlikely to be cost-effective. An old but much-quoted American study calculated in 1994 the relative cost-effectiveness of different types of effort.²⁶⁷ In terms of savings in the societal cost of crime and lost productivity, these were the returns on a dollar spent in the following ways:

Coca plant eradication in South America	17¢
Cocaine interdiction between South and North America	32¢
Domestic law enforcement (customs and police)	52¢
Treatment for dependence	\$7.48

Before the Strategy Unit had even reported, the Home Office was already expressing doubts about the financial wisdom of placing so much emphasis on supply reduction. In his evidence to the House of Commons Home Affairs Select Committee in February 2002, the then Drugs Minister, Bob Ainsworth, remarked:

Whether or not we should be investing in a substantial increase of work on enforcement – all of the money comes out of a finite pot at the end of the day – at the expense of education, at the expense of treatment, is another thing. When we have tried to look at what actually works, we think that we have evidence that treatment does work and that pound for pound we are getting more out of treatment than we are out of law enforcement activity.

A year later, the Strategy Unit confirmed the Home Office's suspicions. The annual cost of the enforcement strategy, it reported, had now risen to £450 million per year. Of this total, £85 million was being spent on police actions against drug dealing within Britain that could otherwise have been targeted

on reducing the harms caused by drugs, at least to some degree. The remainder – that is, some £365 million spent on ‘activities in source countries’, interdiction of drugs in transit abroad, ‘import investigation’ and efforts to secure Britain’s borders – ‘does not produce any material payback in reducing drug harms’. This money, the Strategy Unit concluded, should ‘be invested in other objectives, such as development, countering organized crime, failed states, drug treatment, or other public goods’.

²⁶⁸ Commentary from SCD3(3) MPS Drugs Directorate, May 2005.

²⁶⁹ Sir Stephen Lander, incoming Chairman of SOCA, defined its objective in those terms on the Today programme, 3 April 2006. Lord McKenzie of Luton, a Government Whip in the House of Lords, described CIDA’s main aim as ‘harm reduction in UK communities’ in a Parliamentary Answer on 14 July 2005.

Reducing supply: a more practical approach

Efforts to reduce the supply of drugs through seizures, raids and arrests have always had a range of uses. International operations have been valuable in terms of foreign relations with producer countries, as well as with the United States, which seeks to promote foreign intervention and interdiction as part of its ‘war on drugs’. Aggressive action against drug traffickers and dealers is necessary in order to influence their perceptions of the ratio of risk to reward. In the absence of robust enforcement, the risks involved in drug trafficking diminish appreciably and more entrepreneurs are attracted into the market, intensifying competition between rival suppliers and increasing the risk of violence.

An aggressive approach is also good for the image of law enforcement agencies, and it goes some way towards meeting public concerns. In evidence to the House of Commons Home Affairs Select Committee, Deputy Assistant Commissioner Andy Hayman of the Metropolitan Police observed: ‘We must not lose sight of what reassures the community. Like it or not, the enforcement activity, though it may not give us the outcomes we expect and hope for, is a reassurance to the community.’

Footage of raided crack houses and drug hauls at sea is popular with the media, and statistics on seizures and arrests are useful ammunition for party political debate. However, enforcement agencies themselves are increasingly keen that their performance should be assessed in more meaningful terms, related to their capacity to protect the public from actual harm. The Metropolitan Police Service Drugs Directorate has observed that ‘seizure targets are worthless. This is an important point that needs to be emphasized more forcefully as politicians still seek to focus on quantities of drugs seized rather than other outcomes.’²⁶⁸

The main objectives of both the Concerted Inter-agency Drug Action group and the Serious Organised Crime Agency have now been defined or re-defined as ‘harm reduction’.²⁶⁹ Launching SOCA in 2006, the then Home Secretary,

Charles Clarke, promised that its performance would be measured in a different way from those of the organizations it was replacing:

Law enforcement has tended to be judged on easily quantifiable measures, such as the number of groups disrupted or amount of illegal commodity seized, which are simple to measure but very hard to connect with outcomes that matter to communities.²⁷⁰

From now on, Clarke continued, the direction of the Agency's work must be related not to numerical targets but to its impact at individual and community level. Is the damage caused by organized crime in an area going down? Are criminal markets being dislocated? Are the houses, cars and cash of known criminals being confiscated, sending the message that crime does not pay?

People, not substances

In our view, efforts to disrupt the supply of drugs should not be discontinued, but they should be targeted at people rather than products, at criminal networks rather than consignments of heroin or cocaine. As the Prime Minister's Strategy Unit observed:

There is no reason not to seize drugs whenever the opportunity arises, but the drive of the police and other agencies should be to deal with the criminality of those who supply drugs, recognizing that drug seizures in themselves are having little or no impact on reducing harms... but the estimated hundreds of major importers and low thousands of wholesalers in the UK are organised criminals involved in a business which causes enormous harm.

The Metropolitan Police Service, for example, is already implementing this change of focus. It stated in a 2006 document, *Criminal Networks: a new approach*:

Police will always reactively investigate crimes as they happen, but our challenge is to pro-actively target criminal networks and take a holistic approach to prevent these crimes occurring... To tackle crime trends in the long term we will identify and disrupt criminal networks and so impact on the entire range of crimes they are involved in.

If countering the supply of illegal drugs is seen as one facet of a campaign against organized crime and criminal networks, the expense and effort become far easier to justify. Drug dealing is a critical factor in the success and spread of serious and organized crime. It often requires the use of violence and intimidation, money laundering, corruption, the possession

and use of firearms, illegal immigration and identity fraud. Other crimes – armed robbery, for example – are committed in order to finance drug trafficking, and the profits that trafficking generates are used to fund further crime and to support ‘criminal lifestyles that corrupt and undermine individuals, communities and the legitimate economy.’²⁷¹ Of the 170 criminal networks mapped by the Serious Crime Directorate in April 2006, 100 were involved in both drugs and other criminal activities. Only five were involved in drugs alone.²⁷²

Financial investigation and assets recovery

Financial investigation and asset seizure are major weapons in this task of identifying and disabling criminal networks. Targeting those who handle and launder the money for a criminal trafficking network (who regularly operate within the legal economy) will sometimes have as destructive an effect on the network as arresting the traffickers themselves. Seizing the assets of larger dealers and distributors will almost certainly do more damage to a supply chain than arresting those who handle deliveries on the streets.²⁷³

For these reasons, we join in calling for more resources to be put into assets recovery and the investigation of the financial systems that support drug trafficking. Primary responsibility for these tasks is in the process of being transferred to the Serious Organised Crime Agency. The Home Office announced in January 2007 that the Assets Recovery Agency is to be abolished as a separate body and will be merged with SOCA in April 2008.²⁷⁴ We believe that assets recovery should be among SOCA’s highest priorities. Equally, at the local level there is a need to invest more heavily in Financial Investigation Units within police services. This might perhaps be achieved by allowing police services to retain specifically for this purpose a larger proportion of the assets they have seized, rather than reducing it, as would appear to be the present intention.²⁷⁵

Prolific and Priority Offenders

Disrupting and impoverishing organized criminal networks is undoubtedly the best means of reducing the supply of drugs at the higher level, but police services also need to focus at lower levels on targeting people rather than products – in this case targeting problematic drug users who make up a significant proportion of what have been labelled Prolific and Priority Offenders.²⁷⁶

It is estimated that, of all the people now estimated to be committing crimes – roughly a million people – 100,000 of these offenders have three or more convictions and are responsible

²⁷¹ National Criminal Intelligence Service, *UK Threat Assessment: the threat from serious and organised crime, 2004/5 – 2005/6*.

²⁷² Metropolitan Police Authority, *MPS position on drugs*, 24 April 2006.

²⁷³ This was even acknowledged in the drugs strategy of HM Customs and Excise before its reconfiguration as HM Revenue and Customs.

²⁷⁴ Throughout its existence, the Assets Recovery Agency was heavily criticised for failing to reclaim more than modest amounts of criminal proceeds, or even to cover its own costs. See, for example, a document from Conservative vice-chairman Grant Shapps MP, *Report into the under-performance of the Assets Recovery Agency*, 12 June 2006. Set up and run since 2003 at a cost of approximately £60 million, by 2007 it had only actually recovered £8 million in terms of assets seized and sold. It had frozen assets worth much more than that but had been prevented by legal challenges from realising their value. Critics claimed that the Agency’s successes, such as they were, were mostly scored against lower-level criminals, leaving the most significant offenders untouched. The Crown Office and Procurator Fiscal Service in Scotland has experienced similar difficulties in bringing asset recovery cases to court.

²⁷⁵ It is proposed that in future the benefits from asset seizures will be split three ways between the police, the Crown Prosecution Service and the courts. The police share in the future will be a maximum of 17 per cent, with the possibility that this may have to be further shared with other investigating agencies such as HM Revenue and Customs.

²⁷⁶ Prolific and Priority Offenders are defined as ‘persistent offenders who pose the greatest threat to the safety and confidence of their communities. Many of them frequently have drug problems and commit crime to support their drug habit’. Government Office for the South West website, <http://www.gos.gov.uk/gosw/commsafety/crintiatives/ppos/> The Home Office estimates that 100,000 offenders commit 50 per cent of all crime.

for half of all crime. The most active 5,000 of this group are estimated to be responsible for one in ten of all offences.²⁷⁷ In 2004 the Prime Minister announced a Prolific and Priority Offenders (PPO) scheme for tackling these 5,000: to prevent and deter, catch and convict, rehabilitate and resettle them. This PPO scheme can be written into local policing plans. Under it, a local force can identify a number of its worst offenders and intervene to help reduce their offending and reintegrate them into society. The police can intervene when these offenders appear in court but can also take the initiative themselves and approach identified individuals and ask them to participate in the scheme before they have committed any particular crime. The core of the PPO scheme is individual case management based on a care plan. It may involve helping the offender with housing (an appointment with housing agencies on the day of release from prison and support with housing benefit claims). It may consist of help with employment and training (such as payments towards courses or equipment like safety gear for use on building sites), help in getting a doctor, a dentist or a counsellor, or the provision of food vouchers on release. It may involve trying to re-engage offenders with their families. In essence, it amounts to preferential treatment offered to members of a particularly problematic group of offenders on the practical ground that helping them out of crime will be of the greatest benefit to the whole community.

²⁷⁷ Home Office crime reduction website, <http://www.crimereduction.gov.uk/ppol/ppominisite01.htm>

²⁷⁸ Metropolitan Police Authority, *MPS position on drugs*, 24 April 2006.

Drug-related offences are reckoned to constitute over half of all offences.²⁷⁸ Within the category of Prolific and Priority Offenders there is therefore without doubt a large core of problematic drug users, many of them user-dealers, and in our view they need to be identified as such. Unless they are distinguished from other prolific offenders, their particular needs will not be met and their offending is unlikely to be reduced. Some have an extraordinarily high rate of offending: the top 10 per cent of problematic drug users – those suffering harm or causing harm from their drug use – commit more than half of all drug-related crimes, accounting for 21 million offences per year, an average of some 680 offences each. Given the number of offences they commit and the depth of support that many of them need, we believe that problematic drug users should officially be given priority within the PPO scheme and police services need to make more systematic use of the scheme to tackle the twin problems of drug supply and demand in their localities.

Drug-related targets and performance indicators

We also believe that drug-related issues should be given higher priority within police work at the local level. In theory, the

establishment of the Serious Organised Crime Agency has freed police forces to concentrate on local and regional concerns, but it is often hard to promote tackling drugs as one of the most pressing of these concerns. Drug dealing frequently promotes the committing of other kinds of crime such as gun crime; drug use is closely entwined with a large proportion of acquisitive crime; drug trafficking is one of the most attractive areas in which criminal networks can make money. Yet drug offences are not always pursued with the energy that this combination of circumstances would seem to require. This is largely because, at a time when police work is dominated by targets, measures and performance indicators, there are no performance indicators in the National Policing Plan or the Police Performance Assessment Framework that relate specifically to drugs, other than a single indicator relating to public perceptions of the prevalence of drug-related crime.²⁷⁹ As so often, perception trumps reality.

There are broad and general statements in the National Policing Plan of the aspiration to ‘reduce overall crime – including violent and drug-related crime’. There is an expectation that ‘forces and authorities should describe in their local policing plans how they will address... drug-related crime in their communities’ and that Basic Command Units will ensure that clear plans are produced for tackling violent crime which will ‘include strategies for tackling gun crime and the drug crime which frequently drives a local gun culture and significantly impacts fear of violent crime’.²⁸⁰

However, there are no more precise targets and no single indicator against which police performance will be measured at the operational level of the Basic Command Unit. There is therefore less incentive than there should be for officers at this level to tackle drug dealing and other drug-related crimes. Drug use and dealing very often go unreported and police officers can choose not to investigate individual instances. Targeting low-level dealing would probably most effectively meet the government’s objective of improving public perceptions of drug crime. (In general, all that the public will perceive is low-level dealing, as the higher levels remain more carefully hidden.) However, it is a time-consuming and often unrewarding task and without specific targets there is little incentive to give it any degree of priority.²⁸¹

The first of the present Public Service Agreements for the criminal justice system in England is to ‘reduce crime by 15 per cent, and further in high crime areas, by 2007–08’.²⁸² In order to achieve this objective, in the words of the National Policing Plan, ‘[police] forces and authorities will have to continue to focus on

²⁷⁹ Statutory Performance Indicator 10(c) is ‘perceptions of local drug use/drug dealing’, using the British Crime Survey.

²⁸⁰ The Basic Command Unit is the largest regional unit into which a police force may be divided. Most forces will have at least three and some have many more. It may also be referred to as an Operational Command Unit; the Metropolitan Police use the term Borough Operational Command Unit. Most Basic Command Units are subdivided into smaller units. Home Office, *National Policing Plan 2005–06: Safer, Stronger Communities*, 2004.

²⁸¹ In Scotland, the annual DAT Corporate Action Plan reports to the Scottish Executive on local police performance against national targets to reduce significantly the proportion of under-25-year-olds who are offered illegal drugs, to reduce by 25 per cent the number of those who are offered heroin, and to increase by 10 per cent per year the detection of people supplying Class A drugs. However, there are fundamental questions about the basis for, and achievability of, the targets in the given timescales.

²⁸² HM Treasury, *Spending Review 2004: Public Service Agreements 2005–08*, 12 July 2004.

volume crime'. 'Volume crime' is defined as comprising burglary, robbery and vehicle crime. Drug use may contribute to all three of the offences designated as 'volume crime', but police spend more effort chasing volume crime targets and are only incidentally concerned with the link with drugs. It is not obligatory for police officers to identify an acquisitive crime as drug-related and it may complicate their lives to do so. Information about the drug habits of those charged with acquisitive crime will sometimes be missed.

²⁸³ Baroness Scotland of Asthal, Parliamentary Answer, 6 July 2006.

The success of the Drug Interventions Programme, and the government's efforts to use the criminal justice system as a means of channelling drug-using offenders into treatment, depends to a large extent on operational police officers making the link between drug use and crime and ensuring that, where appropriate, offenders are drug tested. At present the Home Office, through the National Policing Plan, has given them precious little incentive to make this link.

The Home Office, in discussion with the Association of Chief Police Officers and HM Inspectorate of Constabulary, is considering new policing targets for drugs. 'Part of this work will consider whether new or revised performance indicators relating to the trade, distribution and use of illegal drugs are needed and, if so, what if any targets should be set.'²⁸³ We believe that at the local level the best way of pursuing the overall objective of reducing harm through restricting the supply of drugs would be to give police services more specific drug-related performance indicators, with targets set at the level of the Basic Command Unit. They should obviously be linked to local conditions and ideally to any local Prolific and Priority Offenders scheme.

These targets should be shared with other agencies. In some forces, Basic Command Units match local government boundaries, and in England a proportion of these will also be coterminous with Primary Care Trusts. Where this is the case, the police unit might, for example, share with the health service and the housing and social service departments of the local authority the target of reducing the number of problematic drug users in their area. A shared target would have the effect of binding outside agencies more closely into the Prolific and Priority Offenders scheme as a means of rehabilitating some of the offenders with the most complex needs. A first evaluation of the PPO scheme has concluded:

A welcome finding is that the police, probation and youth offending teams are very strongly engaged with the programme. Conversely, accommodation (13%), employment (9%) and

education agencies (5%) seem to be largely absent from PPO work.²⁸⁴

²⁸⁴ Home Office Development and Practice Report 46, *Early Findings from the Prolific and Other Priority Offenders Evaluation*, 2005.

A shared target of reducing the number of problematic users would also give local police more incentive to identify these users more precisely. This would improve the quality of the information they possess on their PPO scheme, besides making it possible for them to ensure that the people with some of the most serious drug problems as well as the most persistent records of offending are given the most intensive support available in order to reduce harm both to them and to their communities.

As police services are well aware, efforts to reduce the supply of drugs are just one term in a complex equation. Senior police officers have been among the first to point out that supply reduction is not only extremely difficult, for the reasons set out above, but at best a partial solution. Efforts to reduce supply are largely pointless unless they are complemented by even more determined efforts to reduce demand. The next three chapters are concerned with current policies on demand reduction and the ways in which they are implemented.

11 Reducing the demand for drugs: attitudes, awareness and behaviour

In the previous chapter we have looked at strategies for reducing the supply of drugs. We turn now to strategies for reducing demand. These fall broadly under two headings:

- reducing the number of people who are dependent on drugs, mainly by means of treatment and other forms of support; and
- undertaking activities to improve people's knowledge about the risks of using drugs, to influence their attitudes and behaviour and to encourage the development of skills to resist the pressure to use drugs.

We will discuss treatment and social support in Chapters 12 and 13, looking at what can be done to help once people have already begun to experience problems from their use of illegal drugs. In this chapter we focus on what can be done to forestall those problems: when, where, how and by whom information may be most effectively conveyed, skills developed and behaviour influenced.

What we have described as 'influencing attitudes, awareness and behaviour' is often given the shorthand label of 'prevention'. The term is used loosely to cover a wide range of activities that may have different intentions. It may be used to describe activities

that seek to discourage young people from starting to use drugs in the first place. It may focus more on activities that aim to prevent those who are experimenting with drugs from progressing to dependent use. Alternatively, it may be used to describe activities that aim to prevent those who are regular or dependent users from becoming problematic users. It is important to appreciate that education about drugs is only one part of any prevention activity. Others might include parenting programmes, mentoring services or diversionary schemes such as organized sport or arts programmes.

²⁸⁵ Northern Ireland Department of Public Health, Social Services and Public Safety, *New Strategic Direction for Alcohol and Drugs 2006-11*, 2006.

Proponents of prevention may differ as to whether their intention is to prevent the use or the *misuse* of drugs. Those seeking to prevent use are, broadly, promoting the cause of abstinence. Those seeking to prevent misuse may acknowledge that abstinence is the safest possible course, but they also believe it is unlikely ever to be achieved. In their view, therefore, prevention programmes should also include activities that aim to reduce harmful drug use. Policy makers are often under pressure to pursue both of these separate objectives. The moral and political forces that lead to the demonization of drug use create pressure on policy makers to try to eradicate it altogether. At the same time, there are both humanitarian and economic pressures to tackle the drug-related harms that persist despite all attempts at eradication.

For politicians, harm reduction may be a riskier goal than abstinence, and some policy makers are bolder than others in attempting to champion it. Northern Ireland's revised drug strategy, for example – led from the Department of Public Health, Social Services and Public Safety – has five strands or pillars. The first pillar, 'Prevention and early intervention', explicitly acknowledges the importance of promoting harm reduction as well as abstinence. Prevention, it states, aims not only at 'preventing and/or delaying of initiation into drug use' and 'discouraging continued drug use' but also 'reducing the harm associated with drug use'.²⁸⁵ Harm reduction is also listed as a separate pillar of the Northern Ireland strategy. On this view, abstinence and harm reduction are seen as complementary rather than contradictory activities.

Current policy in England distinguishes less clearly between these two facets of prevention. In the 'Drugs' section of the main Home Office website, on the page entitled 'Tackling drugs misuse', a heading reads: 'Preventing drugs misuse', which implies that the aim is to prevent the *harmful* use of drugs. Clicking on this heading, however, leads to a passage that states: 'It's estimated that 20,000 young people become adult problem drug users

every year, so we're focussing our drug misuse policy on encouraging young people to choose not to take illegal drugs', suggesting that the objective is to prevent drug use altogether.²⁸⁶ Again, on the Crime and Drug Strategy Directorate's own website, the link on the 'Young People' page to 'Young people's drug strategy' is captioned 'Government targets for preventing young people from taking drugs', implying that the aim is to promote abstinence. The related link yields a statement of the aspiration that 'Young people choose not to take drugs'. However, directly above it is an exhortation to 'prevent today's young people from becoming tomorrow's *problem* drug users [italics added]' and below that comes the statement: 'Young people's services must be fully committed to identify [sic] drug misuse in young people and intervening before the problem becomes acute'. The latter two statements give the impression that drug use is conceded to be a reality and the ambition therefore must be to minimise the problems it can cause.²⁸⁷

²⁸⁶ <http://www.homeoffice.gov.uk/drugs/drugs-misuse/preventing-drug-misuse/?view=Standard>

²⁸⁷ <http://www.drugs.gov.uk/young-people/strategy/?version=1>

The two objectives – total abstinence and harm reduction – are jumbled together here. One way of avoiding becoming a problem drug user is obviously not to become a drug user at all. Another is to use drugs but in ways that avoid problems and minimize risks. It is not clear which form of prevention is being advocated by the Home Office, and the ambiguity may be partly intentional. However committed health agencies may be to minimizing the health damage that may result from drug use, the National Drug Strategy is driven from the Home Office and is presented primarily as a strategy for reducing crime. Crime cannot appear to be condoned in any form; therefore, drug use should not appear to be condoned. It follows that, while many of those who implement the current drug strategy may in fact be working hard to help people who use drugs to use them more safely, they must not be seen to be doing so too overtly.

To avoid this kind of confusion, we prefer not to use the word 'prevention' at all. We focus instead on *increasing knowledge and awareness* of drugs and the potential risks associated with them as a means of influencing attitudes and behaviour and discouraging both the first use and the misuse of drugs. In our view the government should acknowledge that there is no way of preventing all people from using all drugs and that there may not even be a way of preventing a large number of people from using drugs. That being so, the government should pursue a policy focused on increasing people's knowledge of drugs and their awareness of the harms that drugs can cause. Avoiding drug use altogether is obviously the surest way of avoiding incurring or causing drug-related harms. But, if people nevertheless insist

on using drugs, then the aim of policy should openly be to encourage them to use the least harmful drugs and to use the drugs that they do use in the least harmful ways. In other words, ministers should acknowledge publicly that they are indeed doing what they are doing already: that is, *both* trying to discourage people from using drugs at all *and* encouraging those who do insist on using drugs to use them sensibly. Such an approach seems to us more honest and more likely to succeed.

²⁸⁸ The DfES shares responsibility with the Home Office for the delivery of the Public Service Agreement on young people's drug use.

²⁸⁹ DfES, *Drugs: guidance for schools*, 2004. The Health Promoting Schools programme in Scotland aims to develop effective drugs programmes within schools.

What is currently being done to discourage people from using and misusing drugs?

One of the key functions of Drug Action Teams, at least on paper, is to ensure that young people and their parents or carers receive education, advice and support on substance misuse, both in and out of school settings. They are helped and monitored in this task by the Government Offices for the Regions, which have been made responsible for identifying and promoting best practice in drugs prevention. It is the Department for Education and Skills (DfES), however, that has lead responsibility for policy on preventing problematic drug use.²⁸⁸

In schools

The main push towards discouraging drug use comes through formal drugs education programmes in school. The National Healthy Schools Programme, sponsored jointly by the Department for Education and Skills and the Department of Health, includes drugs education as one of its core themes, and official guidance from the DfES, revised in 2004, states that all schools should have a drugs education programme.²⁸⁹ A majority of primary schools (80 per cent) and of secondary schools (95 per cent) had adopted drugs education policies by 2004.

According to the DfES guidance, drugs education should run throughout a pupil's school years and should be appropriate at every stage to pupils' age, maturity and ability. To some extent, such education will be delivered automatically through the statutory science curriculum, which includes various components relating to drugs (set out in Table 3 below).

Table 3: The current statutory science curriculum as it relates to drug education

Age group	Key Stage	Components relevant to drugs education
5-7 years	1	The role of drugs as medicines
7-11 years	2	The effects on the human body of tobacco, alcohol and other drugs, and how these relate to people's personal health.
11-14 years	3	The fact that the abuse of alcohol, solvents and other drugs affects health.
14-16 years	4	The effects of solvents, alcohol, tobacco and other drugs on body functions.

In addition, drugs education may be delivered in citizenship classes and through the Personal, Social and Health Education (PSHE) curriculum.²⁹⁰ At present PSHE is non-statutory, but most schools provide it in some form.²⁹¹ Table 4 below sets out the messages relating to drugs that are contained in the current PSHE framework:

Table 4: The PSHE framework as it relates to drugs education

Age group	Key Stage	PSHE messages relating to drugs education
5-7 years	1	The fact that all household products, including medicines, can be harmful if not used properly.
7-11 years	2	Identifying which commonly available substances and drugs are legal and which illegal, and what their various effects and risks are, the idea being that pupils should learn how to make informed choices about their health, how to resist pressure to do wrong and how to take more responsibility for their actions.
11-14 years	3	The basic facts and laws, including school rules, about alcohol, tobacco, illegal substances and the risks of misusing prescribed drugs, the idea being that pupils should learn the skills to recognise and manage risk and find out where they can go for help and advice.
14-16 years	4	The health risks of alcohol, tobacco and other drug use, early sexual activity and pregnancy, and food choices, the idea being that pupils should learn how to make safer choices, discover more about the effects of drug misuse on family, friends, community and society and gain greater understanding through clarifying their opinions and attitudes in discussions and debate and considering the consequences of their decisions.

²⁹⁰ Citizenship education is non-statutory at Key Stages 1 and 2 but a statutory requirement at Key Stages 3 and 4. It covers social and moral responsibility, community involvement and political literacy.

²⁹¹ Though it will become statutory in Northern Ireland in 2007 when 'Learning for life and work' becomes part of the main curriculum. An amendment to the 2006 Education and Inspections Bill which would have made PSHE statutory was rejected after a debate in the House of Lords on 24 October 2006. Lord Adonis' response was that he believes the right course is to strengthen the teaching of PSHE and not to create a new statutory subject.

These various messages concerning drugs should be taught in parallel, so that the factual knowledge learned in science is reinforced and given social context by being discussed in citizenship and Personal, Social and Health Education.

²⁹² Jenny McWhirter, 'Credibility drive', *Druglink*, July/Aug 2006.

The DfES guidance makes it quite clear what drugs education should be like. It should be taught primarily by skilled and confident teachers on the regular staff, teachers who know the children well and are most likely to have their trust. It should aim at shaping skills and attitudes as well as imparting knowledge, and it should be taught in an interactive way. It should be geared to what pupils want and need, focusing on the substances that are most relevant to them. It should be sensitive to their existing views and tailored to what they already know, so that it can reinforce those of their perceptions that are accurate and challenge those that are not. It should be sensitive to their differing cultural backgrounds, and it should form part of a coordinated approach that will also involve parents and communities in discouraging drug use.

Drugs education in schools, outside the factual content taught in science lessons, follows two main approaches, which can be described as 'social influence' and 'social competence'. Social influence seeks to achieve a kind of psychological inoculation against drug use by encouraging anti-drug attitudes. Young people frequently over-estimate the number of their peers who are taking drugs, assuming that 'everyone' is doing it. If so, they conclude, they should take drugs too in order not to be in an isolated minority, and anyway taking drugs must be harmless since so many people are doing it without apparently suffering.²⁹² The social influence approach works to counteract the belief that drug use is 'normal'. It also helps pupils to develop techniques for resisting social pressure to take drugs. The social competence approach, on the other hand, seeks to develop more general life skills, a broad range of personal and social skills that people need if they are to make good decisions, including decisions about drugs.

Peer educators, young people of the same age or slightly older, similar in experience and cultural background, with influence in their peer group, are quite often trained to deliver drugs education to older pupils. Schools may also bring speakers in from outside – police officers, former drug users, drugs workers, representatives of community organizations, theatre groups – to vary the format of drugs education classes at all levels. Some schools have access to regular drugs advisers supported by their local Drug Action Teams.

A few schools are supplementing drugs education classes with random drug testing of their pupils, and significantly more are using sniffer dogs to detect traces of drugs on them.²⁹³ Testing usually involves taking mouth swabs and must have the consent of both the children and their parents. Prime Minister Tony Blair announced plans to introduce testing in 2004, and a pilot scheme involving several schools in Kent is under way. The Abbey School in Faversham, one of the first schools to adopt the scheme, has claimed that drug testing was one of the factors that led to record GCSE results in 2005. Terry Creissen, head teacher of the Colne Community School in Essex, sees testing as the stick to accompany the carrot of citizenship education and would like to see it made compulsory in all state schools.²⁹⁴ Some students claim it is useful as a means of resisting peer pressure, and several teaching unions have expressed support for the idea of its being available as an option.

However, Ofsted has said that school drug testing raises serious issues that require national debate, and the Advisory Council on the Misuse of Drugs (ACMD) recommended in 2006 that it be abandoned. Many drugs practitioners agree.²⁹⁵ There is as yet no evidence that testing discourages drug use, and it could instead undermine the kind of open relationship between pupils and teachers that allows them to discuss drugs and drug use freely. One head teacher has described testing as 'ruling by fear'.²⁹⁶ According to a joint briefing from the Drug and Alcohol Education and Prevention Team, random testing fits better with the 'war on drugs' approach than with the struggle for hearts and minds that teachers tend to prefer.²⁹⁷ It clearly does nothing to encourage the development of personal responsibility, and it could have the undesirable consequences of stigmatizing children who are already vulnerable and glamorizing those who cultivate an image of defiance. In addition, there is a significant risk of false positives resulting from medicines such as decongestants and painkillers and from poppy seeds in food. The use of sniffer dogs is even more controversial. Dogs are considered unclean in Muslim and Buddhist cultures and are in any case feared by many children. Dogs' identification of 'suspects' is done in public and may reveal only that a child is taking prescription medicines for an illness they may have wanted to keep private or that a child has been exposed to an environment in which other people have used drugs. We are very doubtful about the appropriateness and the utility of both random testing and use of sniffer dogs.

Outside schools

School-based drugs education has the advantage of reaching most of an entire age group. Outside schools it is hard for organizations

²⁹³ A *Druglink* magazine investigation carried out in 2004 found that at least 100 secondary schools use drugs dogs regularly. Drugscope Policy Briefing, *Drugs Dogs*, 2005. Sniffer dogs are brought in by the police, a relatively cheap measure.

²⁹⁴ Interview, 21 April 2006.

²⁹⁵ See, for example, Chief Executive of Adfam, Vivienne Evans, 'The drug tests don't work', *Observer*, 20 January 2002, and N. McKeganey, *Random drug-testing of schoolchildren: a shot in the arm or a shot in the foot for drug prevention?*, Joseph Rowntree Foundation, 2005 (though Professor McKeganey has since suggested that pilot programmes should perhaps be conducted to explore the effectiveness of testing).

²⁹⁶ John Schield, principal of Witchford Village College in Cambridgeshire, suspended but did not expel a group of pupils known to have been smoking cannabis in school. The school prefers to operate a negotiated drug policy and Mr Schield dismissed the idea of random drug testing as 'inappropriate'. *Cambridge Evening News*, 8 November 2006.

²⁹⁷ A joint Alcohol Concern and Drugscope project.

working to discourage drug use to make their presence felt, and often equally hard for young people beyond the reach of schools to find information and support. Adults too are often in great need of help and advice, not just drug users but their families. The FRANK campaign has developed an action pack on how to target families. More specifically, the national charity Mentor UK is currently engaged with Adfam and Grandparents Plus on a project to identify the information, support and advice that is needed by grandparents looking after the children of problem drug users.²⁹⁸ Research suggests that it is often better for children to stay with grandparents than to go into foster care or children's homes, but many grandparents are unaware of the help to which they are entitled, nor do they know anything about drugs or how they might protect their grandchildren from drug-related harm.²⁹⁹

²⁹⁸ Mentor UK is the British wing of the Mentor Foundation, an international non-government agency working in the field of drug misuse prevention. Mentor UK seeks to undertake, identify, support and share information on effective, proven and promising practices that will protect children and young people from the harm that drugs cause and that will make misuse less likely.

²⁹⁹ e.g. ed. B Broad, *Kinship care: the placement choice for children and young people*, Russell House, 2001.

School drugs education has the disadvantage of missing some of the young people who are most likely to be having problems with drugs: those who persistently truant or have been excluded from school. Local authorities are required to establish Pupil Referral Units to provide education for pupils who cannot attend mainstream schools, either because they are ill or because they have been excluded, and these special educational centres are also bound by the DfES' *Drugs: guidance for schools* and are expected to deliver drugs education.

The youth services run by local authorities are aimed primarily at young people who are considered vulnerable in a variety of ways: children looked after by social services, truants and those excluded from school, young offenders, the young homeless and young people being sexually exploited. Those in all these groups are more likely than the average young person to have problems with drug use. The services provide a range of youth programmes and interventions outside school. Some interesting work has also been done for young people outside school in the form of schemes aimed at 'disaffected youth' that have been developed by fire services in several regions, notably the Cheshire Fire Service. Of all the emergency services, the fire services have perhaps the most glamour for young people, being action forces without the police's 'crime and punishment' associations. They also have the advantage of having buildings almost everywhere that can easily be used for community meetings of this kind.

The national 'Connexions' initiative, established in 2001, is a support and advice service for young people aged 13-19. Its provisions include the screening of young people at risk and referrals to specialist drugs services. In Scotland, Lloyds TSB Foundation provides funds, matched by the Scottish Executive,

for the Partnership Drugs Initiative, which between 2001 and 2006 allocated some £18 million to around 100 voluntary sector projects addressing the needs of young people affected by or at risk of drug misuse. The ‘Positive Futures’ scheme – a ‘national social inclusion programme using sport and leisure activities to engage with disadvantaged and socially marginalized young adults’ – is run from the Crime and Drug Strategy Directorate in the Home Office.

³⁰⁰ ACMD, *Pathways to Problems: hazardous use of tobacco, alcohol and other drugs by young people in the UK and its implications for policy*, 2006.

³⁰¹ Memorandum 30 to the House of Commons Home Affairs Select Committee, September 2001.

The other leading Directorate ‘prevention’ initiative in recent years has been the ‘Talk to FRANK’ project. It has run regular information campaigns, the most recent being the series of ‘Brain Warehouse’ advertisements that present some of the effects cannabis may have on mental health. Through its website, FRANK has made 40,000 referrals to treatment and support services since 2003. In Scotland, the Scottish Executive provides public information and education through its ‘Know the Score’ website and advertising campaigns.

These statutory schemes are supplemented by a wide range of drug programmes provided by non-governmental and voluntary community organizations. Many of these bodies provide ‘outreach’ that plays a crucial role in contacting people who are unlikely to approach services of their own accord.

The Advisory Council on the Misuse of Drugs recently remarked that ‘drugs education policy in the UK continues to be based on the assumption that drugs education is effective, investing large amounts of staff and pupil time and resources in such activity.’³⁰⁰ At the moment, however, this assumption is unsupported by evidence. Most evaluations of drugs education have been carried out in the United States and have been criticized for a lack of rigour. The Health Development Agency concluded in 2001:

Most initiatives and innovations in the drug education and prevention field are not evidence-based and have not been subject to evidence-based evaluation. In other words, there are very few peer-reviewed journal articles which employ a rigorous methodology to compare different types of drug education and prevention interventions and their outcomes.³⁰¹

In particular, there have been very few randomized controlled trials where subjects have been randomly allocated to either the intervention group or a control group, the only way of being reasonably certain that differences in behaviours between the groups have actually been brought about by the intervention in question.

The Home Office's 'Blueprint' programme, running from 2003–2007, is the largest drugs education research programme ever run in Britain, a systematic effort to identify the most effective methods of teaching young people about drugs. It seeks to give information, challenge attitudes and develop a range of skills needed to make healthy choices about drug use, and it may well succeed in providing a firmer evidence base. However, for the moment the existing evidence tends to suggest that drugs education in schools largely fails to discourage young people from using drugs. In a major study in 2006 entitled *Pathways to Problems*, the ACMD concluded glumly: 'Most schools in the UK provide drug prevention programmes. Research indicates that these probably have little impact on future drug use.'³⁰²

Formal drugs education seems to work best for young people who have not already started to use drugs and do not intend to do so; such people may find it useful in developing their resistance skills. For most, drugs education may produce short-term gains in knowledge, awareness and even inspiration, following, say, a theatre-based activity or a charismatic presentation from a former drug user. However, what formal education evidently does not do is impel young people to translate knowledge into behaviour. It apparently does not discourage people who either are undecided about whether to take drugs or are strongly inclined to experiment.³⁰³ In the worst cases, drugs education may even encourage drug use. The ACMD comments:

Worryingly... evidence of increasing rather than decreasing prevalence following the intervention was obtained in 17 studies of alcohol or drug prevention between 1980 and 2001, with greater evidence of these negative effects found in the most recent study period between 1996 and 2001.³⁰⁴

Why success is so limited

Being more knowledgeable about drugs and the use of drugs is worthwhile in itself. In that sense drugs education certainly has an effect. Educators point out that the purpose of education in general is to impart knowledge. They add that to expect it also to change social behaviour may be unreasonable, particularly when the behaviour in question is often rooted in some of the most intractable of social and economic problems. The ACMD points out that:

Many of the young people who start taking drugs at an early age have a parental or family background or circumstances which put them at higher risk, or have already shown evidence of patterns of behaviour such as truancy or offending which are strongly associated with using tobacco, alcohol or other drugs. When these circumstances are

³⁰² ACMD, *Pathways to Problems*, op.cit.

³⁰³ See, for example, Beckley Foundation Drug Policy Programme, Report 8, *Cannabis and mental health: responses to the emerging evidence*, 2006. 'An extensive review for the World Health Organization (Hawks et al., 2002: x-xi) concludes that: While the majority of studies reviewed, deriving mainly from the United States, have abstinence as their goal, there is evidence that programmes having this goal consistently fail to produce behavioural effects.'

³⁰⁴ *Pathways to Problems*, op.cit.

combined with an environment in which drugs are readily available, it is perhaps unrealistic to expect a small number of classroom-based exercises to act as a deterrent.³⁰⁵

However, the National Drug Strategy's 'Young People' strand tends to be framed in terms of deterrence and abstinence from drug use, and in these terms drugs education appears to be largely unpersuasive. Why should this be so?

A combination of factors conspires to undermine the effectiveness of drugs education. A lack of attention to the needs of those providing it meets apparent failures of understanding of the interests and requirements of those on the receiving end.

In addition, as we have already seen, the message that drugs education seeks to deliver is often ambiguous. In trying to serve two purposes at once, it serves neither convincingly.

Lack of training

Drugs education is taught sporadically in some schools by whoever is to hand. Even where the programme is more structured, since Personal, Social and Health Education is non-statutory, teachers are only required to become 'familiar with' the PSHE framework as part of their initial teacher training. The ACMD found that a large proportion of the people providing drugs education in schools, whether teachers or outside speakers, had had no appropriate training in the previous three years.³⁰⁶ Local Education Authorities used to receive grants that were specifically ring-fenced for drugs education, but the ring-fencing was removed in 2004 and the DfES now funds extra training for only a few PSHE teachers in each authority.³⁰⁷ The remainder are given little help in keeping up with developments in the use of drugs or in research into drugs' likely effects. Many of the materials they use are out of date.³⁰⁸

External speakers may be equally in need of training.

The Association of Chief Police Officers in England and Wales has recently issued guidance for police officers going into schools which suggests that in the past some officers have not known enough about either drugs or teaching:

Most serving officers receive little training about the effects of illegal drugs on health and behaviour or how to recognise drug use. Police training does not routinely include an understanding of how young people learn, or the educational context for drug education and incident management.

Nor does it delineate the importance of partnership in the development or effective implementation of drug policies in schools.³⁰⁹

Other services also seem to ignore the fact that drugs education

³⁰⁵ Ibid.

³⁰⁶ The issue of improved drugs education training for teachers is being tackled in Scotland by an Education Sector Initiative funded by the Scottish Executive. It was launched in October 2001 following on from the very successful Primary School Initiative which was funded by donations from the business sector. The ESI national staff development initiative offered training to secondary staff involved in the planning and teaching of drugs education in all 32 local education authorities in Scotland.

³⁰⁷ Jenny McWhirter, 'Credibility drive', op.cit.

³⁰⁸ ACMD, op.cit., p.79. A large and detailed evaluation of the effectiveness of drugs education in Scotland has been completed for the Scottish Executive, though it has not yet been published. Its preliminary conclusions are that most schools use methods that have not been found to be effective and many use out-of-date materials. Teachers are often unaware of alternatives or do not have the confidence to try them.

³⁰⁹ ACPO, *Joining Forces: Drugs – guidance for police working with schools and colleges*, 2006.

is a specialized professional task. A recent Europe-wide study remarked: 'It is a common phenomenon in some member states that treatment services and professionals feel entitled and skilled to do prevention work as a side job, without any additional training.'³¹⁰

Pupils are perfectly capable of judging the quality of teaching as well as its content, and they are entitled to ask why they should be expected to take drugs education seriously if their schools do not. One study has found that Personal, Social and Health Education in general 'sometimes has low status and is disliked by students and teachers'.³¹¹ At the time of writing, Ofsted is reviewing the delivery of PSHE in schools, and more importance may be placed on raising the standard of PSHE programmes in the future as a provision in the Education and Inspections Act 2006 places a statutory requirement on schools to promote children's wellbeing as well as their academic achievement.

Inconsistency

While some schools work out integrated drugs education programmes, others string together a miscellany of different lessons without reference either to the PSHE programme as a whole or to other parts of the curriculum. Different teachers may convey different messages, and they may all be at odds with the policeman or the recovering drug user who is brought in to deliver the occasional presentation. The fact that pupils may get different answers to the same questions from one lesson to the next does not add to the credibility of the overall message.³¹²

Irrelevance

A 2006 report from Ofsted commented that teachers frequently fail to understand exactly what their pupils need in the way of advice on drugs issues.³¹³ Pupils are likely to want to know about the social implications of drug use, the factors that may lead to misuse, how much drugs can cost and the impacts that they may have on their lives, but the teaching they receive is often confined to scientific facts on the potential health effects of drugs. Another Ofsted report pointed out that pupils believe that alcohol and tobacco pose the most significant risks to health and have more questions about them than they do about, say, injecting heroin use.³¹⁴ In general, school drugs education tends to concentrate too much on the extreme consequences of dependence on Class A drugs, whereas the majority of pupils are more likely to encounter solvents, cannabis and amphetamines.

Lack of integration

Too often the messages delivered in school are not reinforced at

³¹⁰ G Burckhardt and L Crusellas, 'Comparison of school-based prevention programmes in Europe. An analysis of the EDDRA (Exchange on Drug Demand Reduction Action) Database', EMCDDA, 2002.

³¹¹ L Millward et al., 'An interim report of the evidence for effective drug prevention research activity and learning to date', Health Development Agency, 2004.

³¹² Alcohol Concern, 'Continuity and progression: a briefing paper', 2005.

³¹³ Ofsted, *Healthy Schools, Healthy Children? The contribution of education to pupils' health and wellbeing*, 2006.

³¹⁴ Ofsted, *Drug education in schools*, 2005.

home or anywhere else in pupils' lives. Sometimes the messages are actively resisted by parents, either because they resent what they see as preaching about the misuse of alcohol and tobacco alongside illegal drugs or, in some ethnic communities, because they feel the whole subject is unsuitable. The Ethnicity and Health Unit of the University of Central Lancashire has reported some instances where 'young people have taken leaflets home from school on drug education and have been hit or verbally abused by the family for bringing such pictures into the home'.³¹⁵

³¹⁵ Evidence to the House of Commons Home Affairs Select Committee, September 2001.

³¹⁶ Drugscope, 'Drug education for hard to reach parents', 2005.

³¹⁷ <http://web.archive.org/web/20051104090458/http://www.talktofrank.com/tribes/quiz.aspx>

Efforts by schools to involve parents in drugs education tend to meet with little success. Information evenings are often poorly attended, very probably because they are usually held in the schools themselves and take the form of presentations or lectures followed by question-and-answer sessions. Formats like these may well deter a wide variety of parents: from poorer families or those experiencing disruptions like divorce or unemployment, from black and ethnic minority families not comfortable with this kind of discussion in English, single parents, drug using parents, or simply people who hated school themselves.³¹⁶ Fathers are much less likely than mothers to come to such meetings, and parents who themselves drink or smoke heavily tend to stay away. There is also a fear of stigma attached to meetings explicitly about drug use and nothing else. In some areas, better attendance and results have been achieved holding such meetings in neutral venues such as department stores. In East Lothian a group of drug-using parents ran meetings for themselves on the model of the Tupperware party, facilitated by drugs key workers. Another project targeted Bengali fathers, approaching them in the environment of the mosque towards the end of Ramadan, when they were already meeting socially for the breaking of the fast.

Misjudged style

The DfES advises that the tone and style of drugs education should be appropriate to its audience, but this is easier said than done when the audience is largely teen-aged and the deliverers of the message are not. Trying too hard to be 'tuned in' can be disastrous. A feature on the Home Office-run FRANK website entitled 'Frank's Tribes' was an embarrassing attempt to speak the lingo of the natives, claiming that young people congregate in 'tribes' – scallies, trendies, gangstas, moshers(?) etc. – with distinguishing features of dress and musical taste, the underlying message being that it is not necessary to take drugs in order to 'belong'.³¹⁷ 'There are,' the website said, 'currently ten leading tribes in the UK! Each one consisting of a group of teens united by their musical tastes, social behaviour and appearance... Remember, no matter what tribe you belong to, you should

never feel pressured into taking drugs.’ But many young people resent the suggestion that peer pressure, rather than individual choice, is what prompts them to use drugs, and in any case it is asking for trouble to pronounce from the outside on ‘youth culture’. On the other hand, it is equally unproductive to be distant and adopt a position of superior knowledge. A genuinely interactive drugs education class might involve pupils in determining the topics to be covered and would certainly involve opportunities for discussion. Too often classes simply take the form of dictation and worksheets, and a lecture is still a lecture even if delivered by a former drug user rather than a classroom teacher.

³¹⁸ R. Skager, ‘On Reinventing Drug Education, Especially for Adolescents’, paper delivered at 2nd International Conference on Drugs & Young People, Melbourne, Australia, 4-6 April, 2001.

A misdirected message

Most importantly, school drugs education often fails to convince because it still presents a message – ‘Just say No’ – that is too simplistic and takes no account of the experience of the pupils at whom it is directed. It comes across as artificial and, when delivered by adults who smoke and drink, as somewhat hypocritical. As children get older, realism and honesty become more persuasive than exhortation and instruction, but some teachers do not realise or accept when this point has been reached. One drugs educator complains:

We assault them with a moralistic, didactic, adult driven process of instruction that ignores real-life experience they can bring to the table. We tell them lies or half-truths that are easily refuted by their own experience. We patronize them with exercises designed to fix the deficits we assume they must have by virtue of being kids. Then, just to be sure that they will be good, we threaten them with punishment for doing something that they see as normal behaviour within their own social world, thus providing for many a delicious opportunity to get back at adults by doing exactly what they are forbidden to do.³¹⁸

Is drugs education therefore a waste of money that could be better spent on drugs treatment? Or could the money simply be better spent on other ways of trying to forestall the use of drugs?

Funding and the problem of measurable outcomes

Since 1998 the National Drug Strategy has considerably increased the number of what the government characterises as ‘prevention’ initiatives. However, the ‘Young People’ strand of the strategy, under which drugs education and other attempts to discourage drug use fall, is still consistently the least well-funded of the four strands. In 2005/6, for instance, it received £163 million as compared with £367 million allocated for reducing drug-related crime, £380 million for supply reduction and £573 million for

improving access to treatment. Far less has been spent on mass media campaigns against drugs than against tobacco, and at the local level the funding provided to Drug Action Teams to support drugs education is meagre.³¹⁹ A recent survey of DATs suggested that 'funding and support for drug education is in a state of flux', with most of the respondents reporting 'uncertain' funding for drugs education in 2005/06. The DAT contribution to drugs education is often the largest in an area, and a decrease in it means a loss of drug adviser posts in schools.³²⁰

³¹⁹ In 2005/6 spending on advertising for tobacco control totalled £23m, while spending on both media and advertising for FRANK only amounted to £1.4m. (Caroline Flint, Parliamentary Answer, 21 March 2006.)

³²⁰ Drug Education Forum, 'Support for Drug Education 2004/5: survey of DATs by the Drug Education Forum', August 2005.

Part of the reluctance to fund 'prevention' stems from the difficulties of demonstrating that it is effective and putting a figure on its value at a time when measurable outcomes are all-important to government. No one has yet produced a formula for the amount of money that £1 spent on discouraging drug use might save in terms of not having to treat its consequences. This Commission believes we need to accept that some things are not easily measured and that the lack of a neat cost-effectiveness formula should not be taken as an excuse for under-funding the concerted effort to forestall harmful drug use.

Alternative proposals

In our view, the overarching aim of such a campaign or programme should be to discourage as many people as possible from using drugs in a way that results in harm either to themselves or to others. It is unrealistic to expect that no one will choose to use drugs. Many people will choose to use them, however much information they possess. That being so, the aim should be to postpone first use for as long as possible, so that choices, when they are made, are made in full knowledge and understanding rather than in ignorance.

Everyone should be made aware, early and accurately, of the varying risks attached to the use of different drugs. Special attention should be paid to those young people who are obviously most at risk of using drugs in a harmful way, in an effort to discourage them from starting, and they should be offered support and advice and not merely formal education.

Once the risks of drug use have been made known, those who have chosen to use them should be provided with help to limit damage to themselves and others. Those who seem most liable to abuse drugs should be given the most advice and support. Those who are already abusing drugs should be encouraged to change the way in which they use them or, better still, stop using them altogether.

The emphasis in school drugs policy should be shifted. At the moment, the resources that are dedicated to universal drugs education are concentrated at Key Stages 3 and 4 in secondary schools – that is, at pupils between the ages of 11 and 15. In order to deter people from first use of drugs, more effort should be concentrated earlier, in primary school. In order to minimise the harm that people do to themselves in using drugs, more effort should be concentrated later, on the period immediately after leaving school. In general, a greater share of resources should be devoted to efforts outside school to increase knowledge and awareness of the risks that drugs can pose.

We now spell out this approach in more detail.

Drugs education in school

Early intervention

Drugs education researchers are increasingly suggesting that the best way of reducing the harm done by the misuse of drugs in adolescence is to take action in children's early school years – or even their pre-school years – to tackle the unhappiness, insecurity and external pressures that frequently underlie problems with drugs. Those at serious risk of drug misuse can be identified very early, but not enough provision is currently made for doing so. The aim of early intervention is to promote the protective factors that make later drug misuse less likely, while at the same time tackling the risk factors that make it more likely. Protective factors protect against a wide range of threats, not simply the likelihood of drug misuse. These factors include positive relationships, clear standards for behaviour and individual characteristics such as confidence, intelligence and resilience. Risk factors are the lack of these things plus more acute problems such as parental drug use or mental disorders such as depression, attention deficit and hyperactivity.

Rather as in the case of preventive medicine, which seeks to reduce the risks of cancer or heart disease through diet and exercise, the earliest interventions in school may not tackle drugs issues directly but instead aim at giving children the support, skills and strength that they will need in future in order to deal with all the problems they will encounter. A recent German study concluded that addiction is essentially a misdirected pattern of behaviour stemming from earlier problems in personality development. Researchers explored the potential for counteracting addictive behaviour in children of kindergarten age by looking at their eating behaviour, their use of sweets and snacking, their television-watching and their attitudes to toys and playing, as well

as giving them more general help in dealing with feelings and with conflict, in taking responsibility and in being aware of their own bodies and their health.³²¹

A belief in early intervention lies at the heart of the Sure Start initiative, in programmes such as ‘Birth to three matters’. The importance of an integrated, holistic approach is central to the philosophy of ‘Every Child Matters: Change for Children’, a government initiative that requires all the organizations providing services to children to work together ‘to protect children and young people from harm and help them achieve what they want in life’. The principles that underpin these two major programmes are also integral to discouraging the misuse of drugs, and we are clear that they should be made explicit in the context of drugs policy. That is to say, schools should take action early to identify children who are at risk of problems with drugs, and they should do so in collaboration with other agencies: social services, health services, drugs services and, where relevant, the police and the probation services.

An integrated approach means involving families as well as children. Family support at the right time may do as much as any other single intervention to avert the pressures that lead some young people to use drugs. One American study looking at vulnerable families found that intensive home support for parents while their children were still of pre-school age, in the form of regular home visits and training in parenting skills, resulted in a lower risk of drug misuse when their children reached their teens.³²² This type of family support produces a wide range of other benefits as well, and measures to counter drug misuse should obviously be coordinated with other early intervention strategies.³²³ The drugs strand of ‘Every Child Matters’ makes the point that drugs issues must be an integral part of the new ‘joined-up’ children’s strategy to the point where it becomes a reflex action for policy makers and planners in every field of children’s activity – crime, mental health, health care, social welfare – to take account of drugs issues in their planning.³²⁴ An awareness of the possibility of drug misuse should be part of every assessment, care plan and intervention that they make.

Drugs education in primary school – a universal message of deterrence

In our view, primary school is the best place for ‘universal’ drugs education, aimed at every child in a class, to take place. The years from ages 6 to 11 are when children are forming their general attitudes to drugs but when the vast majority have not yet started to experiment. This period may be the last opportunity to reach those most at risk of getting into trouble, especially as truancy

³²¹ T Stockwell et al., ‘Recommendations for new directions in the prevention of risky substance use and related harms’, in ed. T Stockwell et al., *Preventing harmful substance use: the evidence base for policy and practice*, John Wiley, 2005.

³²² *American Academy of Pediatrics*, 1998, cited by National Collaborating Centre for Drug Prevention fact sheet 5, ‘Drug prevention among school excludees’, 2005.

³²³ L Jones et al., ‘A review of community-based interventions to reduce substance misuse among vulnerable and disadvantaged young people’, National Collaborating Centre for Drug Prevention, Centre for Public Health, Liverpool John Moores University, 2006. This survey concluded that the interventions most successful in altering behaviour over any length of time were those that focused on whole families and addressed a wide variety of risks and problems rather than simply focusing on substance abuse.

³²⁴ DfES *Every Child Matters: Change for Children – Young People and Drugs*, 2005.

and exclusion from school become far more common in secondary school.³²⁵ Drugs education should form an invariable part of the training syllabus for primary teachers.

The message at this age will be that using a wide range of different substances – alcohol, tobacco, prescribed medicines, solvents and illegal drugs – can be dangerous, and the aim will be to discourage children from using them. It has been generally accepted that this is best done indirectly, through finding out what children already know and through discussing the idea of substance use in general terms rather than simply delivering information on drugs, the fear being that one may create interest where none already existed. ‘Draw and write’ techniques like ‘Jugs and Herrings’³²⁶ have been much studied and evaluated, and their effectiveness is quite widely accepted. They find out what children already understand about drugs (which can be built on), what they almost understand (which can be refined), what they misunderstand (which can be challenged) and what is entirely missing from their understanding (which can be made good).³²⁷ Such techniques encourage children to think for themselves about how they would handle different situations relating to drugs. Techniques like these are less likely to arouse curiosity. Teachers only list drugs that the children mention and always use the third person. ‘We never say “you” to kids in describing anything, because the research shows the first step in doing anything is imagining yourself doing it.’³²⁸

As the age of first use of drugs goes down, however, some educators are suggesting that the approach should perhaps be more direct at an earlier age. In Wales in 2005/6 130 children under 12 were treated for substance abuse, most for alcohol and cannabis problems but some for cocaine, heroin and crack addictions. The number turning up for treatment is likely to be a very small proportion of the number of children of this age who are actually using drugs, and an education adviser in one of the worst affected areas has recommended that children be told about the dangers of drugs and alcohol as soon as they start nursery school. Some children might agree. Lancashire County Council organized a series of conferences for primary-school children designed to consult them about the purpose and content of drugs, alcohol and tobacco education. One of the key messages to emerge from the pupils’ workshops was that too little is taught too late.³²⁹

Even if the aspiration of drugs education at this stage is to discourage children from ever using drugs, we think it should be judged worthwhile even if it does not deter every child from experimenting but instead succeeds in pushing back the moment at which they first do so. While researchers are reluctant to

³²⁵ In 2003/4, around 84 per cent of exclusions were from secondary school, the average age being 14. Of 9,880 exclusions from primary, secondary and special needs schools, 8,320 were from secondary school. BBC website, ‘More children banned from schools’, 23 June 2005. <http://news.bbc.co.uk/1/hi/education/4122408.stm>

³²⁶ A title taken from a child’s rendering of ‘drugs and heroin’.

³²⁷ Drugscope briefing paper, ‘Continuity and Progression’, 2005.

³²⁸ Leeds primary teacher, quoted in ‘Christmas appeal: taking the drugs fight to school’, article in *Independent*, 12 December 2005.

³²⁹ Drug Education Forum, *Involving children and young people in drug education*, 2006.

suggest that the early first use of drugs actually causes later heavy use, they do agree that early first use is almost certainly ‘a major predictor’ of later heavy use.³³⁰

³³⁰ J Toumbourou and R Catalano, ‘Predicting developmentally harmful substance use’ in ed. T Stockwell et al., *Preventing harmful substance use: the evidence base for policy and practice*, John Wiley, 2005.

Drugs education in secondary school – changing the emphasis to harm reduction

Hitting upon appropriate messages for drugs education, and identifying information that will be useful and interesting to a whole class, becomes far more complicated in secondary school, particularly after the first couple of years. It is unproductive to try to discourage people from taking drugs if they are not considering doing it. It is equally unproductive to preach an uncompromising abstinence doctrine to people who are already experimenting with alcohol, tobacco and drugs. The ACMD report *Pathways to Problems* observed that, where drugs education appeared to have the perverse effect of increasing drug use, this happened ‘most notably in the classroom, where both drug users and non-users are taught together.’ Presumably, a badly judged message delivered to a whole class may have the simultaneous effect of irritating users into defying it while piquing non-users’ curiosity.

We believe that the only sensible message for universal drugs education, in the later years of secondary education at least, is one that has harm reduction as its main objective. As the Northern Ireland *New Strategic Direction for Alcohol and Drugs* points out, whole-class education would appear to work better for alcohol and tobacco, less well for drugs:

Recent research suggests that while universal interventions may be more appropriate for licit drugs, more targeted interventions at key developmental stages may have a greater potential for impacting on other drug use and associated risk behaviours.

This may be because young people are far more widely exposed to alcohol and tobacco – at home, in the supermarket, in the street, on television – than they are to drugs. They may be correspondingly more concerned about the effects of these substances and more prepared to listen to advice, particularly when this advice is couched in practical rather than moral terms and when, in the case of alcohol at least, it does not attempt to ‘prohibit’ drinking but only to moderate it.

Where drugs education is delivered to whole secondary school classes, the message can and should be more complex than it is in primary school. A good first line of argument may still be that it is safer not to take drugs at all and, if a pupil is not doing it already, he or she should not start. But at this stage drugs

education should acknowledge that a substantial minority of pupils will actually have started to experiment and that they need therefore to know how to manage their experimentation as safely as possible. In addition, a small minority of pupils may already be having problems with drugs. Presenting drug use as something with stigma and shame attached to it will discourage them from acknowledging that they may have a problem. Instead they need to be told where they can get help.

Limiting harm in this way is an approach which the Home Office's 'Talk to Frank' campaign, operating largely outside schools, accommodates alongside its more obviously deterrent messages. 'Frank's Tribes', for example, were accompanied on the FRANK website in 2004/5 with the 'Frank Fruit Machine', a feature that implicitly accepted that young people were not only experimenting with drugs but were taking a wide range of different substances on a regular basis. In the feature, a fruit machine brought up different combinations of drugs with a different message attached for each combination. 'Mixing drugs isn't a good idea,' the introduction states:

It makes the effects unpredictable and the risks harder to define. But if you're hell bent on doing it, knowing what's downright stupid before you start could save your life... Give the first drug plenty of time to kick in or wear off before taking another one... *Heroin and LSD*. Psychedelic drugs mess with the effects of heroin making the experience unpredictable and usually unpleasant... *Cocaine and ecstasy*. Doubles the stimulation and puts extra physical strain on your body. Take extra care... *Cocaine and alcohol*... Some people set themselves the rule of only one alcoholic drink per line... *Cocaine and LSD*. No point at all.³³¹

As Northern Ireland's *New Strategic Direction* suggests, general classes should be supplemented with extra support and advice on harm reduction for pupils who are considered to be most obviously at risk of having problems with drug use. They are commonly children who are known to have family problems and are already getting into other kinds of trouble in and out of school: smoking, drinking, truanting and offending. In schools with a particularly large proportion of pupils with or at risk of behavioural problems, these pupils may be being given general support by the BEST teams (Behaviour and Education Support Teams) recommended in the DfES report *Every Child Matters*.³³² As far as drugs education is concerned, the DfES' *Drugs: guidance for schools* recommends that teachers dealing with pupils at risk of exclusion or actually excluded from school should 'focus on harm reduction, involving a range

³³¹ http://web.archive.org/web/20040204021532/www.frankgear.com/ecards/home_flash.html

³³² 'Behaviour and education support teams (BESTs) are multi-agency teams bringing together a complementary mix of professionals from the fields of health, social care and education. The aim of a BEST is to promote emotional well-being, positive behaviour and school attendance, by identifying and supporting those with, or at risk of developing, emotional and behavioural problems.' <http://www.everychildmatters.gov.uk/ete/behaviour/bests/>

of external contributors and highly engaging activities including media, film, music and ICT [information and communications technology]'.³³³

Getting the topics right

Whatever the age of the target group and whether or not it is particularly at risk, school drugs education needs to be focused where there is most 'need to know': on the topics that are surrounded by most curiosity and confusion and the substances that the group in question is most likely to use. Teachers need to know what drugs are available in the local area and be aware of changing fashions and trends. Alcohol and tobacco have to be considered alongside currently illegal drugs, both because they present threats in their own right and because leaving out the substances that adults are known to favour gives a strong impression of hypocrisy and undermines the credibility of warnings against other drugs. Younger children probably need a sharper warning against the use of volatile substances like glues and aerosols than against heroin, which they will find harder to obtain, or ecstasy, which is much less likely to kill them. Powder cocaine is being used by an ever younger group of people and should perhaps be singled out to be deliberately de-glamorized and stripped of its associations with success and celebrity. Negative publicity directed at ecstasy has prompted some people to see cocaine as a relatively clean and reliable alternative. One study suggests that the relationship between powder cocaine and crack cocaine should be made more obvious and that the risks of both should be more heavily stressed.³³⁴

A large proportion of external speakers brought into schools to talk about drugs are former dependent heroin users. This is a form of drugs education that is favoured by parents. These speakers can often provide inspiring examples of courage and determination, but equally often they are talking about a form of drug use that is quite irrelevant to the experience of most of their audience, possibly even beyond its imagination. Presenting the miseries of dependent heroin use may be useful as a long-range warning, but there are threats much closer at hand and it would probably be at least as useful – and more immediately useful – to bring in someone with experience of dance drugs and the problems that they can cause.

Equally, cannabis needs to be the subject of a 'massive' education campaign (as it has been in France), according to the ACMD.³³⁵ Young people are often unaware that there are any physical or mental health risks associated with cannabis of any type or that there are in fact many different types and strengths of cannabis.

³³³ L Bauld et al., *Drug prevention for vulnerable young people. Final report*, Department of Health, 2004.

³³⁴ A Boys et al., "'Rich Man's Speed': a qualitative study of young cocaine users", in *Drugs: education, prevention and policy*, Vol.9, No.2, 2002.

³³⁵ ACMD, *Further consideration of the classification of cannabis under the Misuse of Drugs Act 1971*, Home Office, December 2005.

They are not always clear about whether cannabis is illegal or not (though the confusion is not as widespread as the opponents of its reclassification like to suggest). They are not always aware that it is often adulterated, or that this adulteration may have serious effects. They do not in many cases know that using it could affect their concentration and their sleep and could contribute to anxiety and depression – all problems they may simply accept as part of being an adolescent. According to the Home Office, a ‘widespread’ education campaign on cannabis is under way.³³⁶

Most useful of all, according to drugs treatment workers, might be a general warning against combining drugs, either with each other or with alcohol. It has become common for people to drink alcohol with drugs such as cocaine and often to drink more than they otherwise would. A large and increasing proportion of drug-related deaths involve the simultaneous use of alcohol and illegal drugs. A recent European study concluded:

Environmental strategies that modify the availability of legal drugs and the settings where drugs are consumed have been shown to be more effective in preventing drugs than educative–persuasive measures alone.³³⁷

Young people often take a greater interest in drugs issues when they are not simply presented as health warnings but are set in their economic, social and political context. Drugs issues could be tackled elsewhere in the curriculum, through geography, history, literature and economics and should at the very least be integrated with the other subjects taught under the heading of Personal, Social and Health Education as part of a larger strategy for helping young people to understand and explore their feelings and make better decisions about their health. Finding ways for pupils to discuss these issues outside the classroom setting – in debates or student forums and councils – would allow them to exchange ideas more freely.

Young people also need information on the law and its ramifications – the fact, say, that a recorded drug offence will prevent them from obtaining an American visa later on or from working with children – and they are certainly entitled to know their rights under the law. They should understand how expensive regular drug use can be and the effects that such use can have on their families as well as on the users themselves. They should perhaps learn how drugs are trafficked and by whom, about the links with organized crime and the routes by which drugs reach the pubs and clubs where they are often sold. (One survey established that young people who were relatively indifferent to the illegality of drugs like cocaine were thoroughly deterred

³³⁶ The FRANK campaign has updated its cannabis information resources with new television and radio advertisements and leaflets. The Department of Health will be issuing a toolkit for mental health practitioners on the links between cannabis and mental health.

³³⁷ EMCDDA Annual Report 2006, Selected Issue 3, *Developments in drug use within recreational settings*, 2006, and cf A Paglia and R Room, ‘Preventing substance use problems among youth: a literature review and recommendations’, *Journal of Primary Prevention*, 20 (1), 1999.

by the thought that either the ‘mule’ who brought a consignment into the country or the dealer who brought a ‘deal’ into the club might have carried it in a body cavity.)³³⁸ Pupils often want practical advice on how to help friends who might be experiencing problems with drugs. The more these needs, wants and interests can be taken into account, the more likely drugs education is to engage its audience. Organizations such as the Drug Education Forum and Mentor UK strongly advocate involving young people themselves in the shaping of projects and programmes.³³⁹

³³⁸ Central Office of Information report for the Home Office, ‘The Drugs Supply Chain’, Ref. 255891, 2003.

³³⁹ Drug Education Forum, op.cit. Mentor UK have launched a Youth Involvement Project to help ensure that young people are at the centre of planning and development of drug prevention work.

³⁴⁰ M Shiner, ‘Doing it for themselves: an evaluation of peer approaches to drug prevention’, Drug Prevention Advisory Service Paper 6, 2000.

Getting the style right

All authorities agree that drugs education must be interactive. Children are said to remember 20 per cent of what they read, 30 per cent of what they hear, 40 per cent of what they see, 50 per cent of what they say, 60 per cent of what they do and 90 per cent of what they see, hear, say and do. Young people themselves say they want discussions, not worksheets, and they want to hear from each other rather than listen to lectures. If they are going to be led in a discussion, a ‘peer educator’ – a fellow pupil given training to explore issues with a class – will have advantages in terms of credibility. One study quoted a peer educator as remarking, ‘Our teachers were all hairy old 60s funksters and they didn’t know what they were on about, well they might have ages ago, but drugs are different now.’³⁴⁰

Drugs information outside school – discouraging drug use in the community

Targeting drugs education specifically at young people considered to be at risk of drug problems has some practical difficulties in the school context. How is this targeting to be done without further marking out a group of young people who are already liable to stigma? Are they to be taught at different times or in different places? For other young people – the groups identified by the government as being ‘vulnerable’ – the issue simply does not arise because they are already beyond the reach of school.

In avoiding drug problems, vulnerable young people for the most part have to rely for information and help on any support that is available in the community. This support is supposed to come from religious and community organizations, youth services, Connexions and the other agencies by whom they are likely to be assessed: social services, health services or the criminal justice system. However, at present such support is not delivered particularly systematically, either centrally or locally, and it varies widely in quality from place to place. The current drugs advice on the main Connexions website, for example, is skimpy and

unconvincing.³⁴¹ It states that all drugs are addictive, which many people know to be untrue, and maintains that the main reason for taking them is peer pressure, a claim that many young people resent. It also urges them to ‘just say no’. This slogan, devised in the United States in the 1980s and championed by Nancy Reagan, has subsequently become the butt of much satire and is most unlikely to have the effect intended – except on those who already intend to say no.

It is not only the young people officially classified as vulnerable who need more support and encouragement outside school in avoiding problems with drugs. *Pathways to Problems* points out that it is during the late teens and early twenties that most problematic drug use begins – that is, when people have left school and are beginning further education, training or employment for the first time: ‘The combination of new freedoms, greater stresses, peer pressures and more disposable income may all tip the balance for many in favour of smoking, excessive drinking and use of other drugs.’ At the moment, very few further education or training establishments offer information or take responsibility for discouraging the risky use of drugs or alcohol among their students.

Providing adequate resources

Generally speaking, Drug Action Teams, officially tasked with overseeing the provision of preventive measures in the communities in their regions, cannot afford to give any priority to this provision when their performance is largely measured in terms of the treatment and crime reduction strands of the National Drug Strategy. Very often provision is thin and *ad hoc*, with no strategic approach and no consistent attempt to identify greatest need.³⁴² We believe the current priorities should be changed, not least because successfully discouraging drug use through information and outreach will itself contribute significantly to reducing crime. Public information and support in avoiding harmful drug use for people of all ages need to be far better funded than they are at present. In our view, even within the budget for ‘crime reduction’, more resources should be devoted to forestalling harmful drug use in these kinds of ways and fewer to coercing people into treatment.

With more resources at their disposal, organizations at the local level – government agencies, voluntary bodies or private providers – could devote more time and energy to offering information, advice and support to those most at risk of doing themselves harm. Drugs advice could be made more easily available – in surgeries, treatment agencies, police stations and

³⁴¹ <http://www.connexions-direct.com/index.cfm?pid=110&catalogueContentID=482&render=detailedArticle>

³⁴² See, for example, S Parker, *Mentor UK Coastal and ex-mining areas project: a review of the literature*, Mentor UK, 2006: ‘Although the Norfolk Drug and Alcohol Action Team does have a detailed Young Persons Substance Misuse Plan which focuses primarily on schools based drugs education, it admits that there exists “no strategic approach to the provision of harm minimization messages for young people”’.

prisons – both to those who are already experiencing problems and to those who are not. Leaflets, stickers and posters could be more widely distributed, in the lavatories of clubs, pubs and colleges, in music, video, sports and clothes shops, in supermarkets, job centres and social security offices, on public transport, and above cash machines. Information could be provided in settings where people are most likely to see it and are most likely to take it in without conscious effort: on the back of store discount cards and train tickets and on beer mats and paper napkins in fast food outlets.³⁴³

Tailoring the message

In the view of the a spokesman for the National Youth Agency, youth work's flexibility is what makes it effective where reducing drug-related harm is concerned: 'We can advise people to use clean syringes and give them information, rather than just tell them to stop. You can't take that approach in the school system.'³⁴⁴

Outside school, language and imagery can be more outspoken and geared more directly to the people at whom the messages are aimed. 'The key issue in this process,' according to drugs agency Lifeline, 'is in giving precedence to the views of the target audience over and above the middle-class sensibilities of middle-class professionals.'³⁴⁵ For example, the Lifeline publications for users of 'party' drugs focus on very specific features of these drugs and, by acknowledging that their use exists, are able to highlight the considerable risks associated with them: drug-induced paranoia and the dangers of using depressants to deal with stimulant-induced anxiety and heatstroke. Similarly, Lifeline's publications aimed at young people leaving care and at young male sex workers 'are designed as messages that are perceived to come from within the various drugs subcultures. The stories we tell reflect the reality and morality that we find within those cultures.' Lifeline's leaflets are graphic and uncompromising enough to have prompted questions in Parliament; but they take the most basic and essential public health information to people who are unlikely to come across it in any other way, in a form that is credible to them. We support Lifeline's efforts.

Personal contact is even more likely to have an impact. Helplines that stay open all night and drop-in centres offering privacy and a chance to talk are highly valued where they exist. In Edinburgh, for example, just off the Royal Mile, community group Crew 2000 provides information and advice on drugs and sexual health. Crew 2000 also sends teams of volunteers, many of whom have used drugs themselves, into clubs, raves and festivals to target people who use dance drugs, to provide basic health information

³⁴³ The Metropolitan Police campaign 'Don't let drug dealers change the face of your neighbourhood' used beer mats with images of the drastic physical decline of three female drug users.

³⁴⁴ Young People Now, 'Substance misuse: drugs advice – the do's and don't's', www.ypnmagazine.com/news/index.cfm?fuseaction=full_news&ID=13038

³⁴⁵ Mark Gilman, 'Smack in the Eye, Peanut Pete, and the New Puritans', *Lifeline*.

about these drugs, alert them to risks posed by specific drugs that are currently circulating (the content of particular brands of ecstasy tablet, for example) and to offer a crisis intervention service for people who are experiencing ‘negative psychological states’. There is a need for more outreach workers to take the same kind of basic health information and support to the most problematic drug users on the streets, but so far adequate funds to provide the levels of training and back-up that are essential have not been forthcoming.

Despite its dominant rhetoric of abstinence, the Home Office has shown itself willing, where the target audience is not explicitly school children, to put across the harm reduction message, most notably in its publication on *Safer Clubbing*, which contained sound advice on minimizing the potential damage done by dance drugs, by keeping hydrated and avoiding over-heating. Mass media campaigns, too, can afford to be more nuanced and must be if they are to reach a youth audience that is becoming increasingly sophisticated in its consumption of media messages. ‘Terror’ campaigns may deter people who are already half inclined to shy away from drugs (or those who have already begun to experience the symptoms being described) but they can leave the rest of the target audience incredulous and unmoved.

Many practitioners are convinced that close-range campaigns with a specific harm reduction message – safer clubbing, avoiding driving under the influence, the risks of heroin or methadone over-dose after leaving prison – are more likely to have a positive effect than highly visible general-deterrence campaigns like the largely unsuccessful ‘Sorted’ posters that featured photographs of Leah Betts as she was dying. Information presented neutrally and in a less alarmist form stands a better chance of convincing an audience that is naturally inclined to be cynical. Dramatizing the evils of something generically labelled ‘Skunk’, or exaggerating the closeness of the link between cannabis and schizophrenia, is less constructive than publicizing the fact that it is possible to become dependent on cannabis and that an increasing number of people are seeking treatment for problems with cannabis. The current FRANK campaign acknowledges the limitations of alarmism by focusing on the less serious but still inconvenient side effects of smoking cannabis, such as the risk of being sick or finding it hard to concentrate.

It is hard to tell precisely how much impact mass campaigns have. There has been no outcome evaluation, for example, of the ‘Talk to Frank’ campaign, which has cost nearly £15 million since 2003. However, according to research carried out for the Department of

Health, ‘mass media advertising campaigns ... may be a particularly appropriate route for reaching vulnerable young people and socially excluded communities – groups who may not respond well to more formal drugs education.’ These groups are also relatively heavy consumers of television, which is often cited by young people as a primary source of information about drugs. Soaps, ‘reality’ and chat shows are watched especially frequently and should almost certainly be used in a more systematic and intelligent way to increase knowledge and awareness of drug use and its associated risks.³⁴⁶

However, there may be even more scope for effectively increasing knowledge and awareness at the local level, where newspapers are not engaged in circulation wars and because general issues have far more meaning when they are presented in terms of places and even individual people whom the target audience will recognize. Local papers and local radio stations are more likely than the national media to have space to discuss practical small-scale solutions to drug-related problems, and they are also more likely to be willing to promote positive messages about community successes in tackling drugs. Moreover, they may be willing to prod into action local service providers such as housing agencies, medical practices and employers, and they can stimulate and support local community efforts.

It may also be possible in the local context to reframe drug use as a structural problem in society rather than a problem of morality and individual ignorance and weakness. Social problems require social solutions. Prompted to propose ways of keeping young people from drug use, the UK Youth Parliament, composed of young people between 11 and 19, immediately suggested giving them better things to do: opening local facilities at times chosen to be convenient to young people instead of the staff operating them, meanwhile subsidizing transport so that young people can afford to take advantage of such facilities.³⁴⁷ Finding ways of keeping young people in school, getting school leavers into employment and homeless young people out of hostels and into affordable housing all count as drugs prevention and are arguably the best of all methods of demand reduction. In the words of Mentor UK, ‘Drug prevention is not just about drugs... it is about promoting opportunities.’³⁴⁸

The same may, of course, be said of the other principal route to reducing the demand for drugs. Drugs treatment, too, is not ‘just about drugs’ but also about addressing the pressures and problems in people’s lives that lead them to use drugs in damaging ways. It is to drugs treatment and the other means of supporting people in freeing themselves from harmful drug use that we now turn.

³⁴⁶ M Stead et al., ‘Desk research to inform the development of communications to reduce drug use and drug related harm in socially excluded communities’, prepared for Central Office of Information Communications on behalf of the Department of Health, 2002.

³⁴⁷ Memorandum submitted by the UK Youth Parliament to House of Commons Home Affairs Select Committee, October 2001.

³⁴⁸ *Mentor UK Review 2005/6*.
http://www.mentorfoundation.org/uploads/UK_Review_2006.pdf?PHPSESSID=889163633d0ae8cb8ec2085f923c6555

12 Reducing the demand for drugs: treatment and support

‘Treatment’ is too narrow a term to denote the wide range of services that are required by people experiencing problems with drugs. The word has a clinical air and suggests that these services are limited to medical provision. In fact, problematic drug users often have a wide variety of problems – with money, unemployment, relationships, housing – all of which need addressing alongside any physical or mental health issues. Much of the medical and psychotherapeutic help that is provided through the treatment system may be wasted if the other kinds of support are not provided.

Our examination of treatment begins with the medical and psychotherapeutic help that is provided through the treatment system but moves on to deal with the need for what are referred to as ‘wraparound’ services: accommodation, employment, support with child care and other assistance with reintegration into society. The term ‘wraparound’ is, however, misleading, with its suggestion that medical help is the crucial core of treatment and other forms of support merely peripheral. For some drug users, it is the ‘wraparound’ services that are indispensable to stabilization and recovery. In our view, what is needed is a public health approach to drug misuse that gives due consideration to its social, environmental, economic and cultural determinants. Underpinning this kind of approach is the recognition that effective drugs treatment often requires a service that is not just multi-disciplinary but multi-sectoral. It must involve not only doctors and psychologists but also social workers and housing officers. It is rooted not only in the statutory health services of the NHS but also in the work of non-government organizations and of local authorities.

This chapter, which focuses primarily on clinical treatment, deals with current provision and with weaknesses in the current system. The next chapter will suggest how the provision of treatment, based on a public health approach, could be improved.

Clinical treatment for drug misuse may involve dealing with a number of health conditions. These include dealing with the clinical problem of addiction itself, dealing with the clinical consequences of drug misuse (such as communicable infections including hepatitis and HIV) and dealing with the presence of co-morbidities such as mental illness or diabetes that are associated with and/or accentuated by drug misuse.

This chapter mainly discusses clinical treatment for addiction: in other words, the forms of treatment available for helping people to stop or stabilize longstanding drug misuse.

Treating addiction

The treatment of drug addiction incorporates a range of clinical outcomes. In some instances, the desired and attainable clinical outcome is abstinence: the person manages to ‘kick the habit’ and resume a drug-free life. In other instances, it is necessary to treat drug addiction as a chronic-relapsing condition that will involve frequent and regular relapses after periods of abstinence.

It may require long-term substitution treatment, whereby patients are put on a prescribed substance that is less harmful than the original addictive drug: nicotine patches instead of cigarettes, for example, or methadone instead of heroin.

Achieving abstinence from some drugs involves a process of detoxification (detox). This entails reducing the amount of a drug that is present in the body until the user is drug-free and free from the physical and psychological symptoms of withdrawal. Detoxification may be carried out quickly and abruptly, but it is more usually carried out over a few weeks or, in some cases, a few months. It may be done in hospital, in dedicated detox units in the community or at home with support.

Sometimes substitution treatment acts as a stepping stone towards full abstinence. For example, some people may be on substitution treatment for several years, during which time they are able to reorganise and redirect their lives to the point where they are able to achieve abstinence. For other people, substitution treatment may be an integral part of their achieving abstinence at the outset. Substitute prescribing for heroin may be done, for example, on a reducing basis, with doses of methadone growing gradually smaller until the user experiences no withdrawal symptoms and is technically drug-free.

Where abstinence is not a readily attainable clinical outcome, the key is to provide treatment that minimises harm. The failure to achieve abstinence does not immediately imply that treatment has been ineffective. The failure to minimise harm invariably does.

Broadly speaking, there are two categories of treatment for drug addiction: pharmacological and psychological.

Pharmacological treatments

These treatments include substitution drugs such as methadone and buprenorphine, drugs used to treat overdoses, such as

naltrexone, and drugs used to assist with detoxification. Under this heading should also be included prescriptions for drugs of use rather than substitution: for example, the prescribing of diamorphine, or medical heroin, if clinically determined, which we discuss at greater length below.

Psychological therapies

These therapies are used in support of pharmacological treatments, or where no pharmacological treatments exist. They can help to generate the psychological resources and capacities to resist addiction, prevent relapses and assist addicts to make positive life-choices. They can also help to address co-existing disorders such as depression, anxiety and personality disorder (although pharmacological treatments may also be used to treat co-existing mental illness). There is a wide range of different psychological therapies which include cognitive behavioural interventions (such as cognitive behavioural therapy or CBT), motivational enhancement therapy (MET) and other brief intervention counselling approaches.³⁴⁹ Some drugs treatment programmes, such as the Twelve-Step system, invoke religious motivation or strength sought from a ‘higher power’ outside the individuals themselves as a means of fighting addiction, and hold to a ‘disease model’ of such addiction. Positive psychological effects can also be produced by more basic advice and support in the form of individual or group counselling. This advice and support can incorporate advice about safer drug use and better sexual health and can provide practical help with housing, employment, benefit payments and social care. Self-help groups can also play an important role.

How treatment is provided

These types of treatment may be offered on an out-patient basis in the community by community-based drugs services, GPs or even pharmacists. They may also be provided on an in-patient basis in hospitals or residential rehabilitation facilities.

The treatment system is currently categorized according to four separate tiers as described in the National Treatment Agency document *Models of Care for Drug Misuse Treatment*:

Tier 1: Drug-related information and advice, screening and referral by generic services (i.e. not specialist drugs services).

Staff in, for example, schools, police stations, youth services, Accident and Emergency units and ante-natal wards may offer advice, screen people for drug use, make a preliminary assessment of their need for treatment and refer them to specialist services.

³⁴⁹ According to the Royal College of Psychiatrists, cognitive behavioural therapy is a way of talking about how you think about yourself, the world and other people, and how what you do affects your thoughts and feelings. It can help you to change how you think (“cognitive”) and what you do (“behaviour”).

<http://www.rcpsych.ac.uk/mentalhealthinformation/therapies/cognitivebehaviouraltherapy.aspx>

According to NHS Education for Scotland, Motivational Enhancement Therapy seeks to evoke from patients their own motivation for change. The aim of MET is to help people realise they have a problem, to develop intrinsic motivation and to encourage changes in behaviour.

<http://www.nes.scot.nhs.uk/courses/profile1.asp?courseno=306>

‘Brief interventions’, according to the World Health Organization, can range from 5 minutes of brief advice to 15-30 minutes of brief counselling. Their aim is to help the patient understand that their drug use is putting them at risk and to encourage them to reduce or give it up. They are obviously more suited to problematic or risky drug use than to serious dependence. World Health Organization, *Brief intervention for substance use: a manual for use in primary care*, draft version, 2003.

Tier 2: Open access, non-care-planned drug-specific interventions.

These low-threshold services, provided by drug workers, health workers and sometimes by peers, do not require significant behaviour change but meet some simple needs in ways that are cost-effective and easy to access: needle exchange, drop-in advice and information, brief therapeutic interventions, outreach (street work or home visits) and after-care after leaving prison or more intensive treatment programmes.

Tier 3: Structured care-planned treatment in the community.

These services include detoxification, substitute prescribing, psychological therapies, relapse prevention and interventions for drug-using offenders, and generally involve planning and case management over a period of time by specialist drugs agencies.

Tier 4: Drug specialist inpatient treatment and residential rehabilitation.

Tier 4 services involve residential care and after-care: specialist detoxification, crisis intervention and residential rehabilitation and supported housing or halfway-house accommodation. These services may be provided either in hospital or in community-based rehabilitation centres. Inpatient provision in hospital is often in general psychiatric wards, but there is evidence that it has better outcomes in specialist drug and alcohol wards and the *Models of Care* advise that psychiatric wards may only be suitable for drug users who have also been diagnosed as having a severe mental illness.³⁵⁰

Residential rehabilitation

A broad range of differing interventions is offered under the general heading of 'residential rehabilitation'. Its main purpose is to remove drug users from the environment in which they are using drugs and to integrate in a single setting all the different services that they need: talking therapies and counselling, experience of communal living, help with living skills, housing and resettlement. Rehabilitation programmes can last from six weeks to more than a year.

Different providers offer various different types of programme. For example, therapeutic communities are small cohesive communities in which residents have a significant involvement in decision-making and the practicalities of running the unit as well as engaging in both group and individual therapy. Based on ideas of collective responsibility, citizenship and empowerment, therapeutic communities are deliberately structured in a way that encourages personal responsibility and avoids unhelpful dependency on professionals.³⁵¹ To take another example, Minnesota model programmes, associated with the Alcoholics/

³⁵⁰ NTA, 'Commissioning a four-tier framework for drug and alcohol treatment services' in *Models of care for drug misuse treatment. Part 1*.

³⁵¹ 'In the USA, the term "therapeutic community" is more often used to describe user-run communities for substance misusers with: a hierarchical structure; a reward system; fierce encounter groups; and a simple explanatory model of addiction and its treatment. These are referred to as "concept" or "behavioural" therapeutic communities, as opposed to "democratic" therapeutic communities.' P. Campling, 'Therapeutic communities', *Advances in Psychiatric Treatment*, 7, 2001.

Narcotics Anonymous 12-step programme, aim for long term abstinence and include spiritual as well as practical guidance.³⁵² Again, Christian house programmes are usually run by Christian staff with or without any required Christian structure.

³⁵² The Minnesota Model is an abstinence orientated approach to the treatment of the addictions, offering group therapy, lectures, and counselling based upon a pattern developed in Minnesota, in the United States, during the late 1940s and the 1950s.

The use of the word ‘tier’ is misleading in the sense that it suggests a hierarchy of treatments. Drug users do not necessarily proceed through the four ‘tiers’ in ascending order. Some users will need services only from the first tiers. Others may be taking services from more than one tier at once and more than one agency at once. Many people with severe drug-related problems will have a range of other conditions such as hepatitis, HIV and liver disease that require treatment from services and providers that fall outside the four tiers described above.

Those who need both continuing care and specialist advice are often best served by ‘shared care’ schemes in which generalist GPs collaborate in treatment with other practitioners with more specialized knowledge: psychiatrists, drugs workers, drugs liaison nurses and accredited GPSIs (that is, General Practitioners with Special Interest) in drugs treatment. The expectation is that everyone throughout the country should have access to the full range of services and that these services are integrated and properly coordinated.

How people arrive at treatment

It is perhaps worth making the preliminary point that many people do not arrive at treatment at all. In some of the most deprived areas of Britain there is no ‘full range of drugs services’ and little infrastructure with which these services could be integrated if they did exist. The ‘gap’ is not simply a gap in the capacity of present services to meet demand, it is a total lack of services.

Where treatment services do exist, people approach them by many different routes. Some will be referred by schools and youth services; others will have come through their GPs or from hospital emergency units. Rather more will have made their first contact through Community Drug Teams and other drugs services run by local authorities or NHS trusts or by voluntary organizations. There is a burgeoning private sector in the field of drugs and alcohol treatment for those able to pay for it themselves.

In addition, as we have already indicated, many people are channelled into treatment through the criminal justice system. Superimposed on the four-tier structure and increasingly

interacting with it (and shaping it, or, in the eyes of critics, mis-shaping it) is the Drug Interventions Programme (DIP) for drug-using offenders. The National Treatment Outcome Research Study (NTORS) revealed that in 1995 the average problematic drug user waited nine years before seeking treatment, ‘problematic’ in this context meaning users who were both damaging their health and also committing crimes to finance their habit.³⁵³ One of the principal aims of the National Drug Strategy was explicitly to get such people into treatment more quickly.³⁵⁴ The Drug Interventions Programme, discussed at p.97 above, provides opportunities for channelling offenders into treatment at several different stages in the criminal justice process:

- on arrest and charge, through drug testing, assessment and referral for treatment;
- on sentencing, through the provision of drugs treatment as an alternative to custody;
- in prison, through treatment during a sentence; and
- as part of aftercare once offenders have been released from prison or have completed community sentences.

The use of the criminal justice system as a conduit into drugs treatment has been evolving over the past three decades. Organisations such as Cranstoun, RAPt (the Rehabilitation of Addicted Prisoners Trust) and Turning Point have been working in the criminal justice system since the 1980s or early 1990s, providing arrest referral services and working directly with prisoners on remand, during their sentences and after their release. However, interventions through the criminal justice system accelerated and expanded considerably with the introduction of the National Drug Strategy, with the following key stages:

1998: the introduction of the Drug Treatment and Testing Order (DTTO), a high-tariff community penalty available to the courts as an alternative to custody for the most prolific drug-using offenders. The order, managed by probation services, requires the offender to attend 15–20 hours of drugs treatment each week for a period of between six months and three years, with regular mandatory testing and monthly reviews by the court. The offender has to consent to the DTTO, which can last longer than the alternative custodial sentence and aims at total abstinence.³⁵⁵

1999: the launch of a national arrest referral initiative, proposing a model of practice for existing arrest referral schemes to follow. Arrest referral workers seek to identify problem drug users around the time of their arrest, in police custody suites or at court and then to offer them referral

³⁵³ The National Treatment Outcome Research Study, a major study of drugs treatment, carried out by the National Addiction Centre in England and Wales between 1995 and 2000, followed up a sample of 1100 clients of various types of drugs treatment – specialist inpatient treatment, residential rehabilitation, methadone maintenance and methadone reduction.

³⁵⁴ *The Government Reply to the Third Report from the Home Affairs Committee, Session 2001–2002 HC 318: The Government's Drugs Policy: Is it working?*, July 2002.

³⁵⁵ DTTOs were superseded in 2004, after the Criminal Justice Act of 2003 replaced the various kinds of community sentence for adults with a single community order to which a range of possible requirements can be attached; Drug Rehabilitation Requirements can now require offenders to be treated and tested for drugs. As the maximum length of a DTTO is three years, there are still substantial numbers of people on orders that were made in 2004. DTTOs are still available in Scotland.

to treatment. These referrals are voluntary and treatment is not an alternative to prison. The scheme still continues and is currently being extended in Scotland.

³⁵⁶ Originally the Criminal Justice Interventions Programme.

³⁵⁷ See, for example, the Turning Point report *Routes into Treatment: Drugs and Crime* (2004).

2001: the introduction of drug testing on charge in England and Wales. The Criminal Justice and Court Services Act 2000 enabled the use of drug testing (for specified Class A drugs) for people aged 18 and over charged with trigger offences including property crime, robbery and specified Class A drug offences. The scheme began pilots in 2001.

2001: the establishment of the first dedicated drug court in Glasgow.

2003: the launch of the Drug Interventions Programme. While drug testing on charge was still being piloted, the Home Office launched the Drug Interventions Programme, initially as a three-year initiative.³⁵⁶

2005: the introduction of drug testing on arrest. Under the Drugs Act 2005, police are now allowed to test people on their arrest for ‘trigger’ offences, before any charge has been brought. Those who test positive are required to attend a compulsory assessment by specialist drug workers to determine the extent of their drug problem and to help them into treatment, even if they are not subsequently charged for the original offence. Those who fail to provide a sample or comply with a required assessment face a fine of up to £2,500 and/or up to three months in prison. For those who are subsequently charged for the original offence, the court may restrict bail if they refuse an assessment and treatment. Similar legislation has been enacted by the Scottish Parliament in the Police, Public Order and Criminal Justice (Scotland) Act 2006.

The increased spending on drugs treatment that has taken place over the past few years has therefore been accompanied by a consistent trend towards more coercive forms of treatment linked to the criminal justice response to drug-using offenders. Some observers feel that this is creating an imbalance between criminal-justice-based treatment services and community services for non-offenders.³⁵⁷

Does treatment work?

‘Treatment works’. Effective treatment not only reduces illness and the likelihood of premature death for problematic drug users, it can also diminish the suffering of their families and friends and

lessen the damage done to their communities by drug-related crime and violence.

There is mounting evidence to support the general thrust of government policy towards increasing spending on treatment. For example, the National Treatment Outcome Research Study found in 2001 that different types of treatment – hospital, rehabilitation and community-based services – could all be seen to have reduced drug misuse.³⁵⁸ A more recent analysis suggests, on the basis of the NTORS study, that for every £1 spent on treatment, £9.50 is saved in health and crime costs.³⁵⁹

However, treatment services that are poorly provided may have little effect. Increasing spending on poor services will not necessarily improve either outcomes or cost-effectiveness. ‘More treatment’ does not always mean ‘good outcomes’, because drugs treatment is complex. As we have already argued, drugs treatment often requires a multi-disciplinary service and a multi-sectoral approach. It can require a mix of physical and psychological treatments. It always needs to be tailored carefully to the specific social, cultural, legal and economic circumstances of the individual patient.

It is therefore essential to look beyond the number of patients treated, the volume of services provided and the size of drugs treatment expenditure to focus on the quality of treatment and its long-term impact on outcomes.

The weaknesses of the existing system

There is now a national framework for drugs treatment whereas before provision was patchy and variable, and the framework is supported by unified guidance on the best methods of commissioning and providing treatment. A National Drug Treatment Monitoring System provides some means of estimating how many people are going into treatment and how long they are remaining there. The number of drug users being treated has increased significantly, not least through the influx of people from the criminal justice system. (The number of offenders on Drug Treatment and Testing Orders or Drug Rehabilitation Requirements had risen, from 4842 in 2001/2 to 14,002 by the end of 2005/6.)³⁶⁰ A 2004 survey of drug users in treatment found that in general they felt services had noticeably improved, with a wider range of treatment on offer and shorter waiting times.³⁶¹

However, the National Treatment Agency’s own Business Plan for 2006/07 stated that ‘there continues to be significant unmet

³⁵⁸ M Gossop, J Marsden and D Stewart, *NTORS At One Year: The National Treatment Outcome Research Study – Changes in Substance Use, Health and Criminal Behaviour One Year after Intake*, Department of Health, 1998. <http://www.dh.gov.uk/assetRoot/04/07/67/46/04076746.pdf> The Scottish equivalent of NTORS, entitled Drug Outcome Research In Scotland or DORIS, has arrived at much the same conclusion for illegal drugs, though it has not established that treatment has the same effect on alcohol consumption.

³⁵⁹ C Godfrey, D Stewart, M Gossop, *Economic analysis of costs and consequences of the treatment of drug misuse: 2 year outcome data from the National Treatment Outcome Research Study*, 2004.

³⁶⁰ National Offender Management Service, *Half Full and Half Empty: an inspection of the National Probation Service’s substance misuse work with offenders*, thematic report, 2006.

³⁶¹ EATA (European Association for the Treatment of Addiction), *Service users’ views of drug treatment: research conducted for the Audit Commission*, June 2004.

need for treatment in most parts of the country'. The NTA carried out pilot studies with the Prime Minister's Delivery Unit into the extent of 'treatment penetration' in 2005 and concluded that 'significant segments of the problem drug-using population [are] not in current contact with treatment services.' There are considerably larger numbers of other drug users who may not fall under the authorities' definition of 'problematic' but could still be helped by treatment. A recent study observes:

There is an enormous gap between those receiving treatment and those needing it or who would benefit from treatment were it available. The size of that gap is difficult to determine but it probably understates demand by a factor of 10.³⁶²

What is more, within the treatment that is offered there is much that could be improved. Broadly speaking, there are three principal weaknesses in the present system of drugs treatment provision:

- 1 the prominence given to referrals from the criminal justice system;
- 2 shortcomings in the treatment offered to non-offenders; and
- 3 the failure to supplement treatment for both offenders and non-offenders with other kinds of support.

1 The prominence given to referrals from the criminal justice system

The overriding priority in the national treatment strategy in England and Wales at present is to get 750 drug-using offenders into treatment per week. This priority is spelt out in the National Treatment Agency's response to a shortfall in the money promised to Drug Action Teams (DATs) in 2006/7. The Pooled Treatment Budget for that year was £385 million. Although this is a substantial advance on the kind of money that was available in 2001, and although it represented an increase of 28-30 per cent on the previous year, DATs had been led to expect an increase of 42 per cent and had budgeted accordingly. The National Treatment Agency acknowledged that the reduced grants meant they would have to think again. Some DATs, the Agency argued, would be able to deliver what they had planned by being more economical, others would have to abandon plans to extend their services, and a small proportion would have to cut everything except the 'priorities'. The most important of these priorities, it was made clear, is treating offenders:

The funding available will be sufficient to ensure sufficient treatment capacity is available for class A drug-misusing offenders, to enable the Home Office to meet its national commitment for 750 offenders to enter treatment each week during 2006/7 while also ensuring that a similar number of service users from non-criminal justice routes can also access treatment.³⁶³

³⁶² P Bean and T Nemitz, 'Drug treatment: what works? An overview', in ed. Bean and Nemitz, *Drug treatment: what works?* (Routledge), 2004.

³⁶³ National Treatment Agency, *Business Plan 2006/7*, 2006.

Treatment for non-offenders is also cited as a target; but while one target is primary, precise and measurable – 750 offenders enter treatment *per week* – the other is secondary and vague – a *similar* number can access treatment during a period of time that is left unspecified.

³⁶⁴ Ibid.

According to the National Treatment Agency, the heavy emphasis on treating offenders is the price that has been paid for the increased resources poured into the drug strategy in recent years. The Agency feels it must continue to be paid:

Maintaining current levels of funding of the drug treatment system during the next spending review period, and any future expansion, depends on continued delivery of the criminal justice agenda.³⁶⁴

There are, however, weighty arguments against persisting with the emphasis being placed on drugs treatment as a means of crime reduction rather than as a health measure:

Demonisation

To characterise drug use as first and foremost a crime issue is to perpetuate the demonization of drug users as criminals and social outcasts.

Inequity

It is unjust to give drug users who have committed an offence faster access to treatment than those who have committed no offence.

Perversity

Currently the National Treatment Agency's declared objective for 'ordinary' users seeking substitute prescribing through the NHS is a waiting time of less than three weeks and this is not always achieved. The Drug Interventions Programme, in contrast, is expected to give offenders substitute medication within five working days. Preventing non-offending drug users from being able to access treatment quickly and effectively runs the risk of them developing more severe addiction and being obliged to commit crimes in order to finance their habit. In this way an over-emphasis on existing offenders could unintentionally encourage an increase in new offenders.

In addition, giving priority to offenders creates a rather straightforward incentive to offend. In a survey conducted by Turning Point in 2004, 30 per cent of the respondents said they had committed crime to gain access to drugs treatment and 41 per cent had considered it. This was most prevalent

in non-urban areas where the treatment infrastructure is less well developed.³⁶⁵

Waste

The Drug Interventions Programme is almost certainly putting into treatment a substantial number of individuals who, so far as their health is concerned, actually need treatment less than many drug users who have not been caught up in the criminal justice system. The criminal justice route into treatment is founded on drug tests that cannot discriminate between occasional drug use and dependent drug use. The presumption is that an offender testing positive has committed the crime ‘because of’ his drug use – to fund it, or as a result of intoxication – but there will be many cases where the two are not actually related. The offender may be an occasional recreational drug user who, on the occasion of this particular crime, happened to have taken drugs and neither wants nor needs treatment. To push such people into treatment is a waste of money and the time of skilled professionals.

Ineffectiveness

Coerced treatment may not be effective, though there is a good deal of disagreement on this issue. Some authorities argue that most drug users enter treatment under compulsion of some sort – from family, friends, teachers or employers – and that therefore legal coercion is not so different in kind as to be likely to have vastly different outcomes. Some studies would seem to support this argument: they show similar treatment outcomes for people who have been coerced into treatment by the courts and for people who have approached treatment services voluntarily. Many drug practitioners, however, believe that successful treatment depends on internal motivation and that forcing into treatment people who have not thought about it and are not ready for it can at best produce short-term results. A recent longitudinal survey of over 26,000 drug-using offenders in Cheshire and Merseyside suggests that increasing the numbers of people in treatment by using the criminal justice system as a fast track has had the effect of speeding up a revolving door into and also out of treatment.³⁶⁶ More people are going into the system, but more people are also dropping out of it early, and a smaller proportion are being discharged from it drug-free. More to the point, the rate of drop-out is higher among those who have entered treatment by way of the criminal justice system than among those who have entered voluntarily.

Problems in implementation

There are also various practical problems with the working of the Drug Interventions Programme. For it to run as intended,

³⁶⁵ Turning Point, *Routes into Treatment*, op.cit.

³⁶⁶ C Beynon, M Bellis and J McVeigh, ‘Trends in drop out, drug free discharge and rates of re-presentation: a retrospective cohort study of drug treatment clients in the North West of England’, *BMC Public Health* 2006, 6:205, 2006. <http://www.biomedcentral.com/1471-2458/6/205> The Cheshire and Merseyside area has consistently collected treatment outcome data on all clients of drugs services annually since 1996, so it provides an excellent opportunity to evaluate treatment outcomes during a period of major changes in drugs services.

drug-using offenders have to be assessed correctly as suitable for treatment, sentencers have to understand the benefits of treatment, treatment facilities have to be available, the treatment programme has to be adequately supervised by drugs workers and probation officers, and breaches of treatment orders have to be handled intelligently.

At present, individuals are being proposed by drugs workers and probation officers for Drug Treatment and Testing Orders (DTTOs) or Drug Rehabilitation Requirements when these individuals have little realistic chance of sticking to them: where, for example, they have co-existing mental illnesses or problems with child care that make regular attendance for drug testing and treatment very difficult, or where they simply lack the motivation to stay off drugs.³⁶⁷ Individuals are put up for DTTOs when they would not otherwise have received a custodial sentence. If they breach the order, they may be liable to imprisonment, in which case they will be punished more severely than they would have been for their original offence.

On the other hand, DTTOs are sometimes not given to people who might have benefited from them because some judges have a generalized suspicion of community sentences as 'soft', even though more than one former Lord Chief Justice has pointed out that such sentences should be seen as giving offenders a chance to address their offending behaviour, something that is tackled more successfully outside prison than in it.³⁶⁸

Lack of resources

Sometimes courts have wanted to give DTTOs or Drug Rehabilitation Requirements but have been unable to do so because the necessary treatment facilities have not been available. Probation officers suggest that this failure results from a failure by Drug Action Teams to commission the right services: the right mix of high- and low-intensity treatment, for example, or simply an adequate range of facilities.³⁶⁹

In addition, probation services simply cannot cope with the increased volume of drug users receiving community sentences that require supervision. Former Chief Justice Lord Woolf has observed that the probation services as presently resourced cannot cope with community sentencing in general, and he warns that 'community punishments will be shunned by judges and rejected by the public if they cannot rely on that supervision [by probation officers] taking place.'³⁷⁰ Community sentencing as an alternative to imprisonment for drug users therefore risks failing to produce better outcomes in terms of their treatment and rehabilitation,

³⁶⁷ Sentencing Guidelines for England and Wales state that for a DTTO to be made, there 'must be clear evidence that the offender is determined to free himself or herself from drugs.' Sentencing Guidelines Council, *Guidance Judgments Case Compendium*, AG's Ref. No. 64 of 2003 (Boujettif and Harrison) [2004] 2 Cr.App. R. (S) 22.

³⁶⁸ See, for example, Lord Woolf, 'Making sense of sentencing', The Sir Leon Radinowicz Lecture, 12 May 2005.

³⁶⁹ 'The ability of probation areas to ensure that DAATs provided the necessary range of drug treatment services varied considerably and was largely determined by pre-existing treatment provision.' HM Inspectorate of Probation, *Half Full and Half Empty: an inspection of the National Probation Service's substance misuse work with offenders*, Home Office 2006.

³⁷⁰ Lord Woolf, 'A new approach to sentencing', 9 April 2003. It is for this reason among others that Lord Coulsfield has argued for far more attention to be paid to the 'intermediate estate' – probation services, hostels, attendance centres and so on. Coulsfield Report, *Crime, Courts and Confidence: report of an independent inquiry into alternatives to prison*, Esmee Fairbairn Foundation, 2004.

not because the policy is wrong but because it is not being implemented effectively.

Clash of cultures

On top of all this, those imposing treatment orders and those responsible for supervising and implementing them often have different attitudes to their purpose and consequently disagree about what is to be done in the event they are breached. Drugs workers and probation officers recognise drug dependence as a relapsing condition and may be satisfied with some improvement in the drug user's behaviour even though it stops short of total abstinence. They may therefore be reluctant to punish breaches of an order, particularly if that may mean that the drug user goes to prison. The Sentencing Guidelines Council is inclined to agree: 'No-one should expect 100 per cent success rate and some lapse is often a feature of an order which turns out to be substantially successful.'³⁷¹ Some judges, magistrates and police officers, however, feel that, unless breaches are strictly punished, treatment orders become a 'soft option'. Some police officers even suggest that breaches should be arrestable offences, taking the discretion for enforcing orders away from the probation services and giving it to the police.

Inadequate prison treatment

The inadequacy of drugs treatment in prisons is a serious gap in the chain of treatment for offenders envisaged by the Drug Interventions Programme, a gap that is so serious that it will be discussed below at pp.164–166.

Unsustainability and downgrading of treatment

As far back as 2001, the national charity Turning Point warned: 'The growth in the numbers of people identified as suitable for treatment through the criminal justice system is not matched by an increase in available provision. This needs to be addressed urgently.'³⁷² The charity's warning coincided with the introduction of drug testing on charge but preceded testing on arrest, which obviously brings much larger numbers of offenders into the scheme. If the Drug Interventions Programme pushes too many people into the treatment system, the budget allocated to the drug strategy will probably turn out to be inadequate, even if current levels of funding are maintained. Already the police and drugs services are complaining that there are too few drugs workers available to carry out the required assessments of offenders who test positive for drug misuse and too few spaces in which the assessments can take place.³⁷³ Without a more discriminating approach capable of targeting those offenders who are most in need of treatment and most likely to benefit from it,

³⁷¹ Sentencing Guidelines Council, *Guidance Judgments Case Compendium*, 'Generic Sentencing Principles: Sentences/Ancillary Orders: Drug Treatment and Testing Orders (DTTOs)', R v Woods and Collins [2005] EWCA Crim 2065.

³⁷² Turning Point, Memorandum 67 to House of Commons Home Affairs Select Committee, September 2001.

³⁷³ Experience of the DIP is revealing that offenders who have tested positive for drugs are less likely to turn up at their mandatory Required Assessments if these assessments do not take place while they are still in custody. It is hard to ensure that assessments do take place in custody as smaller police stations do not have large enough custody suites, nor can they have drugs workers constantly on call to make sure that assessments take place within the detention period authorised by the Police and Criminal Evidence Act. If offenders fail to turn up at their assessments, they have committed an offence punishable by imprisonment, which rather detracts from the objective of steering drug users out of prison and into treatment.

resources may be spread so thin as to make the treatment system generally ineffective.

The National Treatment Agency and the Audit Commission are currently analysing data on the unit costs of different types of treatment 'to identify efficiencies and priorities' in the light of 'the lower than anticipated growth in central funding'.³⁷⁴ There is obviously a risk that treatment in general, not just for offenders, may be watered down, with quality and effectiveness of treatment becoming secondary to the issue of cost.

Broader public policy reforms that may result in the commodification, pricing and marketization of all treatment may even lead to a situation in which each drug user may be allotted a limited ration of treatment.³⁷⁵ While accurate costing studies of treatment can be a useful tool for exposing inefficiencies, it is harder to construct tariffs for treatment of conditions like drug dependence that are chronic and relapsing and that are heavily dependent on contextual factors.

In general, if the custom of giving priority treatment to users who have committed other offences over those who have not becomes entrenched, there is a real risk that the state may become unwilling to pay for drugs treatment *except* as a means of reducing crime. If this happens, we could see three groups of drug users emerge: one group who can afford to pay privately for treatment if they need it (and whom, it could be argued, are less likely to be the most problematic users); a second group who are coerced into treatment by the state because they have committed a crime that is considered to be related to their drug use (many but not all of whom will be problematic users); and thirdly, a treatment 'under-class' of drug users who have either committed a crime without being picked up for it or have not committed an acquisitive crime but do not have the money to pay for private treatment. This under-class, a large proportion of whom are likely to be problematic users, would not receive treatment. That would, indeed, be a bizarre outcome.

2 Shortcomings in the treatment offered to non-offenders

Whatever its shortcomings, the Drug Interventions Programme for offenders, in comparison with the services that are available to other drug users, offers treatment that is more easily available and relatively well planned. Critics charge that some treatment providers are guilty of skewing the services they provide in order to follow the money for treating offenders that is on offer and that community drugs treatment has suffered in consequence.³⁷⁶ They identify a wide range of weaknesses in the general provision

³⁷⁴ NTA, *Business Plan 2006/7*, 2006. The Chief Executive's report to the NTA Board, 4 October 2006, explains: 'Rapid expansion in provision of treatment and absence of any guidance on treatment tariffs have led to wide variations in the unit cost for comparable treatments across the country. Increasing pressure to expand drug treatment provision and competing calls on NHS funding mean that the levels of provision the DH has committed itself to resourcing can only be achieved with greater cost-efficiency. In 2004, the NTA South East Regional Team commissioned the Audit Commission to undertake a pilot data collection exercise to support work on unit costs for substance misuse services... The NTA is working with the Audit Commission to collect data nationally which will inform discussions with the Treasury as part of the Comprehensive Spending Review... The provision of robust unit costs will enable partnerships to take commissioning decisions based on value for money to ensure that treatment systems are configured to deliver the best possible outcomes for their communities.'

³⁷⁵ A Leshner, 'Drug abuse and addiction treatment research: the next generation', *Archives of General Psychiatry*, 54, 1997.

³⁷⁶ Peter McDermott, for example, writes: 'Large parts of the drug treatment field [have been] reminiscent of a self-serving whore, happy to do whatever is asked of it by the government John that happens to be paying the bills for that night's pleasure and rarely stopping for very long to think about the wider consequences of her actions, either on herself or on her customers'. 'A fine romance?', *Druglink*, Nov/Dec 2006.

of drugs treatment, including a lack of easy access to treatment, waiting times that are still too long, variable standards of care, a lack of choice, a lack of integration between different services and failures in provision for a number of particular groups. (In defence of the level of service provided, treatment providers would argue that they can only provide the services that are commissioned and purchased by those who control the resources.)

Access to medical treatment

Access to treatment is uneven and in some places very difficult. The route into treatment that many, perhaps most, drug users would prefer is a referral from their local doctor. The GP, providing care that often bridges physical, social and psychological needs, is most people's normal point of contact with the health service, generally the first one and sometimes the only one they know. Going to a doctor's surgery has, in most cases, less of the stigma attached to attending drug dependency clinics in search of specialist care for which there may in any case be long waiting lists.

However, little more than one-third of all GPs are involved in providing drugs treatment of any kind. Access to drugs treatment from a local doctor is often a matter of being lucky enough to be registered with one of the minority of GP practices that does provide some form of drugs treatment.

When specialist drugs clinics were set up in the 1970s, drugs treatment – and substitute prescribing in particular – was taken out of the hands of individual GPs. With the emergence of HIV and AIDS in the 1980s and the recasting of drug misuse as a problem of public health, pressure grew for GPs to become involved in treatment again, but in the absence of technical support many GPs with an interest in treating drug users became disinclined to do it. Substitute prescribing can be difficult to get right and the risks involved in the miscalculation of dosages are high.³⁷⁷

In addition, according to the Royal College of General Practitioners, many doctors are reluctant to accept drug users as patients.³⁷⁸ Some have moral or practical objections to prescribing substitute drugs (or worry that their colleagues will have objections, given the expense involved), while others simply have little sympathy with illnesses they regard as self-inflicted.³⁷⁹ Some doctors find it hard to establish the necessary rapport with patients who often lead difficult and chaotic lives and who may in addition be involved in criminal activity. Many GPs also find drugs treatment unrewarding because they perceive the chances

³⁷⁷ Dr Clare Gerada, evidence to House of Commons Home Affairs Select Committee, 15 January 2002.

³⁷⁸ Royal College of General Practitioners, Memorandum to House of Commons Home Affairs Select Committee, January 2002.

³⁷⁹ For the average GP treating drug users with mild to moderate problems, 'the cost of the prescribing component of the treatment is currently about £1,000 per patient per episode', according to a written answer from Caroline Flint to a Parliamentary Question on 28 November 2006. For GPs who have trained to treat more complex drug problems, the prescribing component is about £1,800.

of successful treatment as being low, particularly when they are operating in sub-optimal conditions without adequate support from social services. Others find injecting practices distasteful and are worried about the risk of blood-borne viruses. Often their receptionists are afraid of disruption in the surgery and the effect that drug users may have on other patients. Perhaps most significantly, GPs – especially those operating single-handed – are aware that drug users are likely to take up a good deal of time. Drug use is often at its worst in deprived areas where all forms of ill health are more common and there are fewer doctors. The Royal College has estimated that drug users are likely to consult five times more often than other patients and generate a work load that may be up to twenty times as heavy.³⁸⁰

Now, under the new General Medical Services contract offered to doctors since 2004, GPs have to opt *into* rather than *out of* providing drugs treatment, which ranks as an ‘enhanced’ rather than a ‘core’ or even an ‘additional’ service. Those electing to provide this ‘enhanced’ treatment service are paid per patient treated according to their level of experience and training.³⁸¹ Although the current target of 35 per cent of all GPs to be involved in drugs treatment is being achieved, such a proportion can obviously not guarantee equal access to treatment to all those who need it.³⁸² In particular, there are long waiting lists for methadone prescription, which will become even longer as the criminal justice system continues to generate increasing numbers of candidates for treatment. In addition, many of the participating GPs provide little else beside a limited methadone prescribing service. They cannot offer either a holistic treatment service for heroin dependency or treatment for any other types of illegal drug misuse.

Waiting times

Waiting times are decreasing, but they often remain too long, with damaging effects. Unlike most people seeking medical treatment, drug users may not persevere if they are unable to get help quickly. The window of opportunity for matching a point of access to a drug user’s point of motivation is narrow. Having brought themselves, often with much difficulty, to the point of approaching treatment services, people may give up on finding that they may have to wait weeks for a full assessment and even longer between being assessed and actually being given a prescription for a substitute drug. One user recalled:

I remember going to a phone box and being given a phone number. It was actually the local Community Drug Team and then I thought I was going to get off it [heroin] and I was told that I was going to have to have an appointment in a month.

³⁸⁰ Ibid.

³⁸¹ In 2003/04 each practice contracted to provide drug treatment services was given £1000 annual retainer; plus £500 for a withdrawal per patient per annum and £350 maintenance per patient per annum – to go up by 3.225 per cent in 2004/5 and 2005/6.

³⁸² ‘The percentage of GP practices recorded by the Healthcare Commission in 2003–04 within a shared care scheme for problem drug misusers was 35 per cent. The NTA set a 2005–06 target of 35 per cent. of GPs working within shared care. The results of this target will be published in April 2006.’ Caroline Flint, Written Answer to question from David Davis MP, 29 March 2006.

When I went for that appointment, I was told that I wasn't on it too badly and it wasn't a rush for me to be seen. It was over six months.³⁸³

Those who have been given their prescriptions may be unable to gain access to the supporting 'talking' therapies that might help them stick to their new regimes. Perhaps least helpful of all are the delays that often occur between someone emerging from detoxification and being accepted into residential rehabilitation, where a wait of any length may mean that the drug user simply goes back to the places, the people and the habits that he or she has always known. The National Treatment Agency is now aiming at a maximum wait for first treatment, and between different modes of treatment, of three weeks. In Scotland, where there is currently no equivalent of the NTA, figures issued by the Scottish Parliament in October 2006 show that hundreds of people have to wait for more than a year for rehabilitation on the NHS, both in the community and in specialist hospitals. More than 800 people were waiting for community support and rehabilitation at the end of March 2006, 235 of whom had queued for more than six months from the moment when their needs were identified and 255 of whom had waited for a year or more. An additional 118 were waiting for residential detoxification and treatment.

Variable standards

The standard of drugs treatment varies widely across the country. According to the National Treatment Agency's Business Plan for 2006/7, the Agency has concentrated since its inception in 2001 largely on building and strengthening a national system for delivering treatment, giving a higher priority to the structure than to the types or quality of the treatment coming out of the system. In 2005 an NTA survey revealed that standards varied widely, with the most effective service up to seven times better than the worst. A separate study of residential rehabilitation services showed some providers retaining 92 per cent of their clients till the end of their treatment, while others managed no more than 3 per cent.³⁸⁴ There is also evidence that, of the very large numbers of people now offering counselling and therapy, some are much more skilled, sympathetic and successful than others.

The NTA is now implementing a Treatment Effectiveness strategy, carrying out Improvement Reviews of such areas as commissioning, harm reduction services and residential treatment. At the same time the first set of standards for treatment provision in Scotland – *National Quality Standards for Substance Misuse Services* – has been launched. It remains to be seen how effective these initiatives will prove.

³⁸³ A Hopkins and D Clark, *Using heroin, trying to stop, and accessing treatment: a qualitative analysis of the experiences and views of clients on the Peterborough Nene Drug Interventions Programme, WIRED/Peterborough Nene Drug Interventions Programme*, 2005.

³⁸⁴ P Meier et al, 'A national survey of retention in residential rehabilitation services', *NTA Research Report 10*. The rehabilitation centres that retain their clients best have fewer beds, more single rooms, a better ratio of staff to residents, fewer chores, more individual counselling and less group therapy.

Lack of treatment options and a dearth of patient-centred treatment

The range of treatment options that is open to drug users – or, indeed, to the providers attempting to supply them with treatment – is often severely limited.

Where treatment providers are concerned, these limits may be imposed by the lack of resources to provide a variety of services and treatment options – a problem compounded by centrally-imposed directives steering providers towards meeting centrally-determined targets.

Providers themselves, however, are often accused of failing to engage adequately with drug users over their particular needs and preferences, sometimes from a general supposition that the providers know best and sometimes because of an unstated assumption that the usual obligations and courtesies do not apply to drug users. It is widely believed that people are not being given the right or the information or the encouragement to choose, for example, between aiming for total abstinence or being maintained on a substitute drug.³⁸⁵

Again, many problematic drug users are not being offered the opportunity to opt for residential rehabilitation. Residential rehabilitation is for many people the most effective route to abstinence, removing people from the surroundings in which they have been taking drugs. However, up till now it has proved difficult to find places for everyone who would benefit from rehabilitation. The problem is not necessarily that there are too few places. Although some geographical areas are badly served, in other areas existing places are not being filled. In 2006 there was a total of 2,441 residential rehabilitation places in England and, overall, the proportion of these places that are taken up is actually falling.³⁸⁶

The question is one of funding and organization. Residential rehabilitation is funded primarily from local authorities' Community Care budgets. Past efforts to ring-fence money for drug and alcohol rehabilitation within these budgets have failed.³⁸⁷ Now that social services across Britain are often running with huge deficits, drugs treatment has trouble competing with other priorities such as old people's homes and care for people with disabilities.³⁸⁸

Not everyone, however, is suited to residential rehabilitation, which is not the cure-all that some suggest. It has become something of a political football in recent years, with some politicians presenting it as a panacea for all ills and the number of residential places and amounts of money devoted to 'rehab' treated as a symbol of commitment to solving 'the drugs

³⁸⁵ Here too there are choices to be made. Research by Edinburgh, Napier and Adelaide Universities, led by Dr Roy Robertson, has recently suggested that dihydrocodeine is just as effective in the treatment of heroin addiction as methadone, less expensive and less likely to cause a fatal overdose. <http://www.ed.ac.uk/news/06/2006methadone.html>

³⁸⁶ Reply to Parliamentary Question, 25 July 2006.

³⁸⁷ e.g. the 1990 NHS and Community Care Bill, and in 1992 a proposed 3-year grant to safeguard funding for residential rehabilitation. Bill Puddicombe, 'Rehabs – a crisis in waiting', *Druglink*, Jan/Feb 2006.

³⁸⁸ The Local Government Association has calculated that council social services in 2006 will have a funding shortfall of £1.8 billion.

problem’. It is particularly politically palatable because it appears to have the twin advantages of helping drug users towards abstinence and removing them from public view. However, there are large numbers of drug users for whom residential rehabilitation may not be the answer: women with children, for example, or people whose habits are not preventing them from holding down jobs, or people from black and minority ethnic communities who might fear racial discrimination on top of the other stresses that this particular form of communal living imposes.

A lack of integration between services

Drug misuse, itself multi-layered, is often intertwined with a variety of other issues, and the resulting complex problem requires an holistic solution. However, all too often services work in isolation or even at odds with one another.

Very many problematic drug users also have problems with alcohol, and there is an urgent need to fund alcohol treatment as a complement to drugs treatment. Indeed, alcohol abuse can disrupt drugs treatment. It has been identified as an important cause of medical complications during methadone treatment, for example, and is frequently linked to the early discharge of patients from these programmes.³⁸⁹ People often come out of drugs treatment drinking as much alcohol as before, if not more, thereby undermining the improvements in their lives that drugs treatment has made. They may also be risking their lives, especially in the case of injecting drug users with previous liver damage caused by Hepatitis C. ‘Of the clients who die under your care,’ writes one treatment provider, ‘most will die because of alcohol, in combination with other drugs such as benzodiazepines.’³⁹⁰ Separate services are hard for this client group to manage, and integrated treatment would be far easier for them to deal with. At present, however, there is very little NHS funding for alcohol treatment, and there are specific instructions from the National Treatment Agency that drugs funding is not to be sidetracked into alcohol treatment. In the first round of Local Area Agreements in selected areas, requests from Drug Action Teams to be allowed to use funding more flexibly to incorporate some alcohol treatment were turned down ‘whilst drugs remained a critical issue and a political priority’.³⁹¹

In addition, there is a very large overlap between mental illness and substance misuse. Recent European research estimated that between 30 and 50 per cent of psychiatric patients in Europe today use drugs.³⁹² Undoubtedly, many thousands of people in Britain have a ‘dual diagnosis’ of co-existing drug problems

³⁸⁹ Gossop, op.cit.

³⁹⁰ Richard Phillips, Director of Services, Phoenix House, letter in *Drink and Drugs News*, 17 October 2005.

³⁹¹ Office of the Deputy Prime Minister, ‘A process evaluation of the negotiation of pilot Local Area Agreements’, June 2005. And cf. Note on ‘Progress on delivering work on alcohol’ for NTA Board meeting, 29 November, 2005: ‘There is no performance management role for the NTA regional teams around alcohol in the programme for improvement.’

³⁹² European Monitoring Centre for Drugs and Drug Addiction, ‘Co-morbidity – drug use and mental disorders’, *Drugs in Focus* 14, 2004.

and mental illness. These people are very likely to be passed backwards and forwards between mental health services and drugs services, depending on which symptoms are most obvious when they come into contact with the authorities, with each service often insisting that the other problem is primary and should be tackled first. The National Director for Mental Health judges substance misuse to be one of the biggest challenges that mental health services face.³⁹³ 'It can seriously affect the ability of services to assess, treat and care for patients safely and effectively. The use of non-prescribed drugs and alcohol can make symptoms worse and trigger acute illness relapse. On occasion, it can lead to self-harm or violence to others.'³⁹⁴ The use of drugs is in fact the greatest single trigger for violence in in-patient facilities.³⁹⁵

The Department of Health's guidance on dual diagnosis states quite clearly that 'Individuals with dual problems deserve high quality, patient focused and integrated care ... This should be delivered within mental health services.'³⁹⁶ In other words, the care of people with both mental health and drug problems is to be mainstreamed through existing mental health care. However, the provision of dual diagnosis services lacks coherent and adequately resourced strategic direction. Often, mental health services have evolved quite separately from drugs services, and many mental health staff have no training in recognizing or dealing with drug or alcohol misuse. Where dedicated dual diagnosis services exist, they are often under-resourced and under-prioritized. Within the Department of Health, Local Implementation Teams have been tasked with planning to tackle dual diagnosis, but progress is slow.

Disconnecting drug users from their families and communities

Drug misuse causes problems not just for the users but for their families, and the needs of every family member ought, if at all possible, to be met. However, some of these needs are for treatment, others are for social care, and the various agencies involved often pursue their own concerns without attempting to coordinate their efforts or even in open opposition to each other. 'Treaters' are too often at loggerheads with 'carers'. Drug users are entitled, like any other patients, to a degree of confidentiality, and drugs workers will work to defend this entitlement. However, drug users' children are entitled to the protection that they will not get if social care agencies are not made aware that they are living amidst drug use. The debate in this area is particularly fierce in Scotland, where there have been some much-publicized incidents of neglect and harm to children, including the death of a two-year-old boy who drank his parents' prescribed methadone. Dave Liddell, director of the Scottish Drugs Forum,

³⁹³ L Appleby, National Director for Mental Health, *The National Service Framework for Mental Health – Five Years On*, Department of Health, 2004.

³⁹⁴ Department of Health, *Dual diagnosis in mental health inpatient and day hospital settings*, 2006

³⁹⁵ Healthcare Commission/Royal College of Psychiatrists, *National Audit of Violence 2003-2005*, 2005.

³⁹⁶ Department of Health, *Mental health policy implementation guide: dual diagnosis good practice guide*, 2002.

has said that the split between children's and adults' social services is hindering support for families with drug problems, and he has called for a reciprocal understanding of the needs of users and their children and a joint agreement on when their information should be shared.³⁹⁷ The Scottish *National Quality Standards for Substance Misuse Services* (2006) incorporate provisions specifically to safeguard the interests of children, making it clear, for example, that, where appropriate, information about parental drug use will be shared with other services, even without the drug user's permission.

A failure to provide for specific groups

Standards of treatment vary considerably across Britain from area to area and even practice to practice, but it is nevertheless possible to single out specific groups who are consistently receiving less adequate care.

Black and Minority Ethnic (BME) communities

At present, treatment services across Britain are attracting a disproportionately small number of problematic drug users from BME communities. Services have been accused of being skewed towards the needs of older, white injecting opiate users rather than being sensitive to the needs of people from different cultural backgrounds, who may have differing views of themselves and of their drug use and differing relationships with their families and communities.³⁹⁸ People from African, Asian and Caribbean communities (or from newer communities of refugees and asylum seekers) may use different drugs or the same drugs in different ways. They will have a wide range of different perceptions of drug use and drug users, different views on what treatment might be appropriate and different wishes as to how that treatment should be delivered.

Bangladeshi users and their families, for example, generally want only abstinence-based treatments and are resistant to the idea of maintenance prescribing. Many Bangladeshi users are very young, and most smoke heroin rather than injecting it (which means that they are less likely to come into contact with treatment facilities through needle exchanges).³⁹⁹ Few want to share services with older white injecting users, and they are particularly reluctant to go into residential rehabilitation services which may be located many miles away from their own communities and where they may face racial discrimination and language difficulties as well as the usual demands of treatment. Some are being subjected to forcible 'cold turkey' withdrawal treatments at home. Others are being sent by their families on expensive detoxification programmes, in private clinics or else back in Bangladesh, where

³⁹⁷ Community Care Live News, 1 November 2006, 'Split of services hinders support for substance misusing families'.
<http://www.communitycare.co.uk/Articles/2006/11/01/102020/CC+Live+news+Split+of+services+hinders+support+for+substance+mising.html>

³⁹⁸ A recent study of heroin users in America has pointed out that, where treatment depends so heavily on motivation for its success, understanding how drug users see themselves is crucial. White users in the study tended to style themselves as outcasts, victims of addiction, injecting to stave off pain. African American users, on the other hand, cast their addiction as a pursuit of pleasure and themselves as professional outlaws. They rejected any appearance of abjection and for this reason often shunned methadone treatment as a badge of shame. P Bourgeois et al, 'Reinterpreting ethnic patterns among white and African American men who inject heroin: a social science of medicine approach', *Public Library of Science: Medicine*, 3/10, October 2006

³⁹⁹ Many people initially believe that smoking heroin is not addictive.

they are as liable to be exposed to cheaper and more plentiful heroin as they are to withdraw from drugs.

Opinion differs as to whether separate services should be provided for different ethnic communities. Many treatment agencies feel that this is divisive and that the aim should be the provision of mainstream services capable of catering for all users equally rather than a service for white users with a 'Black and Minority Ethnic' unit or worker tacked on to it. Some observers from ethnic communities, however, have suggested that residential services, at least, should be separate.⁴⁰⁰

Drug users in prison

Prisons have the highest concentrations of problematic drug users in either the healthcare or the criminal justice systems. It has been estimated that about 80 per cent of people going into prison have used drugs and that about 55 per cent are problem drug users. In some prisons up to 80 per cent of new arrivals test positive for opiates.⁴⁰¹ Early in 2005 a prison service spokesman reckoned that there were about 39,000 problem drug users in the system at any one time.⁴⁰² A large proportion of these prisoners continue to use drugs while they are in custody, particularly those who are dependent on heroin.⁴⁰³ A Home Office report in August 2006 found that drug use is endemic within prisons in England and Wales, not excluding the so-called 'drug-free wings'. Drug use can also be more dangerous in prison, as people take more risks than they might on the outside, sharing needles more often and being unable to sterilize any of the other paraphernalia of injecting drug use.⁴⁰⁴ The risk of HIV infection, already high, is compounded by the difficulty of obtaining condoms. One observer has described a prison environment that includes 'the rampant dealing of drugs... the widespread prescribing of drugs by prison medical officers, the acceptance by prison officers of cannabis dealing and use as a sedation measure, the lack of anything approaching an open access counselling and treatment service inside... It is an environment which encourages use.'⁴⁰⁵

Given the difficulty of preventing drugs from getting into prisons, the provision of adequate treatment in custody is critical. Concentrating a significant proportion of the country's most problematic drug users in a few heavily supervised locations would seem to offer a good opportunity to intervene, to reduce health harms, to reduce drug-related crime and to prepare one particular group of prisoners for release and reintegration into the community.

⁴⁰⁰ e.g. Basharat Hamzah Hameed, 'Abstinence may be a cultural requirement', *Addiction Today*, Jan/Feb 2006.

⁴⁰¹ Answer to Parliamentary Question, 19 July 2006.

⁴⁰² *Druglink*, Jan/Feb 2005.

⁴⁰³ J Strang, M Gossop et al, 'Persistence of drug use during imprisonment: relationship of drug type, recency of use and severity of dependence to use of heroin, cocaine and amphetamine in prison', *Addiction*, Vol. 101, 8, August 2006.

⁴⁰⁴ A report from Glasgow Caledonian University for the Scottish Prison Service suggests that an 'anti-injecting' culture has developed in many prisons, making smoking heroin more common. D Shewan et al, *SPS Strategy on the management of drug misuse. Pathways and progression: an evaluation of referral, assessment and intervention*, Scottish Prison Service, 2006.

⁴⁰⁵ Robin Burgess, 'Breaking the circle: the drug-free wing challenge', <http://www.drugtext.org/library/articles/four2.html>

However, the Prison Reform Trust reported early in 2006 that no more than 10 per cent of prisoners with drug problems are likely to be in intensive rehabilitation in any one year.⁴⁰⁶ Treatment in prison bears little relation to need but depends more on what happens to be available. Prison doctors are not uniformly trained to deal with drug misuse, and there is a heavy reliance on a few charismatic individuals to drive treatment programmes.⁴⁰⁷ Implementation varies. One sample group of drug users on the Drug Interventions Programme in Peterborough reported that they had received minimal help for their drug addiction while in prison:

They often received some medication, most frequently valium and DFs (dihydrocodeine DF118s) which were intended to help with the withdrawal symptoms. Clients were rarely offered any other form of support and were locked in their cells for long periods of time whilst withdrawing from heroin. None of the clients mentioned being put on a methadone programme whilst in prison.⁴⁰⁸

The general policy at present is that prisoners who are already on a methadone prescription when they arrive may be maintained on it while in custody if their sentences are too short to allow for detoxification. Otherwise they will be required to detoxify, as will those who are using drugs but are not already on methadone.⁴⁰⁹ In other words, methadone maintenance is not standard procedure, although the House of Commons Home Affairs Select Committee recommended in 2002 that it should be a mandatory part of custodial sentences, strictly supervised.

Many within the prison system take the view that drug use is deviant behaviour and that prisoners should be given one chance to ‘get off’ drugs for good. Some of the Peterborough prisoners welcomed the idea of ‘getting clean’ and were glad to be drug-free while in prison. The detoxification that is provided, however, is sometimes crude and administered without any other form of support. Relapse is common, and the procedure has recently been challenged as a violation of human rights. In 2006 the Home Office settled out of court with six prisoners, representing a larger group of about 200, who claimed they had been forced to go ‘cold turkey’ and withdraw from drugs abruptly, a procedure to which they had not consented and one that amounted to clinical negligence and assault.⁴¹⁰

Plans have been drawn up for improving drugs treatment in prison, which since April 2006 has been the responsibility of the NHS rather than the prison service. While this makes

⁴⁰⁶ Prison Reform Trust, *Bromley Briefings: Prison Factfile*, April 2006.

⁴⁰⁷ In Scotland, for example, the Scottish Executive has funded the Royal College of General Practitioners to train prison doctors but the scheme does not extend to those employed by private medical providers, with the result that it excludes, for example, doctors in Glasgow’s Barlinnie, the largest prison in Scotland, where a high proportion of prisoners use drugs. Information from Dr Uday Mukherji, 16 May 2006.

⁴⁰⁸ A Hopkins and D Clark, *Using heroin, trying to stop, and accessing treatment: a qualitative analysis of the experiences and views of clients on the Peterborough Nene Drug Interventions Programme*, WIRED/Peterborough Nene Drug Interventions Programme, 2005.

⁴⁰⁹ cf. policy in prisons in Northern Ireland: ‘A prisoner who alleges that he or she is addicted to illicit substances but who is not on a community substitution programme, will be offered appropriate treatment and support from healthcare professionals in line with the Prison Service detoxification protocol’. Paul Goggins, written answer to Parliamentary Question, 23 November 2006.

⁴¹⁰ <http://news.bbc.co.uk/1/hi/uk/6142416.stm>

prison treatment liable to quality control by the National Treatment Agency, it has also left it vulnerable to NHS budget cuts. At the end of 2005 the government pledged to provide almost £70 million over two years for an 'Integrated Drug Treatment System' in prisons that would bring together medical care and counselling to produce treatment that was comparable with services in the community and that would link up more closely with them. The integrated treatment would include more methadone prescribing and better care planning to meet individual needs. However, in November 2006 the Department of Health admitted that the budget for 2006/7 had been cut to £12 million, with no decision forthcoming on funding for 2007/8.⁴¹¹ At present only 17 prisons are due to benefit from the new programme, less than one in eight of all prisons in England and Wales.⁴¹²

⁴¹¹ Communitycare.co.uk website.
<http://www.communitycare.co.uk/Articles/2006/11/13/102165/Drug+treatment+scheme+for+prisons+sees+funding+cut+due+to+NHS.html?key=HAYES>

⁴¹² Drugscope, 'NHS deficit hits drug treatment for prisoners', 13 November 2006.
http://www.drugscope.org.uk/news_item.asp?a=3&intID=1385

Women

Women with drug problems have special needs that require specialized interventions, but there are few treatment services catering exclusively for women or even taking their particular needs into account. Most services, as noted above, were originally designed primarily for white male injecting opiate users and many have failed to adapt. Women going into residential rehabilitation frequently have to go into mixed-sex facilities and significant numbers drop out of treatment to break away from relationships they have formed with male residents.

Female drug users need help when they are pregnant. In general, where mothers are taking drugs there is a greater risk of miscarriage, premature delivery and slower growth for the babies (plus a greatly increased chance of HIV or hepatitis for the babies of injecting users). Stimulants may promote anorexia in the mother and thus malnutrition in the baby; the mother's heroin use can produce a withdrawal syndrome in the baby that may last for several weeks and can include fever and fits. Cocaine can lead to a far higher risk of Sudden Infant Death syndrome.

Many female users are young single mothers, isolated in the community and lacking family support. Unable to afford childcare or to travel far, they need services that both provide childcare facilities and offer reassurance that presenting themselves for treatment will not lead to their children being taken away. Many other women are locked into violent and abusive relationships. A proportion of injecting women users are involved in sex work. Besides being more isolated and more exposed to dangers, both from their clients and from

the criminals who groom and control them, they are also more vulnerable to blood-borne viruses. One European authority comments, ‘Although, overall, more men inject drugs and die from using them, one cannot ignore the fact that female injectors may be at greater risk and harder to reach.’⁴¹³

Drug users in rural areas

Drug misuse is often taken to be an inner-city problem. In reality, the marketing of drugs is often just as determined outside cities, particularly in areas with declining industries and high unemployment, where drug dealing may be the most lucrative job on offer. The Mentor Foundation points out that not all areas of multiple deprivation are urban. Coastal areas and ex-mining communities, in particular, have the double disadvantage of remoteness and deprivation, and many have serious problems with drug misuse. In coastal areas, employment tends to be seasonal; there is a great deal of temporary accommodation and there are large numbers of short-stay migrants. In ex-mining areas, some villages have become like sink estates, with deteriorating housing, poor transport and high crime rates, all in semi-rural isolation.⁴¹⁴

Young people in rural areas may be more rather than less likely to be offered drugs and more likely to accept them when there is little else to do. Rates of Class A drug use are higher, for example, in rural Dumfries and Galloway than in Edinburgh or Aberdeen.⁴¹⁵ The main motorway from England runs through the area, and the ferry from Northern Ireland lands at Stranraer. Anyone transporting drugs through Scotland is likely to cross the region, and it has one of the highest rates of injecting drug use in the country.⁴¹⁶

The principal difference between city and country is to be found in the levels of social support and access to treatment. Young people are more visible in rural areas and small settlements where everyone knows everyone else. The stigma of drug use is greater, people are less willing to acknowledge that there may be a problem, and users are less likely to come forward for treatment – even supposing it is on offer.⁴¹⁷ Many rural areas lack even the basic treatment facilities, let alone the ‘wraparound’ support in terms of social care that is needed in order to consolidate the gains made in treatment. Country and coastal areas rarely have specialist drug clinics nearby, as treatment providers may have difficulty finding suitable premises. Users may have to travel long distances to services or rely on long-range outreach. Otherwise they must depend on generic health provision, but fewer rural than urban GPs are involved in drugs treatment,

⁴¹³ Recent data from studies of injecting drug users in nine EU countries found that HIV prevalence was higher on average (21.5 per cent) among women than among men (13.6 per cent). EMCDDA, ‘Harm reduction measures may be failing women’, *Drugnet Europe 56*, October-December 2006.

⁴¹⁴ S Parker, *Mentor UK Coastal and ex-mining areas project: a review of the literature*, Mentor UK, 2006.

⁴¹⁵ <http://news.bbc.co.uk/1/hi/scotland/4241696.stm>

⁴¹⁶ <http://www.scotland.gov.uk/Publications/2005/06/28112330/23407>

⁴¹⁷ See, for example, Scottish Executive Effective Interventions Unit, *Rural and remote areas: effective approaches to delivering integrated care for drug users*, 2004.

and many community pharmacists are unwilling to dispense substitute prescriptions.

Older users

The drug-using population may be getting younger, but it is also getting older. Some of the ‘baby boomers’ who started using recreational drugs in the 1960s are continuing to use them into middle age and beyond and there is even a body of ‘late onset’ misusers of benzodiazepines and over-the-counter medicines.⁴¹⁸ Thanks to the success of methadone maintenance and other treatment programmes, more opiate users, too, are surviving into old age. When these drug users do require medical help, however – and drug-related conditions in later life may include deep vein thrombosis, liver damage, hepatitis C and depression – it is often hard to find, as drugs treatment is generally embedded in adult services rather than those for the elderly.

Users of stimulants

The National Treatment Agency has long recognized that the problematic users of certain drugs lack access to generally effective treatment. There are, for example, relatively few treatments available for users of stimulants such as cocaine and crack. In Lambeth, for example, an inner London borough with approximately 2,000 drug users in treatment per year, some 93 per cent of all problematic drug users use crack, on its own or in combination with other substances. Seventy per cent of the treatment budget, however, goes to sustaining services for opiate users.

The reasons for this kind of imbalance are not entirely clear. It may be because there are no pharmacological treatments to compare with the substitution treatments that are available for heroin addiction.⁴¹⁹ Instead, stimulant abuse requires a psycho-social approach to treatment – a combination of psychological therapies and practical social support. One treatment option that has been shown to reduce cocaine use in the short term is a combination of the community reinforcement approach with contingency management. Community reinforcement consists of recruiting the drug user’s family and friends to encourage them to make social contacts, improve their self-image and find other, more rewarding things to do. Contingency management aims at influencing people’s behaviour by offering them incentives such as presents, vouchers and privileges in return for cocaine-free drug tests.⁴²⁰

This wider range of treatments can be harder for conventional treatment agencies to provide. Talking therapies are, of course,

⁴¹⁸ Dr Daphne Rumball, presentation to the Society for the Study of Addiction 2005 conference, York, 18 November 2005.

⁴¹⁹ Work is going on into a vaccine, originally developed in Britain, that encourages the development of an immune response to the cocaine molecule, blocking its effects and making it easier for the user to remain abstinent, but the vaccine (drug-protein conjugate TA-CD) is not yet available. B Boland and N Shingadia, ‘Cocaine vaccines: can they help?’, *SCANbites*, Spring 2006.

⁴²⁰ S Higgins et al, ‘Community reinforcement therapy for cocaine-dependent outpatients’, *Archives of General Psychiatry* 60, 2003, and H Roozen et al, ‘A systematic review of the effectiveness of the community reinforcement approach in alcohol, cocaine and opioid addiction’, *Drug and Alcohol Dependence*, 74, 2004.

particularly vulnerable to the problems posed by language barriers and different cultural interpretations of illness and behaviour.

Also needed is a quick response to crises and frequent relapses and the ability to provide both some respite from drug use and a level of continuing care for a group of service users who are volatile, acutely addicted and particularly prone to anxiety and paranoia. Short-stay rehabilitation centres may create some of the conditions for recovery, but many agencies are able to offer little more than sporadic counselling and anti-depressants plus alternative therapies such as acupuncture and massage that may help to reduce or manage cravings.⁴²¹

The problem may also be that many drug workers have not been trained to deal with the particular problems that stimulant use can cause. ‘Historically, drug treatment has focused on the needs of heroin users,’ according to Paul Hayes. He continues:

The reality is that most addicts use a whole menu of drugs, including heroin and crack/cocaine. These drugs have different effects, all of which must be tackled in treatment. There is limited value in managing someone’s heroin addiction, if they continue to misuse crack... The problem has been that many drug workers don’t have the appropriate support, confidence and knowledge to deal with crack/cocaine misuse. As a consequence, crack misusers don’t see them as providing services to meet their needs and fail to come forward for treatment.⁴²²

Cannabis users

Across Europe as a whole, the number of people seeking help for problems with cannabis use appears to be rising. In many countries, cannabis is the second most frequently reported drug for which treatment is sought. In England and Wales, between 2003/4 and 2005/6 there was an increase of 117 per cent in the overall number of people seeking treatment primarily for cannabis while the number of young people under 16 seeking treatment rose from 2,963 in 2003/4 to 7,559 in 2005/6.⁴²³ There now appear to be more heavy users of cannabis who are young, and most of the treatment demands made by the very young are for cannabis dependency.⁴²⁴

This rise in the numbers seeking treatment may partly be the result of more young people being referred by concerned parents, schools, courts or health and social workers with little experience of drug issues. Some assessment workers complain that they are being sent occasional users who need nothing more than a little advice or information. The rise may also be related to increasing

⁴²¹ Bill Nelles, founder of The Alliance, a user-led advocacy service for users in treatment, to House of Commons Home Affairs Select Committee, 27 November 2001. And see www.treatmentworks.co.uk

⁴²² National Treatment Agency website, <http://www.nta.nhs.uk/frameset.asp?u=http://www.nta.nhs.uk/news/030320.htm>

⁴²³ Caroline Flint, answer to Parliamentary Question, 17 October 2006.

⁴²⁴ The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2004.

levels of adulteration in cannabis bought on the street. However, it could also signify an increasing number of people using cannabis more heavily and consequently suffering harm. The European Monitoring Centre for Drugs and Drug Addiction warns:

Estimates would suggest that intensive [cannabis] use may affect between 0.5% and 2% of the adult population and between 1% and 3% of young adults [across Europe]. The prevalence among young males is likely to be substantially higher... Although the effects of cannabis dependence or abuse are less severe than those of other drugs, this may nevertheless have a considerable public health impact because of the scale of use and the fact that many of those most affected are young and may be using the drug intensively during important developmental stages or when they are particularly vulnerable. Among socially disadvantaged families or communities, cannabis dependence or abuse may compound individuals' problems by harming education or employment opportunities.

As yet there is no evidence of any effective pharmacological treatment for cannabis dependence. Treatment approaches include cognitive behavioural therapy, motivational interviewing, assisted reduction in use, treatment for withdrawal symptoms, training in resisting social cues for use, relapse prevention and out-patient counselling. One problem in cannabis treatment is that cannabis users are sometimes reluctant to be treated alongside opiate users. Another is that they may be equally reluctant to be treated within mental health services, where much drugs treatment is provided. There are virtually no specialized centres for cannabis treatment and, while the great majority of people who use cannabis experience little harm, wider provision of treatment is clearly needed for those who do have problems.

Polydrug users

Polydrug use – heroin with benzodiazepines, heroin with cocaine, cannabis or alcohol, cocaine with alcohol and amphetamines, ecstasy with LSD or any other combination of substances – is increasing fast enough for many treatment providers to see such use as the norm, and treating it presents a variety of problems. When people are using more than one drug at a time, or are combining drugs and alcohol, they are more likely to be leading a chaotic lifestyle and are less likely to be able to commit to treatment. They may be at different stages of their use with different drugs, requiring treatment at different levels of intensity. There is also a risk of separate treatments interfering with one another. Where someone is using both heroin and benzodiazepines, for example, the benzodiazepines may interfere

with methadone prescribing aimed at addressing the heroin dependence.⁴²⁵ There is an urgent need for more research into the toxicity of various combinations of drugs and for a protocol to be developed for integrated treatment of polydrug use.

⁴²⁵ EMCDDA, *Annual Report 2002*, 'Selected Issues: I. Polydrug Use', <http://ar2002.emcdda.europa.eu/en/page62-en.html>

3 Failure to supplement treatment with other kinds of support

The third main weakness in the current treatment system is the failure to supplement clinical treatment, whether this be pharmacological or psychological, with other kinds of support: in other words, the failure to implement an effective public health response to drug misuse.

A large proportion of people in treatment were originally prompted to use drugs by problems with family breakdown, homelessness, unemployment and a lack of prospects. Even when this was not originally the case, drug users are likely to face precisely these problems when they come out of rehabilitation or out of prison, and they may be experiencing them even as they undergo treatment in the community. Unless they can be found somewhere to live where they are not surrounded by drug users, can be helped to find something else to do and can be supported in the effort to establish daily routines for looking after themselves and their families, their chances of sustaining the improvements they have made through treatment are likely to be drastically reduced. Some drug users have spent most of their adult lives in the pursuit of intoxication. They have invested nothing in their personal development as adults and lack some of the most basic skills they need to lead independent lives.

Offenders would seem to have a better chance than non-offenders of being offered the kind of practical support they need. If they have gone to prison, they will come within the reach of the CARAT (Counselling, Assessment, Referral, Advice and Throughcare) scheme. The scheme was established as an attempt to coordinate drugs treatment while people are in custody with any treatment they may have received before sentencing and with any treatment they should receive after their release. CARAT workers often try to arrange for people to be collected from the prison gates on the day of their release, as doing so has been found significantly to reduce the risk of their dropping out of treatment. In addition, many prisoners are released on Fridays and the majority of community treatment services are closed over the weekend. Because their tolerance to drugs will usually have been reduced while they were in custody, prisoners at the point of release are forty times more likely than other users to overdose if they relapse and it is not a coincidence that the majority of all drug-related deaths occur on Fridays and

at the weekend. Once offenders have left prison, or completed a community sentence, the intention is that Criminal Justice Intervention Teams, latterly Drug Intervention Teams, will, according to the Home Office 'provide, or broker the provision of, appropriate wraparound services... such as housing, support with benefits, managing finances, employment, education and training opportunities, access to mental health services, and rebuilding family relationships'.

⁴²⁶ Addaction, 'Collecting the evidence: clients' views on drug services', 2004.

⁴²⁷ Audit Commission, *Changing Habits*, 2002.

⁴²⁸ Audit Commission, *Drug Misuse 2004: Reducing the Local Impact*, 2004.

⁴²⁹ NTA, *Care planning and practice guide*, 2006.

In practice, however, the standards of aftercare for offenders vary widely. The drugs charity Addaction found in a 2004 survey that less than one in four of their drugs service users were offered adequate aftercare while they were still in prison.⁴²⁶ But even if offenders are well provided for in this way, there is no equivalent formal structure of 'throughcare' for drug users who have not committed any other offence. An Audit Commission report on general drugs treatment in 2002 underlined the lack of coordinated care planning for individuals.⁴²⁷ A second report in 2004 recognized that a start had been made on care plans but observed that further improvements were needed 'to ensure clients' health, social functioning, employability, housing status, and other factors likely to enable clients to achieve stability and contemplate progression out of treatment'.⁴²⁸

The NTA's Treatment Effectiveness strategy divides the treatment journey into four overlapping components: treatment engagement; treatment delivery (including maintenance); community integration (which underpins both delivery and treatment maintenance or completion); and treatment completion (for all those who choose to be drug-free and who can benefit).

Community integration involves providing 'a range of social support (e.g. housing support, educational support, employment opportunities) to maximise positive gains ... made during treatment'. Likewise, treatment completion involves providing pathways from treatment, both drug-related and non-drug-related, 'e.g. access to housing, supported accommodation, relationship support, education and training, support to gain employment, and parenting and childcare responsibilities'.⁴²⁹

In other words, the importance of these 'wraparound' services is fully recognized at the policy level and set out on paper. But in practice such services are not being delivered consistently, if at all. A joint NTA/Healthcare Commission Improvement

Review in 2006 found that 32 per cent of Drug Action Teams were ‘fair’ in providing individual care plans and 48 per cent were ‘weak’, leaving only one in five DATs meeting this particular requirement adequately.⁴³⁰

⁴³⁰ Healthcare Commission website, <http://www.healthcarecommission.org.uk/service-providerinformation/reviewsandinspections/improvementreviews/substancemisuse.cfm>

This chapter has identified some of the weaknesses, then, both in the way in which clinical treatment is delivered and in the provision of the support services that are essential if clinical treatment is to have its full effect. In the next chapter, we offer suggestions as to how both might be improved.

13 Reducing the harms from drugs: improving treatment and support

This chapter sets out the positive measures we believe should be adopted in order to improve the provision of drugs treatment – using ‘treatment’, as always, in its broadest sense, to express a service that is multi-disciplinary, multi-sectoral and located explicitly within a framework of public health.

In broad outline, we propose the following:

- 1 a greater emphasis on drugs treatment as a health measure, with the narrower demands of the criminal justice system exerting a lesser influence on the organization, pattern and provision of treatment;
- 2 ensuring the availability of a range of different treatment options, with scope for greater user preference and treatment that is user-centred;
- 3 providing service users with easier access to treatment and more responsive services;
- 4 providing better integrated services: for combined alcohol and drugs treatment, for people with a dual diagnosis of drug-related and mental health problems and for families;
- 5 the provision of more varied and flexible services for black and minority ethnic drug users, for women and for stimulant users;
- 6 the provision of better ‘wraparound’ services in connection with, for example, housing and employment;
- 7 a better focused role for the criminal justice system in bringing people into treatment; and
- 8 more humane and realistic ways of measuring the effectiveness of drugs treatment.

Drugs treatment as a health measure

In our view, many of the problems associated with drugs misuse should be framed primarily as issues of public health. Drugs treatment and its funding should therefore receive greater emphasis as a health measure and one that addresses a clear public health priority. Politicians and policy makers should have the

courage to discuss drugs treatment more often as a health and social care measure, rather than constantly justifying it largely in terms of crime reduction. If they fail to take this step, they will perpetuate the distortions and perverse incentives that afflict the current provision of treatment.

Surveys have repeatedly shown that the general public have some sympathy for people suffering health damage as a result of their drug use and feel that treatment, not prison, is the most appropriate response.⁴³¹ The RSA's YouGov survey, for example, found in June 2006 that 62 per cent of a sample of the general public felt that, where individuals use drugs but have not committed any other crime, they should be treated as people who may need medical treatment and other forms of support. Less than half that proportion, 30 per cent, felt they should be treated as criminals and brought before the courts. Those in charge of the drug strategy can well afford to present drugs treatment primarily as a health issue, especially given that, in our view, an effectively resourced treatment service organized on public health principles would itself also contribute to reducing crime. Failure to present treatment in this way allows hard-pressed health-service agencies to repudiate responsibilities that they would rather not take on.

Ensuring the availability of a range of different treatment options

Treatment is effective when the type of treatment offered is appropriate to the particular needs and circumstances of the individual and when it is tailored to his or her social, cultural and environmental context. A 'one-size-fits-all' approach to drugs treatment is both inefficient and ineffective, particularly when many problematic drug users have complex needs. Substitute prescribing will not be the answer for everyone. Among those who find it helpful, there will be variations in dosage. Similarly, different people – some with learning disabilities, others with mental health problems, many with poor education and difficulties in communicating – will respond in different ways and at different speeds to psychological therapies.

For treatment to be tailored, service providers must be able to ensure that a range of different treatment options is available. They must be willing to create a culture of provision that is user-centred and places a premium on user preference. To create this kind of culture, the health and social care system has to be able to ensure that the resources available for treatment are invested in a way that is equitable and cost-effective. A balance has to be struck between overall service planning and resource allocation

⁴³¹ See also the survey conducted for EATA (the European Association for the Treatment of Addiction) in 2003, which revealed that 91 per cent of those contacted felt that providing treatment was an appropriate way to tackle the drug issue as opposed to 61 per cent who considered that harsher penalties were the solution. *Drug Treatment Research: survey of 1001 people in England*, Continental Research, 2003. http://www.eata.org.uk/treatmentworks/docs/TreatmentWorks_Report.pdf

decisions made at the population level, with treatment provided in a manner that is responsive to the needs of the individual.

Within this broad discussion of a more user-centred service, we would draw attention to specific areas where it is particularly important that options be available and that an appropriate balance be found:

- substitution and maintenance treatment as against abstinence-oriented treatment;
- different options within substitution treatment; and
- intensive or non-intensive treatments, with particular reference to residential as against community care options.

Maintenance or abstinence

One of the key tensions in the provision of drugs treatment is the tension between substitution and maintenance treatment and abstinence-oriented treatment. For many people, the ideal treatment outcome is abstinence, which entails stopping taking drugs altogether. For others, however, such an outcome may be neither realistic nor feasible. These people may require a different approach, focused not on achieving abstinence but on reducing harm as far as possible. Some proportion of this group may need a period of controlled 'therapeutic addiction' before being able to take the ultimate step of achieving abstinence. For yet others, addiction will be a chronic, lifelong relapsing condition.

A range of treatment options must clearly be made available, but at the same time a balance must be kept between them. For example, it would be inappropriate and, in the long term, too costly to be satisfied with placing a relatively high proportion of heroin addicts on methadone substitution programmes indefinitely with no real attempt to encourage some of them to become abstinent altogether. At present, drug users are coming into treatment faster than they are leaving it, partly because the incidence of problematic drug use is rising, partly because the criminal justice system is making a large number of referrals to the treatment system, some of them inappropriate.

While it is entirely correct to warn against complacency and lack of ambition in treatment services and to complain about a comparative lack of financing for abstinence-oriented treatment programmes, it is unhelpful to allow policy on treatment provision to be shaped by arguments on the moral superiority of abstinence programmes. It must be remembered that some of the people experiencing the most serious problems with drug abuse also have the most serious problems with lack of self-esteem, isolation, homelessness, unemployment and social

exclusion. Stabilization on methadone or other substitutes may enable them to make major improvements in their lives, which could then lead on to abstinence. At the same time, for some people there will be no ‘cure’ for their addiction. They will suffer from a long-term, chronic relapsing condition and their treatment must be geared to reducing harm as far as possible rather than to complying with narrowly-construed moralities. Finally, maintenance treatment is associated with significant success in reducing the transmission of blood-borne diseases such as HIV and hepatitis and improving other aspects of health and human functioning.

Methadone or heroin

Some drug users for whom substitutes have been prescribed complain that methadone is actually more addictive than heroin, with more unpleasant withdrawal symptoms and side-effects such as chest pains, confusion, impotence and difficulty in breathing. For others, often the most seriously addicted, methadone alone is not enough.

Although the Dangerous Drugs Act 1967 removed the universal right of GPs to prescribe diamorphine, or pharmaceutical heroin, without a licence from the Home Secretary, a small number of doctors have continued to be licensed to prescribe it for heroin users for whom methadone has failed to work. Record-keeping has been poor, but it is thought that in 2001 around 40-50 doctors were licensed, and about 450 users were receiving prescribed injectable heroin.⁴³² The suggestion has repeatedly been made that this system should be extended to include a far greater proportion of problematic heroin users, if not all of them.

Others beside drugs-services practitioners and harm reduction campaigners have advocated heroin prescribing. Over the last five years, the Association of Chief Police Officers, the House of Commons Home Affairs Select Committee and a range of individual police chiefs have all proposed it as a means of reducing drugs-related crime.⁴³³ David Blunkett, when Home Secretary, was in favour of increasing the number of doctors licensed to prescribe. More recently, the Deputy Chief Constable of Nottinghamshire, Howard Robertson, observed that spending £12,000 a year on prescribing heroin for an addict could save up to £45,000 in terms of the property that he or she would otherwise have stolen.⁴³⁴ The Home Office and Department of Health are already running a pilot programme in two clinics, one at the Maudsley Hospital in London, the other in Darlington, prescribing heroin to some 150 heroin users for ‘clinical need’. Larger programmes have been running for some years in the

⁴³² Professor Gerry Stimson, evidence to House of Commons Home Affairs Select Committee, 27 November 2001.

⁴³³ ACPO's proposal in 2002 involved a registration scheme for addicts and a series of specialist units in police stations, hospitals and surgeries where registered users could take prescribed heroin under supervision. ACPO proposed a national roll-out of the scheme on the grounds that a piecemeal approach could result in the selected clinics being swamped with addicts, provoking local hostility.

⁴³⁴ *Guardian*, 23 November 2006.

Netherlands, Switzerland and Germany, where there have been significant reductions in drug use, crime and drug-related deaths among those receiving this treatment. Closer to home, a system of heroin prescription in Widnes, which ran from 1989 to 1994 under psychiatrist John Marks, produced similar reductions in drug-related deaths and blood-borne infections and the police in north Cheshire reported a 93 per cent drop in drug-related crime among those participating in the scheme.

Heroin prescribing has its critics. Some fear that making heroin so readily available will simply encourage users to remain users – unlike methadone, pharmaceutical heroin still produces a high – and the drug itself may leak into the black market. Many doctors resist the idea that heroin prescribing should be extended to all heroin users. Apart from moral scruples about administering a dangerous drug, they have practical objections. There are some 85,000 heroin addicts currently in treatment, according to the Minister for Health, Caroline Flint.⁴³⁵ If heroin were to be supplied free on demand, the number of people approaching GPs and other services for treatment would undoubtedly increase, and it would be extremely difficult for GPs, in particular, to decide who was in real need and how great their need was.

The scheme would also be costly in terms of time and money. Heroin doses have to be carefully gauged, they have to be administered three times a day (again, unlike methadone, which lasts for 24 hours), and injection has to be supervised to make sure that the drug is not diverted onto the black market. Pharmaceutical heroin is also considerably more expensive than methadone, probably four or five times as much.⁴³⁶ Many feel that the money would be better spent extending the methadone programme and ensuring that everyone who could benefit from it gains access to it.⁴³⁷ At present, methadone prescribing is rationed in the sense that certain groups (including offenders on relevant court orders) are given priority, and health budgets do not extend to cover all of the rest.⁴³⁸ Some Primary Care Trusts and Scottish Health Boards have been forced by budget cuts to put a cap on methadone prescribing, and drugs practitioners complain of the frustrations of having to add other service users to waiting lists that are already too long.

Our view is that heroin prescribing should be considered part of the regular armoury of treatment options. Methadone is simply not effective for all heroin addicts.

Intensive or non-intensive care

Drug users, like the mental health patients envisaged in

⁴³⁵ Answer to Parliamentary Question, 17 October 2006. This is partly because the business is monopolised by a very small number of companies, as a result of restrictions on the licensing of imports for opium derivatives.

⁴³⁶ NTA, *Injectable heroin (and injectable methadone): potential roles in drug treatment. Executive Summary* (2003) states: 'Whilst reliable figures are difficult to obtain, it is estimated that injectable maintenance treatment can cost between 5 to 15 times as much as oral maintenance treatment programmes.'

⁴³⁷ The NTA's guidelines on injectable heroin, for example, state: 'Priority should be given to improving the effectiveness of oral maintenance treatment (on methadone or buprenorphine) for the majority of patients in all drug action team areas in England.'

⁴³⁸ Current priority groups, according to the NTA's resource pack for commissioners, *Service specification Tier 3: Community prescribing*, are: those who are HIV symptomatic or who present with other severe physical co-morbidity; those with mental health co-morbidity; pregnant women (and their partners, where they also require treatment), chaotic injectors, those using high-risk injection sites, long-term injectors, and other locally defined groups, and offenders on relevant court orders.

Our Choices in Health, should be given more options as to where, how and, arguably, how much they are treated. Individual needs and circumstances will vary. Some users may be in a precarious employment situation, with a pressing need to hold on to jobs. Some may have families or children to look after. Others may come from religious or cultural contexts that preclude particular treatment options.

One major weakness in the existing array of treatment options is in the provision of services involving residential care. Residential rehabilitation has been found to be generally more effective than treatment in the community where 'effective' is taken to mean enabling people to become drug-free.⁴³⁹ We urge that every effort be made to ensure that everyone who wants residential rehabilitation and has been assessed as being suitable for it should be able to have it.

In recent years, as the treatment system has developed, the residential rehabilitation sector has been neglected in favour of maintenance prescribing and other services at the Tier 3 level, delivered in the community. At present it can accommodate no more than 5 per cent of all the people in drugs treatment.⁴⁴⁰ With the growing need to move people out of treatment faster, a greater emphasis is being placed on services, such as residential rehabilitation, that have the potential for helping people to achieve abstinence. The National Treatment Agency is planning an Improvement Review of residential provision for 2007/8.

At the same time, however, some existing providers of residential rehabilitation treatment are finding it hard to cover the costs of offering a good service. In some centres beds remain empty. One Scottish centre recently complained of a 'postcode lottery' in residential rehabilitation, with some local authority areas consistently refusing to send any patients for residential treatment.⁴⁴¹ Various factors lie behind this drop in referrals: a lack of monitoring and evaluation makes it hard to assess which of these factors is most significant.

Some drugs services or individual drugs workers appear to object to residential rehabilitation because they dislike the fact that it often aims exclusively at abstinence outcomes. Others dislike the fact that a proportion of residential programmes have a religious orientation. Some see residential care as a last resort and an admission of failure; in their eyes, treatment should always be possible on a non-residential basis and residential treatment violates the principle of bringing care into the community.

⁴³⁹ M Gossop, 'Developments in the treatment of drug problems' in ed. P Bean and T Nemetz, *Drug treatment: what works?* (Routledge, 2004)

⁴⁴⁰ In a letter of 3 November 2006 to DAT chairs, coordinators and commissioners, Paul Hayes states that the NTA's aim is to double the capacity of the residential sector to enable it to accommodate 10 per cent of the treatment population each year.

⁴⁴¹ Peter McCann, chief executive of Castle Craig Hospital which treats alcohol and drug dependency in Peebleshire, observed that the hospital gets 100 referrals a year from Glasgow but only 40 from the rest of Scotland. *Herald*, 'Year wait for NHS help for addicts', 16 October 2006.

An inadequate flow of information is also a problem. Some providers feel that those responsible in Drug Action Teams (DATs) for commissioning residential rehabilitation are not always well informed about rehabilitation itself and are not aware of the services on offer. The facilities are not always local – in the sense that a drug dependency clinic or day centre may be local – and those commissioning treatment may not know how good they are. Nor is there always a system in place for assessing how many places an area may need, how soon and how often, and treatment commissioners in a region rarely coordinate their efforts. According to one provider:

There is little strategic planning where Tier 4 [services] are concerned, with which poor local needs assessment goes hand in hand... There has been purchasing but little in the way of genuine, well informed commissioning. This has partly been the result of there being little or no incentive within the treatment system to arrange for residential treatment to be made available to a local population.⁴⁴²

Moreover, even if there were a system in place for making referrals to residential rehabilitation, as often as not the funding is not there to pay for them. Drug rehabilitation has tended to come, like other forms of residential care, out of the community care budgets of local authorities' social services departments and it therefore competes with all the other demands on these over-stretched budgets. Some providers of residential rehabilitation argue that, rather than adding to the stock of accommodation, the National Treatment Agency should be seeking to ensure that better use is made of what is already there, perhaps by spending some of the new money on developing the sector as it currently exists.

The NTA acknowledges that current funding for residential rehabilitation is 'inadequate and needs reform. The residential rehabilitation sector has been funded primarily from a community care system designed for the needs of the elderly.'⁴⁴³

However, the NTA's Chief Executive has argued that it is not within the Agency's remit to argue for a more appropriate national funding structure. Nor, in his view, can the Agency act itself before establishing whether beds are left empty as a result of a systemic failing in the commissioning process or as a result of market forces causing a crisis for individual providers but not for the sector as a whole. In the absence of reliable statistics on occupancy levels – and in 2005/6 more than half of all service providers failed to submit their data to the National Drug Treatment Monitoring Service – the NTA is urging DATs

⁴⁴² Nick Barton, 'Stop the mixed messages', *Drink and Drugs News*, 6 June 2006.

⁴⁴³ Paul Hayes, letter, *Drink and Drugs News*, 9 October 2006.

to allocate a greater proportion of the pooled treatment budget to residential care. It is also urging service providers to work more closely with commissioners and commissioners to work more closely with local authority community care teams.⁴⁴⁴

In addition, the Agency has also written to senior figures in the prison and probation services encouraging them to make more use of residential rehabilitation for offenders as part of community sentences or on their release from prison.⁴⁴⁵

For the future, the NTA is working on plans to promote 'cluster commissioning' by groups of Drug Action Teams that they feel would make it easier to achieve a coordinated strategy.⁴⁴⁶

In our view, more should be done both to rationalise the provision for residential treatment and rehabilitation and to extend it in order to achieve a programme that is integrated, well coordinated and large enough to accommodate everyone who needs it.

That said, residential rehabilitation treatments are relatively costly and do not suit everyone. They also need to be supplemented with support back in the community, if people are to sustain the changes they have made. Community-based treatment and rehabilitation services (in the form of day programmes and supported living, for example) should not be neglected when deciding how to spend a considerable proportion of the overall budget, nor should programmes that provide supported accommodation.⁴⁴⁷ 'Supported housing for people leaving drugs treatment, or stable within drugs treatment, is far more of a problem than the shortage of residential rehabilitation,' according to one observer.⁴⁴⁸

The Scottish Executive is currently funding one of the first NHS abstinence-oriented programmes to be based in the community. After assessment, people will live for three months not in separate rehabilitation centres or hospital wards but in supported accommodation in the community, being offered psychiatric help, education and employment opportunities and encouragement to take exercise and establish daily routines that will be an alternative to drug use.⁴⁴⁹

For some people, treatment in a more familiar context, involving a greater degree of independent living and the development of routine skills, is preferable to the more protected and closely regulated but also more unnatural atmosphere of a residential centre or drug dependency ward (and is certainly preferable to the general psychiatric wards where many drug users are sent as a matter of routine).⁴⁵⁰ Others will thrive on even less intervention. Some researchers argue strongly that many drug

⁴⁴⁴ Annette Dale Perera, Director of Quality at the NTA, quoted in report on proceedings of FDAP Drug and Alcohol Professionals Conference, 2006, *Drink and Drugs News*, 20 November 2006.

⁴⁴⁵ Letter from Paul Hayes, NTA, Sarah Mann, National Probation Directorate, and Martin Lee, NOMS Prison Drug Strategy Unit to prison governors, Assistant Chief Probation Officers, CARAT Service Managers, Regional Offender Managers and Prison Area Drug Coordinators, 20 November 2006.

⁴⁴⁶ In a paper to the NTA Board at its meeting of 4 October 2006, Colin Bradbury, Treatment Delivery Manager, explains: 'The NTA have agreed with the DoH the following commitment: "Regional Forums will facilitate commissioning partnerships to come together on a regional/sub-regional basis and work towards becoming functional in 2007–08. These regional commissioning groups will ensure greater uniformity in contracting with tier 4 services and look to develop more efficient and well-planned utilisation of capacity."'

⁴⁴⁷ The NTA's *Models of residential rehabilitation for drug and alcohol misusers*, 2006 distinguishes between *rehabilitative* programmes, that provide accommodation and a structured programme of therapy, and *supportive* programmes that provide accommodation, often following treatment in a rehabilitative programme, with specialist support for drug, alcohol and other social issues but no structured therapy.

⁴⁴⁸ Sara McGrail, commentary to RSA, September 2006.

⁴⁴⁹ <http://news.scotsman.com/topics.cfm?tid=1162&id=1546342006>

⁴⁵⁰ Professor John Strang, for example, deplores the fact that the general psychiatric ward is offered to heroin addicts seeking treatment far more often than the specialist inpatient drug unit, given that retention rates in psychiatric wards are far lower. In one study, only 40 per cent of patients were still in treatment after a week. John Strang, 'There is no such thing as harmless drug use: but what harms, whose harms and measured how?', lecture to RSA, 25 January 2006.

users cure themselves of dependency without ever contacting professionals and that many others could be encouraged to do the same.⁴⁵¹ Casting drug users as ‘patients’ and depicting psychiatrists and doctors as the only ones who can help them may discourage many people from trying to help themselves.⁴⁵² Neil McKeganey maintains that it is very important to prevent people from adopting a permanent ‘addict’ identity, clutching at medical remedies such as methadone as the only solution and perhaps missing the opportunity for a natural recovery.⁴⁵³

One route to self-help that is developing fast is the use of the Internet to provide information and some forms of psychological treatments online. These programmes have the advantages of being available at all hours and every day of the week and of being accessible to people who might not otherwise be able to reach treatment services. One of drug users’ most frequent complaints about ‘live’ services is that it is often impossible to avoid mixing with people using different drugs or at different stages of treatment. Online treatment gives people the chance to move forward at their own pace, without distraction and in privacy, although it can also be used effectively for peer support.

The National Institute for Clinical Excellence has produced an appraisal of computerized cognitive behavioural therapies in general, as a means of enabling people to take charge of their own treatment, and now requires that from 31 March 2007 all Primary Care Trusts should provide access to a package entitled ‘Beating the Blues’ as an option for the treatment of mild and moderate depression and another entitled ‘FearFighter’ as an option for the treatment of panic and phobia.⁴⁵⁴ We believe that, with appropriate concern for confidentiality and security, self-help methods of this kind specifically for drugs treatment should be encouraged and access to them extended.⁴⁵⁵ (This is, of course with the proviso that self-help modes of treatment should not be seen as a substitute for more conventional modes of treatment, but rather as a complement to them. At a time of cuts within the NHS, the availability of self-help treatments should not be taken as an excuse to cut the budgets of conventional services. Many service providers feel that programmes like ‘Beating the Blues’ only really work when they are combined with group support and counselling in person.)

A great deal of lip service has been paid to the notion of ‘user involvement’ in drugs services as in other health services. Ultimately, however, if individual drug users are not given the opportunity to choose – between residential rehabilitation or day treatment at a local community centre, between maintenance

⁴⁵¹ e.g. Anni Stonebridge of Smart Recovery UK and the WIRED Initiative, at a seminar convened at the Scottish Parliament by the RSA Commission and the Association of Drug Action Teams in Scotland in February 2006. See also Patrick Biernacki, *Pathways from heroin addiction: recovery without treatment*, Temple University Press, 1986.

⁴⁵² D Best et al, ‘Addiction careers and the natural history of change’, NTA Research Briefing 20, 2006.

⁴⁵³ J McIntosh and N McKeganey, ‘Addicts’ narratives of recovery from drug use: constructing a non-addict identity’, *Drugs: education, prevention and policy*, 8, 2000.

⁴⁵⁴ Rosie Winterton, Minister of State for Health Services, Written Answer to Parliamentary Question, 7 December 2006.

⁴⁵⁵ Smart Recovery (UK) is developing a web-based information and treatment service aimed at people who might not willingly present for treatment but could begin the process of self-change at home <http://www.drinkanddrugs.net/features/nov1504/Internet%20treatment%20and%20support.pdf>

or abstinence, between methadone or another substitute, between professional direction or self-help – user involvement in practice means little or nothing.

Easier access to treatment

We believe that urgent attention should be given to creating better access to treatment through primary care. General service providers who come into contact with drug users – social workers, Accident and Emergency staff, teachers, probation officers, housing officers and so on – should be given better training on drugs issues and clear guidance on when and how to refer people for treatment.

It is also our view that GPs should not have the option of completely opting out of providing drugs treatment. GPs are supposed to treat people according to their clinical needs. The General Medical Council's guidance *Good Medical Practice* (2006) states, in a section headed 'Decisions about access to medical care':

You must not refuse or delay treatment because you believe that a patient's actions have contributed to their condition. You must treat your patients with respect whatever their life choices and beliefs. You must not unfairly discriminate against them by allowing your personal views* to affect adversely your professional relationship with them or the treatment you provide or arrange.

* This includes your views about a patient's age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, or social or economic status.

According to the British Medical Association, the general management of chronic disease and caring for people during self-limiting episodes of acute illness are both classed as 'essential' services under the new GP contract, meaning that all GPs must offer them.⁴⁵⁶ However, it is not at all clear which aspects of a drug user's health care would be considered part of an essential or core GP service.

It can be argued that drug dependency is often a chronic condition. Acute withdrawal symptoms or complications resulting from drug use could both be classed as 'self-limiting episodes of illness'.⁴⁵⁷ On both these grounds, drugs treatment could be considered an essential service. However, the current GP contract and the manner in which it is interpreted has effectively resulted in a patchwork of uneven and inconsistent provision for those in need of drugs treatment services. In some instances services are provided by GPs under the heading of 'additional' or 'enhanced'

⁴⁵⁶ BMA, Parliamentary Unit briefing on 'GP contract and workload', December 2006. <http://www.bma.org.uk/ap.nsf/Content/GPcontractandworkload>

⁴⁵⁷ Dr Clare Gerada, 'New GP contract and drug misuse', Substance Misuse Management in General Practice, Resource Library, <http://www.smmgp.org.uk/html/others/other001.php>

services. In other instances they might not be provided at all. There is currently no clear allocation of functions and duties to GPs, Primary Care Trusts and other health care providers nor a division between them of the obligation to provide a comprehensive health service for drug users. There is an urgent need for clarity and strategic coherence to be brought to this important aspect of public health, and there is a need to boost both the competence in providing drugs treatment and the confidence of the GPs who act as gatekeepers into the mainstream health service.

We would also urge that drugs treatment be included in the annual list of priorities issued to health services as part of the National Service Frameworks. National Service Frameworks, introduced in 1998, are long-term strategies for addressing specific areas of health care. They identify the interventions that are recommended in particular areas and impose strategies for getting these interventions implemented to a consistent standard. There is an overall rolling programme of interventions for key areas such as coronary heart disease, cancer, diabetes and the care of older people. In addition there is an annual list of more specific priorities.

The operating framework for 2006/7, published in January 2006, sets out the government's strategic vision for the NHS until 2009. It includes a section entitled 'Priorities for 2006/7', listing six areas for immediate attention: reducing health inequalities, reducing waiting times for cancer treatment, reducing waiting times for hospital treatment to a maximum of 18 weeks by 2008, reducing levels of MRSA, improving the patient appointment system and the choice of providers for hospital treatment, and improving sexual health and access to genito-urinary clinics.⁴⁵⁸ Singling out drugs treatment in a comparable way would do much to make the point that it should be considered part, and a crucial part, of the mainstream health service. This commitment exists on paper: in the Department of Health's own words, 'Success will be the provision of drug treatment services *as a core part of NHS business* [italics added], with the necessary arrangements in place to sustain delivery at national, regional and local level.'⁴⁵⁹ But the commitment has yet to be realized in practice.

While GPs and family practices are considered to be an important hub for the provision of treatment services, other disciplines and providers within the health services also have a potentially useful role to play. Pharmacists, for example, should be given a greater role in drugs treatment. According to the National Treatment Agency, 'every year, pharmacists provide more than 14 million

⁴⁵⁸ Commonly known as 'the Selbie 6', as the priorities were notified to health services by Duncan Selbie, then Director of Programmes and Performance in the Department of Health. http://www.tvip.nhs.uk/a_/The_NHS_Priorities_for_2006-07.doc

⁴⁵⁹ 'Reconfiguring the Department of Health's Arm's Length Bodies', DH and NHS, 2004.

face-to-face contacts with drug users'.⁴⁶⁰ For many drug users, pharmacists working not only in hospitals but also in ordinary pharmacies and high street chemists' are the principal point of contact with the health service. For drug users who are not in treatment, pharmacists may be the only healthcare professionals they see.

Pharmacists can dispense and supervise the consumption of methadone, exchange used needles for clean ones, refer people to specialist services, offer harm reduction advice (on immunization against Hepatitis B, for example) and help with day-to-day health problems. As part of the healthcare team involved in providing drug users with treatment, a pharmacist can play an important liaison role as the person in closest contact with them on a day-to-day basis. Under new legislation, suitably trained pharmacists can already prescribe controlled drugs such as methadone and buprenorphine in accordance with a clinical management plan agreed with the patient and their doctor, though they cannot prescribe these drugs independently.

In theory, pharmacists could also, for example, adopt a more proactive approach to health education and harm reduction, engaging with schools and community organizations to provide a credible professional perspective on drugs prevention while at the same time challenging public perceptions about drug users. They could experiment with providing services outside traditional pharmacy premises, in day centres or hostels for the homeless.

Pharmacists have been pressing for some time for greater involvement in the strategic and operational planning as well as the delivery of drugs treatment services. In the past, they have not been regularly represented on either national bodies or local bodies. Drug Action Teams have tended not to recognise the role played by pharmacists or support it through funding. We support the recommendation of a joint working group of the National Pharmaceutical Forum and the Scottish Medical and Scientific Advisory Committee that pharmacists should be represented at a senior level on Drug Action Teams.⁴⁶¹ We also believe that the NHS and other agencies should explore the opportunities for engaging pharmacists more fully in the planning, provision, delivery and extension of services for substance misusers.

Increasing the number of GPs involved in drugs treatment and making more extensive use of pharmacists would make treatment accessible to a larger number of drug users, as well as allowing treatment to be more responsive, flexible and better tailored to individual needs and preferences.

⁴⁶⁰ Paul Hayes, foreword to *Best practice guidance for commissioners and providers of pharmaceutical services for drug users*, NTA/Royal Pharmaceutical Society of Great Britain, 2006.

⁴⁶¹ Scottish Executive, *Prevention and treatment of substance misuse. Delivering the right medicine: a strategy for pharmaceutical care in Scotland*, 2005.

Successful drugs treatment depends to a considerable extent on timing. There are windows of opportunity for offering treatment – when people go into prison, for example, or immediately after they come out, or as soon as a drug user displays interest in reducing or giving up their drug use – but these windows are narrow and they close easily. A waiting time of weeks rather than days may send a tentative potential service user away. A bad first impression, one of delay and frustration, will shape people's expectations of a service. In younger people especially, this may colour their own reactions and condition their behaviour. Research suggests that long waiting times do not necessarily stop people presenting for assessment once they have been referred or from taking up treatment once they have been assessed.⁴⁶² Nor do they affect the length of time that people are ultimately retained in treatment, but they do seriously discourage potential clients from seeking help in the first place: 'The waiting time reputation may lead to referral apathy both on the part of clients and agencies that discourages client presentation.'⁴⁶³

Conventional health services are geared to conventional life styles, not chaotic ones. Service users themselves suggest that services that close during the night, at weekends and over public holidays, or that require pre-booked appointments, or that cannot respond quickly to crises, or that mix people at widely different stages of treatment, are failing to meet their needs. Some providers argue, in contrast, that the discipline of being required to follow some kind of regimen is part of the treatment. Both would agree, however, that treatment requires a care plan that is shared by the service and the service user.

The NTA Business Plan for 2006/7 sets treatment services a target of providing written care plans for 91 per cent of new clients and stipulates that clients must be involved in their preparation. The care plan is supposed to be based on a thorough assessment of the client's needs. It should outline not only the best course of treatment for them but also the kind of support they should have in solving problems with money, housing, employment and family relationships.⁴⁶⁴ These plans have to be based on intelligent assessments of people's current physical and psychological states and their varying degrees of motivation, but if they are purely the constructs of the professionals in charge, they will not work. They must be tailored at least in part by the individuals themselves, and this requires a different kind of 'user involvement' – more intensive, more personalized and adequately funded. Increasing emphasis is placed in policy pronouncements on the notion of 'user involvement', but this involvement seems

⁴⁶² Though where the wait after assessment is shorter, a greater proportion of people are likely actually to present for treatment. J Strang et al, *Randomised clinical trial of the effects of time on a waiting list on clinical outcomes in opiate users awaiting out-patient treatment*, Department of Health/NTA, Research summaries for providers and commissioners, 2004.

⁴⁶³ M Donmall, 'Waiting for treatment: effects on uptake and immediate outcome', Department of Health Drug Misuse Research Initiative, 2004.

⁴⁶⁴ In 2006 a private member's bill was placed before the Scottish Parliament proposing that there should be a statutory requirement to provide a holistic care plan of this kind within seven days of a request for it. The scheme would be financed from a percentage of the assets seized from drug dealers. (The bill fell in December 2006 for lack of parliamentary time to progress its consideration.)

to be viewed in collective rather than individual terms: 'users' are to be involved as a body and consulted on issues instead of being asked individually how they would like to be treated.⁴⁶⁵ Nor does this user involvement fare well when it has to compete for over-stretched funds, as it is not directly related to the main performance targets. When efficiency savings are called for, user involvement programmes are often the first to go. In our view, drug users should be engaged with on an individual basis, not simply through collectivist programmes that inevitably run the risk of being purely cosmetic.

Better integrated services

Providing a fully coordinated service is challenging when each of the elements to be coordinated is itself in flux. The National Treatment Agency complains with some justice that it is being required to manage 'in an environment of instability brought about by current and potential reorganization of all the key partners who are collectively responsible for the delivery of drugs treatment', with local authorities awaiting the Lyons Report, police services recovering from the threat of merger and facing the redrawing of their boundaries, the probation service facing its second major restructuring in five years, and the NHS in the middle of a major rebuild that involves reducing twenty-eight Strategic Health Authorities to ten and 303 Primary Care Trusts to 152.⁴⁶⁶

Nevertheless some basic linkages in the drugs treatment services are important and could be achieved.

Alcohol and drugs treatment

A recent publication from the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) has pointed out that over the past few years the scope of drugs strategies in a number of EU member states has increasingly been extended to cover all drugs, both licit and illicit:

While a broadening of the scope of drug strategies is not always highly visible, strategic or institutional integration of licit and illicit drugs is increasingly common, even in those countries where the drug strategies refer only to illicit drugs.⁴⁶⁷

Drug strategies in Belgium, France, Germany, Spain and four other EU countries consider alcohol, tobacco and prescription medicines alongside illegal drugs, and the bodies responsible for coordinating drugs strategies have additionally been made responsible for running their country's alcohol and often their tobacco strategies. In France, for example, the Inter-ministerial Mission for the Fight Against Drugs and Drug Addiction now

⁴⁶⁵ A recent report from the Joseph Rowntree Foundation entitled *Making user involvement work: supporting service user networking and knowledge* (2006) underlines the usefulness of service user networks in general as giving people a chance to work collectively for change and mutual support, but makes the point that these organizations are often isolated, under-funded and under-representative of black and minority ethnic service users or those with transport or childcare problems.

⁴⁶⁶ NTA, *Business Plan 2006/2007*, September 2006.

⁴⁶⁷ EMCDDA, *Annual Report 2006: Selected Issue 1, 'European drug policies – extended beyond illicit drugs?', 2006.*

coordinates the fight against alcohol and tobacco as well, and in Germany the drugs commissioner of the federal government is required to coordinate activities relating to all addictions. In some countries, drugs treatment centres have been merged with alcohol treatment centres or new joint centres have been established. In France, centres for the treatment and prevention of addiction have replaced both outpatient alcohol clinics and specialist drugs treatment centres.

This shift in focus reflects the fact that distinctions between the roles of alcohol, illegal drugs and psychotropic medicines are gradually being eroded, in both theory and practice. Addictive behaviour is increasingly studied as a single phenomenon rather than as something that is substance-specific, reflecting the fact that people use a range of psychoactive substances in different ways to achieve the particular effects that they want or need. Heroin and cannabis are used as if they were medicines, to counter fear and anxiety. Cocaine is used to improve performance, at work and in sport. Over-the counter medicines are used to get high. Alcohol is used to get drunk. Prescribed drugs are used to stay awake. One authority observes that ‘framing the issue according to the legal status of drugs and their stereotypical functions/purposes (psychotropic medicines to care, illegal drugs to have fun or to escape from reality, legal drugs to socialise, etc.) is no longer relevant’.⁴⁶⁸ Another points out that excessive use of any substance may have the same or shared roots: ‘For drug users who drink, the difficulties in controlling consumption of both substances are likely to be deeply interwoven.’⁴⁶⁹

In terms of the general principle of improving public health by countering the effects of addictive behaviours, the distinctions between legal and illegal substances are largely irrelevant, even if the specific harms caused may be quite different. In addition, the distinctions are often rendered useless by the fact that the early use of alcohol and tobacco is the strongest risk factor associated with initiation into the use of illegal drugs, and also by the fact that so many people use both legal and illegal drugs at the same time.⁴⁷⁰

In England, Wales and Scotland, the drug strategy is still set apart from the alcohol and tobacco strategies. It does, however, incorporate references and links to alcohol and tobacco – for example, in its approach to substance misuse education – and the bodies required to implement the strategies are often one and the same. Caroline Flint, the Minister for Health, stated categorically in May 2006, ‘The Government have no plans to create a separate agency to take forward the alcohol strategy’.⁴⁷¹ As well as its

⁴⁶⁸ A Ehrenberg, *Drogues et médicaments psychotropes. Le trouble des frontières*, 1998.

⁴⁶⁹ Richard Phillips, Director of Services, Phoenix House, ‘Your clients will die of alcohol’, letter in *Drink and Drugs News*, 17 October 2005.

⁴⁷⁰ Ibid. ‘Without implying causality, there seems to be a degree of correspondence between lenient anti-tobacco policies and a higher prevalence of tobacco smoking amongst young people, and it is interesting to observe that several countries with high rates of adolescent smoking and lenient tobacco policies also have a high rate of cannabis consumption.’

⁴⁷¹ Written Answer to Parliamentary Question, 10 May 2006.

remit on drugs treatment, the National Treatment Agency is also commissioned to undertake specific work on alcohol treatment. In 2006 it published both *Models of Care for Alcohol Misusers* and a *Review of the Effectiveness of Treatment for Alcohol Problems*. The Agency has also worked with the substance misuse team at the Department of Health to produce a framework for tackling the misuse of volatile substances. At the local level, Scotland's Drug Action Teams have now become Alcohol and Drug Action Teams; and in England, where Drug Action Teams have been urged under the Alcohol Harm Reduction strategy to coordinate local action on alcohol, some have gone on to become Drug and Alcohol Action Teams. However, there is no coherent guidance for DATs in relation to alcohol.

Northern Ireland has taken a different tack. Whereas alcohol and drugs policy was split into separate strategies in 1999 and 2000, the *New Strategic Direction for 2006-11* merges them again, in an inter-agency plan that covers illegal drugs, alcohol, prescribed medicines, over-the counter medicines and volatile substances.

We strongly recommend that the drug and alcohol strategies in England should be similarly integrated when they come up for review in 2008 and 2007. There are indications that such integration may already be under consideration. Minister of Health Caroline Flint noted in a Parliamentary Answer on 27 June 2006 that the government had been able recently 'to... ascertain where we can achieve better connectivity between the different forms of substance misuse... We need to pay attention to that.' We agree – though it should be noted that many service providers would resist this if it meant that alcohol treatment would be linked to the criminal justice system just as drugs treatment has been harnessed in recent years.

It has been accepted in the field of education and prevention that trying to forestall or postpone early drinking and smoking is a crucial part of postponing or preventing illegal drug use. In terms of credibility, it may even be impossible to reduce harmful drug use without being seen to do likewise in the case of alcohol and, to a lesser extent, tobacco. The EMCDDA report is emphatic on this point:

Universal prevention efforts face a more challenging task in a society in which, for instance, binge drinking and smoking in public places are widely accepted and have positive value associations such as extroversion and fun (in the former case) and civil liberty (in the latter case). This weakens the credibility of prevention measures, because it appears to adolescents

that disapproval of illicit drug use and attempts to prevent it stem only from legal concerns and not from a real social commitment to avoid harmful substance use.

⁴⁷² Department of Health, *Alcohol Needs Assessment Research Project (ANARP): the 2004 national alcohol needs assessment for England*, 2005.

It needs to be similarly accepted in the field of treatment that it is not cost-effective to treat problem drug users in ignorance of the fact that a large proportion of them also drink in a way and in amounts that additionally damages their health and may well interfere with their drugs treatment. Alcohol abuse needs to be recorded alongside drug use and drugs treatment workers need training in how to respond to their clients' drinking rather than simply referring them to a separate agency.

⁴⁷³ Scarman Lecture, 24 November 2006.

One model of large-scale local service coordination is the integrated Glasgow Addiction Service created by combining all the mainstream specialist drugs and alcohol resources of Greater Glasgow NHS and Glasgow City Council with additional Scottish Executive funding for drugs and alcohol, amounting to an annual budget of £37 million. However, few organizations have the money to integrate data collection or referral systems or invest in joint training, as such a scheme requires. In England, the National Treatment Agency and Drug Action Teams have been urged to take responsibility for alcohol without any significant extra funding being made available to them. In surveys of DAT professionals carried out as part of the Department of Health's Alcohol Needs Assessment Research Project, 86 per cent of respondents said that their alcohol treatment budgets were much lower than their drugs budgets and that they were aware of a 'very large gap' between the demand for and the provision of alcohol treatment.⁴⁷² In a public lecture in November 2006, the Conservative leader, David Cameron, observed:

People now recognise that alcohol abuse is as great a problem as drug abuse. Yet Drug Action Teams are required to chase government targets which prioritise drugs, leaving not enough money left over for tackling alcohol. The DAT in my constituency in Oxfordshire has decided to take matters into its own hands and is raising money from local businesses to support its alcohol strategy.⁴⁷³

Alcohol treatment is currently funded out of mainstream NHS allocations and there is no specific funding to implement the Alcohol Treatment Requirements that can form part of courts' community sentences. Closer integration of drug and alcohol strategies has so far been impeded by the fear that alcohol treatment will siphon off hard-won funding from drugs treatment. The National Treatment Agency has been careful to stress the limits of its responsibility for alcohol treatment, and

substance misuse treatment providers have revealed they have been told to treat alcohol problems only after all their drug targets have been met.⁴⁷⁴ Constant comparisons between the relative levels of funding for drugs and alcohol treatment are unconstructive, as is the sense of competition that these comparisons breed. The Commission believes that the integrated treatment of substance misuse, both drugs and alcohol, should be given a higher priority for funding within the National Service Frameworks as part of mainstream health services.

⁴⁷⁴ See, for example, letter 'Alcohol and drugs inextricably entwined', from Rosie Brocklehurst, Director of Communications, Addaction in *Drink and Drugs News*, 31 October 2005.

⁴⁷⁵ Department of Health, *Mental health policy implementation guide: dual diagnosis good practice guide*, 2002.

⁴⁷⁶ *Ibid.*

Drug use and mental illness

The Department of Health's guidance on dual diagnosis states quite clearly that 'Individuals with dual problems deserve high quality, patient focused and integrated care.'⁴⁷⁵ Each person should have an individual care plan, coordinating the contributions of different agencies. However, the guidance continues, 'This should be delivered within mental health services.' In other words, the care of people with both mental health and drugs problems must be mainstreamed through existing mental health care.

However, better care of people with drugs problems by mental health staff will require extensive planning and training. At present, it has been suggested, there is both extensive drug use within mental health facilities and a *laissez faire* attitude to it. The borough director of one London mental health trust is on record as saying that it is quite common for patients to use drugs on the wards; he estimated that in one hospital about 14 per cent were using drugs, including crack cocaine.

Mental health services need to make the assessment and treatment of drug use a routine element in their planning and also a more central one. While drug specialists will continue to be responsible for assessing and treating the more severe or complex cases of drug use where it is combined with mental illness, all mental health services staff need to know how to 'make simple prevention and treatment interventions'. 'Staff in mental health services must realise that it is an environment that can put individuals at a higher risk than usual of misusing substances.'⁴⁷⁶ In addition, staff training should include information about local drug and alcohol use, and all cultural competence training should include a knowledge of the patterns of drug use in different cultures and communities.

Families

More often than not, drugs are an issue affecting whole families. Millions of people are affected by drug use in addition to

the users themselves, making this a major public health issue. However, as we have argued above, the general tendency is for treatment to be fragmented. Each agency treats its own client – patient, offender, child – and workers feel unqualified to deal with problems outside their own area. Where it is the parent that is the drug user, the interests of the parents, as we have argued above, are often considered separately from those of their children. Where it is the child that is the user, the problems experienced by parents, brothers, sisters, grandparents and friends are often not considered at all. Help may be difficult to find. Parents worn down by anxiety, anger and exhaustion may find themselves fobbed off by their doctors with anti-depressants and excluded from any real involvement in their children's treatment. The telephone contact offered by the National Drugs Helpline is not close enough to be comforting and yet some families are very reluctant to risk gossip and stigma by looking for more direct and personal help from support groups, which are in any case not always easy to discover.

The Aberlour Child Care Trust has been closely involved in implementing the recommendations of the *Hidden Harm* report on the protection of children of drug-using parents. During 2006 the Trust, supported by the Scottish Association of Alcohol and Drug Action Teams, published reports by two multi-agency think-tanks which considered the risks and responses associated with illegal drugs and alcohol. The conclusions identified some key practice issues and placed them firmly within the context of mainstream best practice governing protection for all children. The Trust's Chief Executive Romy Langeland argues that what is needed is a culture change, 'so that when you are looking at an adult or a child you look at them in terms of their families and their communities'.⁴⁷⁷

The same plea is made for the children of adults who misuse alcohol in Turning Point's *Bottling It Up* report, which calls for 'all services across adult based alcohol services and children's services to be reconfigured to provide a coordinated approach to meeting the needs of the whole family... All agencies should adopt a family-focused approach and promote initiatives that bring parents and children together'.⁴⁷⁸ A more general need for this kind of holistic approach has recently been acknowledged in the Government's social exclusion action plan, *Reaching Out*, which pledges:

ACTION 21: By summer 2007 the Government will review and consult on how well services aimed at at-risk children and adults are working together on the ground. We will identify any further actions or powers that are needed to

⁴⁷⁷ www.communitycare.co.uk Community Care Live News: 'Split of services hinders support for substance misusing families', 1 November 2006.

⁴⁷⁸ Turning Point, *Bottling It Up: the effects of alcohol misuse on children, parents and families*, 2006.

deliver a coherent whole-family approach for those most in need of help, challenge and support... Of paramount importance are: identifying problems across family members and sharing information; analysing how services engage with and work with families with additional and complex needs; addressing issues that affect the thresholds for intervening with support for families; and addressing the workforce so that practitioners are better aware of the multiple problems affecting families and their members.⁴⁷⁹

⁴⁷⁹ Cabinet Office, *Reaching out: an action plan on social exclusion*, 2006.

⁴⁸⁰ 'Parenthood after addiction', *Children Now*, 24-30 November 2004.

⁴⁸¹ Sam Hart, 'Rehab revolution' *Druglink*, May-June 2005.

The ideal solution is indeed to treat the family as a whole. Lack of family support is a key factor in many people's misuse of drugs, and a lack of outside support *for* the family may help create this situation. Family therapy should be seen as an important preventive tool as well as a cure. However, at present services of this kind are scarce. Family therapy is offered by only a few treatment providers, as it falls outside the scope of their usual remit and dedicated funding. The Nelson Trust, for example, provides a family therapist to work with those closest to a drug user, so that the user and their 'support network' are receiving help at the same time. The Trust is also hoping to establish a programme looking at the dynamics of family relationships which may be an integral part of the pattern of drug use. Clouds Families Plus uses the Home Office's recovered assets fund to provide fourteen free weekly support groups for families in the South and West. A pilot project for 40 teenagers with drugs and alcohol problems is to start in Glasgow in 2007, based on the holistic family therapy approach developed by the University of Miami. A few residential rehabilitation units for families also exist – for example, the Trevi House Project in Plymouth, the Brighton Family Service run by Phoenix House and, in Scotland, two residential rehabilitation services run by the Aberlour Child Care Trust for mothers and children up to 12.⁴⁸⁰ This type of service generally combines detoxification with parenting support, giving parents (most commonly mothers) the chance to stay with their children in a safe environment. But other similar units have closed because not enough people have been referred to them. The funding for the women and their children comes out of different social services budgets and there is insufficient coordination between these departments, let alone between social services and the treatment agencies.⁴⁸¹

Most of these specialist services are struggling for money, and there is currently no budget to provide help to the families and carers of drug users on a wider scale. We would like to see greatly increased resources put into dealing with families as a whole. Resources should be earmarked within drugs funding. 'Family

policy’ is moving up the political agenda, and drugs treatment needs to be seen as an integral component of family services when funding for them is allocated.

⁴⁸² *Sunday Times*, 14 May 2006.

Better tailored services

This Commission fully supports the generally acknowledged demand for services tailored more closely to the needs of groups who are badly served at present.

Black and Minority Ethnic communities

Services should recognise the varying needs of different communities, where these exist, but without creating an artificially segregated system. One answer is to make separate services available rather than compulsory. Tower Hamlets Drug Action Team, for example, has set up a new detoxification centre, believed to be the first non-private unit of its kind in London. Run by the Salvation Army for the DAT, it caters predominantly for non-injecting heroin users from the Bangladeshi community and aims to give them a chance to get physically clean and mentally strong enough to go into longer-term care, without having to leave the borough.

Women

Women in pregnancy, women with children and women in sex work all need more than ordinary drugs services have traditionally offered them. Pregnant women certainly need help to protect their own health and that of their babies. One model might be the pregnancy support team set up in Edinburgh by Action on Alcohol and Drugs. The team consists of a midwife, a community psychiatric care nurse and a number of nursery officers; together they help women address drug-related health problems before and after delivery, as well as reducing the threat to the babies of low birth weight, premature birth, neonatal abstinence syndrome and sudden infant death.

Susan Deacon MSP has argued that family planning services for female drug users should be improved and a wider range of contraceptive options offered, as advocated in the 2003 *Hidden Harm Report*. ‘Every woman should have access to a range of advice and services in the right place at the right time to enable them to make informed choices about their reproductive health and fertility.’⁴⁸² She argues that this should include the option of long acting contraceptives, such as injections and implants. Dr Mary Hepburn is a consultant obstetrician who leads the Glasgow Women’s Reproductive Health Service, providing services for women with a range of social needs, including drug and alcohol addiction, mental illness and learning difficulties.

'In our experience, the women welcome information,' Dr Hepburn told the *Herald* on 13 February 2007. If you make it punitive – saying, for example, you are not a fit mother, therefore we are not going to allow you to have children – clearly, they don't take kindly to that and it does not encourage them to come to services.'

⁴⁸³ See, for example, presentation by Dr Jo Phoenix at the 'Sex as Crime' conference, Birmingham, 5 April 2006.

⁴⁸⁴ Information from COCA, 24 January 2007.

Female drug users with small children need services that include childcare facilities as well as providing links to other services such as obstetrics and paediatrics, housing, benefit entitlements and counselling by female therapists on issues such as sexual abuse, domestic violence, loneliness, depression, self-harm and eating disorders.

Since January 2006 courts have been allowed to impose compulsory drugs treatment orders on sex workers, 90 per cent of whom have been estimated to be using heroin or crack and who are working on the streets as an alternative to burglary and shoplifting as means of funding their habits. The aim is to give them priority for treatment, but some critics suggest that the risk of their breaching their orders is high, in which case they will have a criminal record that is likely to make it harder for them to leave the industry.⁴⁸³ Manchester Action on Street Health is a registered charity providing a night-time service for sex workers and drug users, using a mobile unit and outreach workers to contact women working on the street and in saunas, offering needle exchange, vaccination for Hepatitis A and B and testing for Hepatitis C, pregnancy testing, screening and treatment for sexually transmitted infections and basic first aid. They also offer a fast track to drugs treatment. We believe that this kind of service should be funded so that it becomes more widely available, providing a fast track into treatment outside the criminal justice system, supported by assistance with housing and alternative employment.

Stimulant users

There is no effective pharmacological solution for the problems caused by stimulants such as cocaine and crack, in the sense that there is no substitute drug comparable with methadone or buprenorphine. Doctors in the US have developed an integrated approach that uses both medical and psychological interventions to treat stimulant users, but it is too early to assess the effectiveness of this approach.⁴⁸⁴ In the UK it is more common to use psychological therapies such as cognitive behavioural therapy and motivational interviewing. COCA, a charity providing information specifically on stimulant use, has developed for crack and cocaine users a twelve-week programme incorporating a series of brief intervention sessions

and tackling such subjects as the triggers for stimulant use and techniques for resisting cravings.⁴⁸⁵

More generally, there is a national shortage of the kind of talking therapies that have been found to be successful. An Early Day Motion in the House of Commons in April 2006 pointed to the existence of a post-code lottery for treatments of this kind: ‘Research by the Conservative Party has confirmed huge disparities in the availability of psychological therapies despite their efficacy and cost-effectiveness in long-term treatment.’⁴⁸⁶ The government has launched an initiative to address this problem, the Improving Access to Psychological Therapies (IAPT) programme, the objective being ‘to develop a service model for delivering a range of evidence-based interventions, with the focus being on cognitive behavioural therapy (CBT) because this has the broadest evidence base’.⁴⁸⁷ The case for investing in local psychological therapies services will be submitted to the Treasury as part of the 2007 comprehensive spending review.

There has also been a good deal of work to find more informal answers to the problem of treatment for stimulant users. Haringey Drug and Alcohol Action Team, for example, has supported the BUBIC scheme: ‘Bringing Unity Back Into the Community’. BUBIC employs former crack users as outreach workers to encourage others into treatment and as mentors to support them through the process. Its aim is then ‘the personal transformation of drug and substance misusers by providing community based activities that will aid ...rehabilitation.’⁴⁸⁸

Schemes like this, which involve no medication, sometimes struggle to find recognition and funding as ‘treatment’, partly because it is hard to quantify their outcomes. However, they reach some of the people with the most intractable problems, people who would never approach services of their own accord, and they engage them with the treatment system, even if the links are indirect. The National Treatment Agency acknowledges that ‘crack misusers are more likely to seek help through informal services tailored to meet their needs and staffed by knowledgeable workers, including former drug users. Drop-in services, peer networks, and 24 hour telephone helplines have been successful.’⁴⁸⁹ This Commission believes that ‘unofficial’ outreach services of this kind should be recognized, encouraged, extended and more generously funded as playing a valuable role in reducing the harm caused by stimulant use.

⁴⁸⁵ The scheme is being run in conjunction with the NTA and treatment provider Rugby House and it is hoped to implement it more widely in the future.

⁴⁸⁶ Early Day Motion laid down on 19 April 2006 by Andrew Lansley MP and others.

⁴⁸⁷ Rosie Winterton, Minister of State for Health Services, Written Answer to Parliamentary Question, 7 December 2006.

⁴⁸⁸ BUBIC website, <http://www.bubic.org.uk/>

⁴⁸⁹ NTA, *Background briefing on crack/cocaine misuse and treatment*, <http://www.nta.nhs.uk/frameset.asp?u=http://www.nta.nhs.uk/news/030320.htm>

Better 'wraparound' services

Treatment is more likely to work when the treatment in question is of a person rather than a substance, and people attempting to give up or reduce drug use have needs beyond medical help. Crucial to managing or giving up a drug-using life is the ability to construct an alternative way of living. This requires help in finding a place to live, away from dependent drug users, and something to do to fill the long hours that would otherwise be spent finding the money, finding the drug and using the drug.⁴⁹⁰ The National Treatment Agency, acknowledging the need for kinds of support for drug users other than medical treatment, is creating a senior management post for engaging with other departments and carrying out research into accommodation needs and the available employment schemes. In the meantime, there is an urgent need to help more people in treatment or coming out of treatment to find accommodation and employment.

Housing

Some of these people might be able to live completely independently if they were enabled to find accommodation but many more of them will need supported housing. The range of supported housing that is supposed to be on offer varies widely. Some takes the form of high-support hostels, with staff living on site, or smaller shared units, with support workers coming in but not living on the premises. Much of this kind of accommodation and support is provided by voluntary organizations. Other forms of support may be offered to people in accommodation provided by Registered Social Landlords. Having helped to resettle people, 'floating support' workers help them to protect their tenancies by keeping them in touch with treatment, steering them towards daytime activities and so on. As a result of one such support project, it was reported that neighbour complaints were reduced by 93 per cent and rent arrears reduced by 57 per cent in six months, with 97 per cent of tenancies safely retained.⁴⁹¹ Rent deposit and guarantee schemes are an inducement to private landlords to take drug users as tenants.

The Home Office, with the Office of the Deputy Prime Minister (now the Department for Communities and Local Government, stated in 2005:

Housing is an important part of the National Drug Strategy and the national Reducing Re-offending Action Plan. Access to appropriate housing and support to sustain this housing can have a positive impact on problematic substance misuse and related problems.⁴⁹²

Nevertheless, it can be very difficult even for people coming

⁴⁹⁰ Some would argue that it also requires the adoption of new values and attitudes. 'The key to successful recovery from addiction is the construction by the addict of a new identity incorporating non-addict values and perspectives of a non-addict lifestyle.' J McIntosh and N McKeganey, *Beating the dragon: the recovery from dependent drug use*, Prentice Hall, 2002.

⁴⁹¹ Release, *Tackling drugs in rented housing: a good practice guide*, 2002.

⁴⁹² ODPM/HO, 'Housing support options for people who misuse substances: guidance for Supporting People commissioners and officers', March 2005.

out of treatment to make their case for re-housing. One former heroin addict recalled:

I went down and declared myself homeless. The guy I spoke to at the council said he couldn't help me and shoved me out the door. I told Bill, my keyworker, and he said it was wrong and he should have at least signed a homeless declaration or something like that. I don't know much about it. Bill knew more and then found out more about what they should have done... Bill sat next to me and told them exactly what was going on and they tried to push us out the door again, but Bill seemed to know what he was talking about and afterwards I was re-housed the same day.⁴⁹³

These problems are greatly intensified for people who are continuing to use drugs.⁴⁹⁴ They are often excluded from supported housing by strict eligibility criteria. The Supporting People initiative, in the words of its website, is 'a working partnership of local government, service users and support agencies' whose aim is 'to offer vulnerable people the opportunity to improve their quality of life by providing a stable environment which enables greater independence' in the form of 'housing-related services'.⁴⁹⁵ Supporting People is run by the Department of Communities and Local Government. Although on paper the initiative extends its services to drug users, the Audit Commission reports that in practice there have often been shortfalls: 'Inspection of Supporting People partnerships by the Audit Commission paints a mixed picture, with some areas providing effective services that benefit drug users, and little provision in others.'⁴⁹⁶

Local authority housing departments, for example, have enough trouble finding housing stock without having to deal with the extra potential problems that they anticipate from drug users (described in a recent government circular as 'vulnerable or unpopular').⁴⁹⁷ In the past there have been reports that housing departments have been less engaged in tackling drug misuse than education or other social services.⁴⁹⁸ Local authority housing policies frequently exclude drug users from priority housing unless they can prove that they are 'vulnerable under the terms of the policy', and drug use is often not itself accepted as a mark of vulnerability.⁴⁹⁹ Too often people known to have, or to have had, problems with drug use end up in the same neighbourhoods and estates, those attempting to stay clean alongside those who are still using.

The situation in Scotland is similar. The Scottish Homelessness Framework sets out a clear timetable for change: by 2012 every

⁴⁹³ A Hopkins and D Clark, *Using heroin, trying to stop, and accessing treatment: a qualitative analysis of the experiences and views of clients on the Peterborough Nene Drug Interventions Programme*, WIRED/Peterborough Nene Drug Interventions Programme, 2005.

⁴⁹⁴ See, for example, S McKeown, *Safe as houses: an inclusive approach for housing drug users*, Shelter, 2006.

⁴⁹⁵ <http://www.spkweb.org.uk/>

⁴⁹⁶ Audit Commission, *Drug misuse 2004: reducing the local impact*, 2004.

⁴⁹⁷ Office of the Deputy Prime Minister/ Home Office circular, 'Housing support options for people who misuse substances', March 2005, says that strategies for housing drug users 'should be developed as with strategies and services to other vulnerable or unpopular groups'.

⁴⁹⁸ e.g. Audit Commission, *Drug misuse 2004: reducing the local impact*, 2004.

⁴⁹⁹ Release, *Tackling drugs in rented housing: a good practice guide*, 2002.

homeless person should have a right to permanent accommodation which is sustainable and supported by appropriate health and other services. These aspirations are backed up with new legislation.⁵⁰⁰ In addition, each of the 32 local authorities and 14 NHS Boards has a multi-agency Homelessness Strategy in which drug users are included.⁵⁰¹ A national Homelessness and Substance Misuse working group is now developing an action plan. However, the number of homelessness applications is rising and it is feared that too little accommodation and too few support services will be available to meet the 2012 deadline.

A 2005 report from the then Office of the Deputy Prime Minister, *Benefits Realisation of the Supporting People Programme*, effectively concluded that, in economic terms, using Supporting People to help drug users with accommodation was not worthwhile: 'the financial benefits to the exchequer do not break even'.⁵⁰² At an estimated £22.5 million, the cost of providing Supporting People services to drug users would not be counterbalanced by equivalent benefits in terms of an impact on crime reduction, savings to the health service or tackling homelessness.⁵⁰³ However, the authors point out that these calculations leave largely out of account any benefits to the drug users themselves. These 'uncosted benefits' include 'greater stability [allowing] for transition into a more stable lifestyle; decrease in anti-social behaviour in the community; increased likelihood of completing rehabilitation; and decreased risk of suicide and self harm,' all of which, the authors conclude, 'are benefits that are highly valued by the individual and the community even if no monetary value can be attached to them'.

The Commission believes that the failure to make housing available to drug users, whether or not they are in treatment or coming out of it, compounds their problems and undermines the effectiveness of any treatment they may be receiving. Since stable accommodation is a significant factor in helping people to stay in treatment and avoid relapse, it also contributes significantly to ensuring that the money spent on treatment is not wasted. It could be argued that 'greater stability' is a benefit to which a monetary value should most certainly be attached. On practical grounds as well as grounds of principle, we recommend that more funds be made available for the supported housing of drug users from within the *Supporting People* initiative.

Employment

It is widely recognized that finding employment is one of the most effective routes back to a sense of self, of self-worth, of feeling 'normal' and of making progress. Having a job can

⁵⁰⁰ The Housing Scotland Act 2001 and the Homelessness etc. Scotland Act 2003.

⁵⁰¹ In addition, National Health and Homelessness Standards have been published and NHS Boards must account for them in their performance assessment frameworks.

⁵⁰² ODPM, *Benefits Realisation of the Supporting People Programme: Working Paper 8: People with Drug Problems*, 2005. http://www.spkweb.org.uk/search/channels/www.spkweb.org.uk/subjects/supporting_people_independent_review/wp8_peoplewithdrugproblems.pdf

⁵⁰³ The report acknowledged that providing better housing to drug users could well result in some reduction in the number of visits to Accident and Emergency, the use of acute mental health services, the number of arrests for drug offences and acquisitive crime and the number of days in prison, the numbers of tenancy failures and the social care costs of looking after the children of drug users. However, these reductions and the related savings would not amount to £22.5 million.

break drug users' contacts with drug dealing, create a sense of belonging, promote self-sufficiency and generate optimism and a feeling of opportunity. The Progress2Work scheme is run by the Department of Work and Pensions. Drugs treatment agencies are required to work with the employment service, referring suitable clients to JobCentres, while employment service staff are supposed to identify people whose failure to get a job they can attribute to drug use and to refer them for treatment. Progress2Work has helped some drug users into jobs that they appear to have sustained for some time. Launched in 2001, the scheme had 7,797 participants by the end of November 2003. Of these, 1,402 people had been helped into work, 968 were still receiving support on the job from their case worker, and a further 434 were in sustained employment, working independently in jobs they would have been very unlikely to have got otherwise.⁵⁰⁴

⁵⁰⁴ Written Answer to Parliamentary Question by the Minister for Work, Des Browne, 27 January 2004.

⁵⁰⁵ A suggestion made by Rowena Young, Director of the Skoll Centre for Social Entrepreneurship, in *From War to Work: drug treatment, social inclusion and enterprise*, The Foreign Policy Centre, 2002.

However, critics suggest that helping people into employment is often too much of an add-on, glued onto treatment rather than being part of it. It should be better embedded in the process, with drug users being given opportunities to train and work while they are still in treatment. The spectrum of employment opportunities should be far wider than it is at present. At one end of the spectrum, there is a key role for social enterprises. They can be flexible and effective in bringing together all the services that drug users need and they are in the best position to offer a high level of support to people who may find it hard to adjust, or re-adjust, to a working life. One possibility would be to launch a business incubator dedicated to stimulating social enterprises that would train and employ long-term drug users.⁵⁰⁵ Other alternatives might concentrate less on affording drug users special treatment and aim instead at removing the barriers keeping drug users out of mainstream employment. Private employers might be subsidized, for example, to take on drug users in rehabilitation. Whatever the means employed, we support the suggestion that training and work experience should form part of the treatment process wherever this is practicable as a means of building confidence and developing alternative lifestyles from an earlier stage.

Many former drug users need help simply to establish the daily routines that they will probably have lost while they were using drugs and may never have had. Recovering users remark that being offered training courses in information technology is obviously beneficial in the long run, but sometimes it would be more immediately useful to be shown how to use a washing machine or be helped to go shopping or encouraged to pay bills. One former heroin user explained: 'I didn't realise how difficult

it is to get back to a normal life... Unless you've been on it [heroin], you don't realise. I couldn't even go shopping without being on it, because I got paranoid that people are looking at me and I didn't like a lot of people round me.' Another pointed out that the past catches up with the recovering drug user in the form of outstanding debts: 'For all those years when I didn't pay any bills, you go to turn on your gas and electric and they know where you are. So I've got bills coming from there and fines, because we didn't bother with any of that.' A third spoke of the relief of being able to spend money on 'normal' things: 'I'm in a routine now. My home's nice and tidy, you know. We've got money in the bank, but we go shopping every week, the cupboards are always full. I've got loads of gas and loads of electric... It's just nice, you know...'⁵⁰⁶

⁵⁰⁶ Hopkins and Clark, op.cit.

⁵⁰⁷ Home Office, *DIP Tough Choices project: FAQs*, 2006.

<http://www.drugs.gov.uk/publication-search/dip/tough-choices-FAQ?view=Binary>

A better way for the criminal justice system to bring people into treatment

The Drug Interventions Programme

Everyone is agreed on the importance of providing treatment for offenders who are experiencing or causing harm through their use of drugs. Some coercion through drug testing on arrest and other measures does bring into treatment many people who would not otherwise have approached treatment services. The intention is that the Drug Interventions Programme (DIP) should provide a series of interventions, both medical treatment and other types of support, properly coordinated between different agencies. In other words, the Programme is intended to provide better individual case management for one specific group of people.

However, apart from the objection that short-term coercion cannot produce long-term motivation, the point is made that the DIP scheme is unsustainable on its current scale: there are simply not enough drugs workers or suitable facilities to support a full-scale programme of testing on arrest and referral to treatment. Official guidance describes the general approach of the scheme as 'making sure we drug test people at every legal opportunity'.⁵⁰⁷ As the scheme is being applied, testing is causing many people to be steered towards treatment who have no intention of benefiting from it.

We believe that universal testing on arrest for the various specified trigger offences should be abandoned and the Drug Interventions Programme should be confined to a smaller group of people with more serious drug problems and more personal incentive to address them. The DIP might, for example, be restricted to the 70 DAT areas where levels of crime are highest,

originally designated as ‘DIP-intensive’ areas. Alternatively, it might operate in every area but be limited within each area to the drug users identified as most actively engaged in acquisitive crime by the Home Office’s Prolific and other Priority Offenders (PPO) Scheme, discussed above at p.114.

⁵⁰⁸ See *Drug Interventions Programme and Prolific and other Priority Offenders Programme: Partnership guidance for CJITs and PPO schemes*, July 2004.

⁵⁰⁹ Home Office, 2006.

Along these lines, a database could be compiled in every police borough of prolific and priority offenders who are also known to be drug users – all ‘problematic’ drug users, on the Home Office definition. These people could be approached proactively, before they have been arrested for any particular crime (as they would be under the PPO scheme), or identified on arrest (as they would be under the current DIP scheme) and then offered the coordinated support that is currently provided both by the PPO scheme and the DIP scheme. Both rely on a range of services taking joint responsibility for a core group of drug-using offenders and offering them the interlocking support they need – not just drugs treatment but support in constructing a different way of living that will involve neither problematic drug use nor crime.

In the 70 ‘DIP-intensive’ areas, where levels of crime are highest, Criminal Justice Integrated Teams (CJITs) have already been established within the DIP scheme and tasked with working closely with the PPO scheme.⁵⁰⁸ In Peterborough, for example, the Nene Project started with a focus on PPOs, with the CJIT approaching drug-using persistent offenders and offering them treatment, both for their own benefit and to curtail their contributions to the crime rate in the area. Then the team drew on a network of contacts in other agencies – housing agencies, local employers, careers services, counselling services – to help their clients back into the community. Formally aligning the two schemes on a national basis would be both economical and effective.

The Criminal Justice System Review in July 2006 entitled *Rebalancing the Criminal Justice System in favour of the law-abiding majority* made a commitment to aligning the PPO strategy with the DIP scheme.⁵⁰⁹ We recommend, as an alternative, limiting the DIP scheme to the confines of the PPO scheme. Although this would not yield such statistically impressive numbers ‘in treatment’ as the fully extended DIP programme does, a closer focus and a concentration of resources could well produce better outcomes in terms of reducing drug-related harm, allowing the resources ‘saved’ to be expended on other service provision for drug users, along the lines highlighted elsewhere in our report. Requiring the two schemes to be more closely aligned might also act as a spur to putting the

PPO scheme itself on a more systematic basis and might demand a higher standard of information gathering. Neither police nor probation services uniformly gather data on PPOs at a local level. A recent report from HM Inspectorate of Probation revealed that:

Some areas were unable to identify a small sample of PPO cases for inspection purposes. This highlighted difficulties at an area level with management information systems... There were no NPD [National Probation Directorate] targets concerning interventions or outcomes for PPOs, leading to a lack of focus on these stages.⁵¹⁰

Restricting the Drug Interventions Programme in this way and dramatically reducing the number of offenders tested on arrest would save considerable sums of money currently being spent on the testing process alone.⁵¹¹

Prisons

Money is urgently needed elsewhere in the system to bridge what is currently a damaging gap in the DIP chain: namely, drugs treatment in prisons. Any strategy that emphasises reducing crime through addressing problematic drug use is going to be crippled by any failure to provide treatment at this critical point in what is both a crime career and a drug-taking career.

In December 2006 the Department of Health, having assumed responsibility for drugs treatment in prisons some eight months earlier, issued new guidance on drugs treatment in prison.⁵¹² The guidance makes several proposals for extending the range of treatment options beyond simple detoxification to include 'stabilization on a licensed opiate substitute medication for a minimum of five days' before progressing to one of three further options: standing opiate detoxification (minimum duration of 14 days), extended opiate detoxification (21+ days) and 'opiate substitute maintenance (up to 13 weeks or beyond, dependent on individual clinical need)'. There is a clear recognition here of the need for more humane drugs treatment for prisoners, better coordinated with any treatment they may have been receiving already and better preparing them for release:

While detoxification may remain the preferred method of clinical management for some drug-dependent prisoners, it is now apparent that a range of clinical treatment options are required to manage the varied and complex needs of this patient group.

The abrupt 'cold turkey' detoxification for which the Home Office was taken to court in 2006 and the failure to offer any other

⁵¹⁰ HM Inspectorate of Probation, *Half Full and Half Empty: an inspection of the National Probation Service's substance misuse work with offenders*, Home Office, 2006.

⁵¹¹ Cozart Biosciences won a contract from the Home Office in 2001 to supply the Cozart® RapiScan (a saliva-based system that can test for five different drugs and give results in minutes) for the purposes of the DIP scheme, at that point restricted to testing on charge. The contract was then worth £500,000. In October 2005 the contract was extended through to April 2007, and expanded to allow for testing on arrest. 'The Home Office anticipates that the number of tests performed, and therefore the number of Cozart cartridges used... will more than double – and perhaps even triple. In the six months up to November 2005, the DIP consumed 59,300 cartridges, so it is entirely possible that within a few years more than 300,000 a year will be being used. The list price of each cartridge is approximately £8, while an electronic reader sells for £2,000, which suggests that this contract alone could deliver well over £2m a year of ongoing revenue'. *Money Week*, 7 December 2006.

⁵¹² In partnership with the NTA, the Royal College of General Practitioners, the Royal College of Psychiatrists and the Royal Pharmaceutical Society. The guidance is entitled *Clinical management of drug dependences in the adult prison setting, including psychosocial treatment as a core part*.

options are acknowledged to have been damaging to prisoners' welfare and possibly a factor in 'self-destructive behaviours':

A broader range of clinical response to drug dependence, such as extended opiate detoxification and maintenance programmes, could serve to reduce incidents of suicide and self-harm among those most at risk, including individuals with co-existent drug and mental health problems.

⁵¹³ See, for example, A Taylor et al, 'The role of methadone maintenance in Scottish prisons: prisoners' perspectives', Scottish Prison Service, 2006.

From now on, the guidance continues, there is to be 'effective, evidence-based management of benzodiazepine withdrawal', 'clinical monitoring of stimulant withdrawal', and the provision of 'a minimum 28-day open intervention of psychosocial support' for all prisoners with drug problems. Perhaps most significantly, methadone maintenance is to be seen as a valid treatment option within prisons:

In its review of drug policy and treatment, the Home Affairs Select Committee (2002) recommended that methadone maintenance should be available across the prison estate.

It is acknowledged that there has been considerable unease around this practice within the Prison Service, but through careful evaluations and study, it has become apparent that this intervention within a prison setting can lead to important harm reduction benefits.

Research published in 2006 on prisoners' perspectives on methadone maintenance in Scottish prisons, which has grown considerably in recent years, gives a useful insight into these issues and identifies some of the benefits that prisoners have experienced.⁵¹³

Methadone prescribing is a way of sustaining continuity of treatment for those who were already being maintained before. It can pave the way to maintenance treatment in the community on release. It increases tolerance to opioids. This increased tolerance reduces the risk of fatal overdose for those people who start to use heroin again when they leave prison and take the amounts that they were taking beforehand, not realizing that their tolerance may have been severely reduced while they were abstinent in prison. At the most basic level, methadone can stabilise prisoners who might otherwise attempt suicide or self-harm if required to deal with both imprisonment and abstinence at the same time.

Needless to say, this Commission welcomes these new provisions as both humane and practical. However, the new Department of Health guidance is introduced subject to the proviso that it 'describes how clinical services for the management of substance

misusers in prison should develop during the next two years *as increasing resources permit* [italics added]. The cut, reported in December 2006, in the budget allocated to the new Integrated Drug Treatment System for prisons seems likely to delay these highly desirable changes. The Commission recommends that funding should be made available to improve drugs treatment in prisons as a matter of urgency, primarily for the health and wellbeing of individual prisoners but also to reduce the already high rates of re-offending that, even so, have risen in recent years. A recent report by Dr David Shewan for the Scottish Prison Service suggests that, while drug use in Scottish prisons continues to be problematic, it would be much worse without the dedicated work of such addiction workers as there are and the encouragement that they can give to prisoners to regulate their own behaviour. The situation should not be regarded as hopeless; change may be slow, but it will come, given effective treatment provision.⁵¹⁴ Imprisonment need not be seen as a direct route to continuing drug use but instead as an opportunity, under controlled conditions, to intervene in it and reduce it.

Drug courts

The effectiveness of drugs treatment within the criminal justice system requires courts, judges and magistrates who understand the nature of drug dependence and what can be achieved through treatment. Drug courts are courts dedicated specifically to drug offences and are staffed by specialist judges, magistrates or, as in Scotland, sheriffs. They deliver treatment orders as an alternative to custodial sentences. Offenders are screened for suitability before referral to the drug courts, and magistrates are briefed beforehand on their assessments for drugs treatment. Magistrates then take personal responsibility for overseeing the progress of those they sentence, with the result that the offender will come before the same magistrate and the same panel at each monthly review.

Drug courts on the modern model were first introduced in America in the late 1980s. There it is claimed that, though expensive, they routinely recoup their costs through making savings elsewhere in the criminal justice system by reducing drug use and rates of re-offending. Some object to what they see as a blurring – or softening – of the court's role. It is not the law's job, in their view, to 'cure' the offender or to solve their social problems. Treating drug use as both a crime and a disease simply perpetuates 'continued national schizophrenia' about drugs.⁵¹⁵ Underlying this objection is the fear that community sentences such as treatment orders may be, in some sense, a soft option. Supporters of community sentencing and drug courts retort that

⁵¹⁴ 'It is noteworthy that a combination of staff vigilance, the provision of care services and prisons' own decision-making has maintained a system that effectively restricts drug-related harm and disruption... The provision of support and intervention for prisoners with drug problems is the next step in this process.' D Shewan et al, *SPS Strategy on the management of drug misuse. Pathways and progression: an evaluation of referral, assessment and intervention*, Scottish Prison Service, 2006.

⁵¹⁵ The view, for example of Colorado Judge Morris B Hoffmann. 'The Drug Court Scandal', *North Carolina Law Review* 78/5, June 2000.

judges retain the power to impose custodial sentences if treatment orders are breached and that in any case community sentences can last longer and require more intensive involvement on the part of the convicted person than imprisonment.

Drug courts were first introduced to Britain in 2001, with the opening of the Glasgow drug court, followed by a second one in Fife in 2002.⁵¹⁶ The scheme has recently been evaluated and found to have produced significant benefits. Sentencing decisions are better informed because sentencers have the benefit of more comprehensive and focused reports on the people coming before them, and the adversarial atmosphere of an ordinary court is replaced by a more direct and personal dialogue between the sentencer and the offender, aimed at solving the latter's problems. Offenders are better motivated, and sentencers develop more realistic expectations. 'Offenders felt listened to and treated "as a human being" and motivated to do well. Sheriffs accentuated the positives, accepted that progress might be incremental and bumpy, and set achievable goals for the next review.'⁵¹⁷

Drug courts do not claim or aim to eradicate either crime or drug use completely. In the Scottish experiment, roughly 70 per cent of drug court clients were found to have been re-convicted within two years. However, in the words of the evaluation, 'There is evidence that a sizeable proportion of clients made subject to Drug Court Orders were able to achieve and sustain reductions in drug use and associated offending behaviour.'⁵¹⁸ The courts are expensive; the two Scottish courts have already cost more than £6 million. However, provided that referrals are limited to some of the most persistent drug-using offenders who would otherwise have gone to prison, they are probably still cost-effective, as drug court orders cost considerably less than equivalent periods in prison. The evaluation of the Scottish scheme suggests that the average cost of an 18-month Drug Court Order in Glasgow was £24,408, whereas the cost of an equivalent period in prison would be £46,008.⁵¹⁹ The Glasgow and Fife courts have now been granted permanent status by the Scottish Executive, which is considering rolling the scheme out further.⁵²⁰ The first two dedicated drug courts in England were launched at the end of 2005, in Leeds and West London.⁵²¹

Drug courts, working through community sentences and aimed more obviously at problem-solving than at punishment, are well placed to help offenders back into the community. The current Lord Chief Justice, Lord Phillips, favours what

⁵¹⁶ Courts in Wakefield piloted some features of the drug court model in the late 1990s.

⁵¹⁷ *Drug and Alcohol Findings*, 10, 2004.

⁵¹⁸ G McIvor et al, 'The operation and effectiveness of the Scottish drug court pilots', Scottish Executive Social Research, 2006.

⁵¹⁹ *Ibid.*

⁵²⁰ The Glasgow and Fife Courts will be reviewed again in 2008.

⁵²¹ An evaluation of the Leeds and West London drug courts is due for completion in July 2007. Harriet Harman, Written Answer to Parliamentary Question, House of Commons, 21 March 2006.

he calls ‘therapeutic jurisprudence’, and drug courts, in his view, are a prime example of this approach.

His predecessor Lord Woolf has suggested, on the other hand, that drug misuse is ideally suited to being tackled by the ‘community justice’ initiatives that are currently being promoted under the *Respect Action Plan* published in January 2006:

A community court as I see it has the resources really to tackle the problems of substance abuse. It is able to provide genuine help to the community so that what is tackled is not the crime but the problem.⁵²²

The Community Justice programme is a key strand of the government’s agenda for tackling anti-social behaviour and the crime associated with it.⁵²³ Its aims are to strengthen the links between courts, the criminal justice system and the local community. People from the community are involved to some extent in deciding penalties, in that the judge takes the opinions of victims into account in sentencing. More directly, they may be involved in tackling the conditions that are the background to crime, repairing vandalism, removing graffiti and otherwise restoring neighbourhoods. Offenders may be required to work alongside members of the community on these projects as part of re-engaging with society. Community Justice projects have so far been launched in Liverpool and Salford: the North Liverpool Community Justice Centre and the Salford Community Justice Initiative. The Lord Chancellor has also announced the creation of ten more projects.⁵²⁴

Community justice centres, such as the one in Liverpool, incorporate courts and are designed to surround the court with representatives of the other agencies that may help people out of crime – not just the police and probation but housing, debt counselling, mentoring and employment. Lord Woolf observes:

It is so much easier to respond constructively to an offender’s individual circumstances if the resources are actually available at the court. Practical solutions can then be found to the problems that underlie offending behaviour and the offender leaves court knowing exactly what he is supposed to do next.⁵²⁵

Drug courts have so far been designed on similar lines to these projected community courts, with the presiding magistrate part of an inter-agency team with good links into community services.

We see drug courts as another means of focusing the use of treatment through the criminal justice system for the purpose of aiming it at the most problematic drug users and making sure that treatment is applied in the way that is most

⁵²² *New Statesman*, ‘Community Justice: concepts and delivery’, 8 December 2003.

⁵²³ <http://www.communityjustice.gov.uk/whatis.htm>

⁵²⁴ Written Statement in the House of Lords, 27 November 2006. The Liverpool and Salford initiatives are being evaluated for their impact on increasing compliance with sentences, reducing fear of crime and increasing community confidence and involvement in the criminal justice system. Written Answer to Parliamentary Question in the House of Commons, 12 December 2006.

⁵²⁵ Lord Woolf, ‘A justice system that the community owns’, 7 July 2003.

likely to succeed. We strongly recommend that the number of drug courts be increased under the aegis of the community justice programme that seeks, among other objectives, to create closer and more positive bonds between offenders and their local communities.

Measurement in terms of more humane and realistic outcomes

At present the effectiveness of drugs treatment is measured in terms of the numbers of people taken into treatment – irrespective of how ‘treatment’ is defined and the quality of the services offered – and the numbers of people retained in treatment for more than twelve weeks. Retention is taken as a proxy for success because evidence has shown that those who stay in treatment longer are more likely to make and sustain reductions in their drug use (and, by implication, reductions in their drug-related offending).

This is, however, a very poor proxy indicator of the quality or the effectiveness of treatment. It provides no real measure of any real progress made by those in treatment: whether they are happier, say, or free of health problems, whether they have somewhere stable to live and something to do, not to mention whether they have made any progress towards reducing their drug use, their offending or the likelihood of their relapse.

The National Treatment Agency itself has acknowledged that the current performance management indicators are inadequate and that they can even have the perverse effect of making treatment agencies retain people for the requisite twelve weeks, regardless of whether or not they are genuinely progressing, thus clogging up the treatment system and prolonging waiting times for new service users. In its 2006/7 Business Plan the Agency observes:

Stakeholders are becoming increasingly impatient with the drug treatment system’s reliance on process to suggest the success or failure of treatment and are demanding that the NTA find ways to measure real outcomes, particularly in relation to the impact of treatment on drug use and offending. This pressure will grow as service users become more involved in setting their own treatment goals, commissioners become focused on the value added by different providers at a given price, and policy makers review the overall impact of the drug strategy.

Accordingly, the NTA is working on ways of building consistent outcome measurements into the care planning process. The Agency is now developing an outcome measurement tool, a short set of questions that will form part of care plan interviews.

It is hoped it will be ready for use in April 2007.⁵²⁶ This tool should enable treatment providers to monitor and record more meaningful changes in their clients' condition. The Agency's Improvement Reviews will also enable it to monitor the achievement of treatment outcomes and directly gauge the effectiveness of treatment.

However, the Business Plan sounds a note of caution. The change to measuring 'real outcomes' is, it warns, 'a significant workstream that will take a number of years to deliver', and, it continues, 'challenging timetables and competing priorities within Health Care Commission (HCC) may delay implementation of Improvement Reviews'. This Commission welcomes the NTA's intention of measuring treatment effectiveness in terms of more meaningful outcomes and urges that funding be maintained so that this change of focus can be achieved without undue delay.

The new system of measurement would have the effect of putting more weight on improvements experienced by drug users themselves. Within the present drug strategy, cost-benefit analyses have tended to be conducted in terms of the strategy's impact on crime and the associated benefits to the community rather than outcomes for the individual. The evaluation of the Scottish drug court scheme, for example, explicitly excludes 'any estimate for so-called "individual outcomes values" – the intrinsic value to the individual and those around him/her of achieving a more ordered and more personally rewarding life'. As the authors point out, this is equivalent to suggesting that drug-misusing individuals have zero value and that treatments are offered to them only because of their potential value to the rest of society, whatever the consequences to the individual.⁵²⁷ The Commission welcomes any shift away from attitudes of this kind. We believe that the principal measure of success in drugs treatment should be improvements in the health and wellbeing of drug users and their ability to control, reduce and eventually give up their drug use.

Improvements in health and wellbeing would be the logical outcome of all the other proposals we have made for improving the treatment and support offered to problematic drug users: characterizing drugs treatment as an essential health measure; ensuring the availability of a range of different treatment options; providing service users with easier access to treatment and more responsive services; providing better integrated services for combined alcohol and drugs treatment, for people with a dual diagnosis of drug-related and mental health problems

⁵²⁶ NTA, Chief Executive's Report to the Board, 4 October 2006.

⁵²⁷ By reference to an earlier observation in C Godfrey, D Stewart and M Gossop, 'Economic analysis of costs and consequences of the treatment of drug misuse: 2-year outcome data from the National Treatment Outcome Research Study (NTORS)', *Addiction*, 99, 2004.

and for families; providing more varied and flexible services for black and minority ethnic drug users, for women and for stimulant users; providing better ‘wraparound’ services in connection with, for example, housing and employment; and finding a better focused role for the criminal justice system in bringing people into treatment.

All these proposals might be broadly characterized as having a single objective: to reduce harm. Harm reduction is, however, just one of the principles on which we consider policy should be based. The next part of the report opens with a description of what we believe drugs policy should be like, before going on to consider the implications of such a policy for the way in which the drug strategy is currently delivered.

Part III A new line of policy

14 What should drugs policy be like?

Our review of current practice in the preceding chapters suggests that in many cases the weaknesses we have identified stem from policies based less on evidence and practical considerations than on politics and pure emotion. The urge to ‘send the right message’ and the desire to be seen as ‘tough on crime’ are allowed to outweigh objective calculations of what is most likely actually to succeed in reducing the kind of drug misuse that damages the users, their families and the communities in which they live.

We believe instead that policy on the use of illegal drugs and other psychoactive substances should be based on five principles:

- it should be pragmatic not moralistic, with means adapted to ends
- it should be aimed, above all, at reducing harm
- it should be honest in its statement of aims
- it should be consistent and coherent
- it should be assimilated into broader social policy, not ghettoized.

Policy on the use of drugs and other psychoactive substances should be pragmatic, not moralistic.

Policy should not aim to send a simple moral message – that all drug-taking is wrong – or to be in the business of punishing ‘deviant’ behaviour. There is nothing like universal agreement that intoxication of every kind is both morally wrong and socially undesirable. People have always used psychoactive substances – cannabis, coca, opium, wine, beer, spirits, mushrooms, cactus, betel, tobacco, coffee, prescribed medicines – to relax, to celebrate, to heighten energy and awareness, to dull anxiety, pain or unhappiness, or simply to see life differently for a time. The desire to alter one’s consciousness is deep-rooted, and it need have nothing to do with fashion or peer pressure, with defying parents, the law or the status quo.

Even if everyone agreed that entirely eradicating the use of a selected psychoactive substance was desirable, it is not possible. In the much-quoted words of the Runciman Report in 2000, ‘In the course of our Inquiry it has become inescapably clear to us that the eradication of drug use is not achievable and is not therefore either a realistic or a sensible goal of public policy.’ Zero-tolerance has been a conspicuous failure in the

United States where it has been attempted on the largest scale. Recreational drug use is now widely accepted, even by those who do not engage in it, as an enduring feature of young people's behaviour. The Home Office itself acknowledged as much when it released its guide to *Safer Clubbing* in 2002: 'Controlled drug use has become a large part of youth culture and is, for many young people, an integral part of a night out.'

⁵²⁸ Foresight 'Brain Science, Addiction and Drugs' project, *Drugs Futures 2025?*, Office of Science and Technology, 2005.

Nor is drug use likely to become less common in the future. A 2005 Foresight study from the Department of Trade and Industry⁵²⁸ observed that the supply of drugs is likely to become more plentiful and access to this plentiful supply progressively easier. The rapid globalization of major industries, the extension of trade agreements and common markets, the growth of international transport and travel and population mobility are all working towards an easier and more abundant international supply of illegal drugs. At the same time, domestic production in Britain is increasing. The development of hydroponics has turned the home growing of cannabis into an industry, with modest suburban semis turned over to the production of hundreds of plants at a time, generating thousands of pounds each week. In addition, new synthetic chemicals which lend themselves to small-scale manufacture in kitchen laboratories are appearing with accelerating frequency. 'Designer drugs' like PCP/'Angel Dust' are synthetic versions of commonly misused drugs, made by producing subtle changes in the molecular structure of existing drug types in order to avoid prosecution. As soon as one substance is classified, another is developed. Britain is already an exporter of drugs of this kind. The mobile phone and the Internet have made access to drugs simpler and more secure, the mobile phone by facilitating orders and delivery, the Internet by providing a home for 'virtual pharmacies' operating around both the clock and the globe to supply huge anonymous markets with a range of synthetic drugs under cover of false identities and encrypted emails. All of these broader underlying trends are irreversible. We have no choice but to face that fact.

It goes without saying that policy must be geared to what is practical or it becomes mere posturing. There are signs in some quarters, including in Scotland, of a push back towards more rigorous law enforcement, and it is worth considering whether this push is based on evidence of enforcement's effectiveness or simply on a mixture of media headlines and moral panic. Similarly, a campaign against the prescribing of substitute drugs such as methadone seems to have been strengthening, most obviously in Scotland as a political ploy in the run-up to the 2007 Parliament elections, but also in the interim report

of the British Conservative Party's Social Justice Policy Group, *Breakdown Britain*.⁵²⁹ The campaigners have some valid points to make about the use of methadone as a cheap method of ticking the 'treatment' box, but they confound their factual arguments with the assumption that the only valid objective of drugs policy is to promote abstinence. We think the best measure of the success of a policy on drugs is not the number of people who are failing the abstinence test by taking drugs but the extent to which the amount of harm caused by their use is being reduced.

Policy should be aimed at reducing such harm

We believe that policy on all psychoactive substances requires a clearer definition of 'harm' – one that is more precise but at the same time more encompassing. 'Harm' should be distinguished from 'risk' – that is, the actuality of harm distinguished from the possibility of harm that is always implicit in risk. And harm in the context of drug use should be acknowledged to include harms both to society and to individuals and the harms caused by the policies relating to drug use as well as by drug use itself. Policy should seek to strike a balance between these conflicting demands that most effectively reduces the sum total of harm arising out of the use of drugs and other psychoactive substances.

Such an approach does not entail trying to eliminate risk. Policy must balance the state's duty to protect its citizens on the one hand with individual freedom on the other. Society generally accepts the individual's right to take risks if he or she regards the corresponding rewards as being sufficiently great and if the activity in question does not threaten the safety or happiness of others. However, while risk is an acceptable part of human behaviour, there are thresholds beyond which it is considered justifiable for the state to curtail individual freedom, and society does regulate risk-taking behaviour. Travelling by car is one of the riskier things that most people do in terms of the likelihood of death or injury. The state does not try to stop us from driving or riding in a car as a passenger, but it does require that we wear seat belts and that we do not impair our capacity to drive with alcohol, drugs or prescription medicines. Riding a motorcycle is even more dangerous than driving a car. It is not prohibited, but riding without a helmet is. Drug use is also a risk taking behaviour. Some drug users are taking very serious risks; others are not. Without trying to eliminate drug-taking behaviour altogether, which would be futile, drugs policy should aim to reduce the risks that people take with the aim of reducing harm.

Patently, the most damaging of the harms caused by drug use is death, whether from overdose, the toxic interaction of different

substances or accidents such as dehydration or choking on vomit. Drug-related fatalities account for more than 7 per cent of all of the deaths of people under 40 in the United Kingdom.⁵³⁰

Among drug-related illnesses, the most serious long-term harms are caused by blood-borne viruses such as HIV/AIDS, Hepatitis B and Hepatitis C. The precise extent of HIV and Hepatitis C infections, and the harms they cause, is hard to establish because injecting drug users are to a large extent a hidden population. However, at the end of 2006 the Health Protection Agency reported the results of its annual survey of injecting drug users. The number of people infected with HIV was reported to have reached its highest level in 15 years, with a particularly obvious upturn in the previous three years. In London in 2005, one in 25 injecting users was infected. Elsewhere in England and Wales, the number in 2005 was one in around 65 as compared with one in 400 in 2003. After a vigorous and successful public health campaign against the spread of HIV in the late 1980s and early 1990s, which reduced the prevalence of HIV among injecting drug users from 5.6 per cent in 1990 to 0.6 per cent in 1996, the gradual increase back up to 1.4 per cent in 2003 and 2.1 per cent in 2005 is troubling. (The rate in London in 2005 was 4.3 per cent. Elsewhere in England and Wales it was 1.6 per cent, more than double the level recorded in 2004.) These figures were based on a voluntary survey of drug users in contact with treatment services. Infection among people who are not in contact with such services, a group that would include many of the most chaotic users, is almost certain to be much higher. Just under half the people surveyed were aware of their infection – the lowest level of awareness ever recorded in the survey.⁵³¹

Levels of infection with Hepatitis C were much higher, approaching 50 per cent of all injecting drug users in the United Kingdom as a whole, and the rate of transmission would seem to be increasing. Hepatitis C can be treated once it is diagnosed, but the scale of the threat was not recognized until recently, and large numbers of drug users are unaware that they have the infection. Untreated, it can lead to severe liver disease – cirrhosis, liver failure and cancer. The disease is also greatly aggravated by alcohol abuse, which is common among injecting drug users. Around 4,500 drug users currently have severe forms of the disease, a number that could rise to 7,000 by 2010.

Harm reduction measures

A series of practical precautions has been proved significantly to reduce the risk of death and blood-borne infections, as well

⁵³⁰ EMCDDA *Annual Report, 2006*.

⁵³¹ Health Protection Agency, *Shooting up : infections among injecting drug users in the United Kingdom 2005. An update: October 2006*.

as many of the other health harms associated with drug use, including tetanus, wound botulism and MRSA:

One of these precautions is preventing overdose. A significant proportion of deaths from heroin overdose occur when people are released from prison and relapse into drug use. If they have been detoxified while in custody and have remained drug-free, they will have lost much of their tolerance, and a return to the heroin doses they were taking before they were imprisoned may kill them. Overdosing in this way can be prevented by the provision of information and advice in prison or, for some, by the prescription of methadone to maintain their tolerance. It also helps if people are supervised in the days immediately after release, especially if they are released at or near the weekend, when many drugs services are closed. The drugs treatment service of the Maudsley Hospital in London has for some years been offering the drug naloxone to all patients who have been through its in-patient detox plan, who are starting methadone treatment or who have just come out of prison. The aim is to equip these patients to help other drug users who have over-dosed. (Naloxone, which has been used by doctors for forty years, works by blocking the opiate receptor cells so they prevent the opiate in the blood stream from taking effect.⁵³²) Glasgow City Council is currently piloting a similar service for drug users, their families and friends.

Another practical precaution is needle exchange. Supplying clean needles greatly reduces the risk of transmitting blood-borne viruses and other infections through injection, while collecting used ones removes a health hazard from the streets where they might otherwise have been discarded. Sometimes needle exchanges also provide help of other kinds – contraceptive advice and equipment, testing for viruses, primary healthcare, referral into treatment – to people who have no other contact with drugs services. Needle exchange services are often based in drugs clinics, but they may also be provided by community pharmacists in high-street chemists' shops, in hostels for the homeless, in mobile vans⁵³³ or even, for the simple dispensing of needles, in specially adapted wall-mounted vending machines.⁵³⁴ Recent audits of services in England, Wales and Scotland found that, while the practice of needle exchange is well established, standards vary considerably, with many pharmacy-based services offering little more than a supply of clean needles, often in quantities too low to meet the needs of most regular injectors. Even those needle exchanges based in specialist drugs services often fail to offer vital supplementary services such as immunization for Hepatitis B, testing for Hepatitis C and interventions to prevent overdose.⁵³⁵

⁵³² See, for example, J Strang et al, 'Take-home naloxone and the prevention of deaths from opiate overdose: two pilot schemes', *British Medical Journal*, 322, April 2001, and <http://news.bbc.co.uk/1/hi/health/1273865.stm>

⁵³³ As in the Hungerford Project in Soho.

⁵³⁴ In 2006 the Chief Constable of North Wales proposed the installation of a machine of this kind outside the police station in Colwyn Bay, which lacks any other facilities for needle exchange, but the proposal was rejected by the local council.

⁵³⁵ D Abdulrahim et al, *Findings of a survey of needle exchanges in England*, NHS/NTA Research briefing 17, 2006.

The provision of needle exchanges can reduce the risk of harm, but so too can the provision of another type of facility: the drug consumption room. Already in operation in eight European countries, drug consumption rooms are places where dependent drug users are allowed to bring their illegally obtained drugs and then to take them in supervised, hygienic conditions. People believed to be new or non-dependent users are not admitted, nor are people who are intoxicated. Dealing and sharing is prohibited.⁵³⁶ Besides reducing the risk of overdose, drug consumption rooms attract some of the most problematic and hard-to-reach drug users and provide an opportunity to offer them general health care and referral into drugs treatment. A 2006 report from the Joseph Rowntree Foundation reported on the success of such facilities in the Netherlands, Germany, Spain and Switzerland in bringing down the number of drug-related deaths as well as reducing nuisance to the public by taking injectors off the street and decreasing the number of discarded needles.⁵³⁷ A study of a similar supervised injection site in Vancouver revealed that the more often users visited the site, the more likely they were to go into detoxification treatment.⁵³⁸ The Rowntree Foundation's Independent Working Party on Drug Consumption Rooms called for a number of pilot drug consumption rooms to be set up in the UK, founded on local accords between key agencies in areas where there is considerable support for the idea. The recommendation was rejected by the government on the grounds that drug consumption rooms might increase localized dealing, anti-social behaviour and acquisitive crime.

As we indicated earlier (p.177–178), we believe heroin prescribing should be extended as a means of relieving the most chaotic and dependent users from the need to buy their supplies from criminal sources – with no controls over the drug's purity – and to finance their purchases through crime. Our concern is that heroin prescribing should be seen as a means of reducing all kinds of harm – as a way of minimizing the suffering of problematic users as well as a means of keeping them off the street and out of prison – and that it should be made available to all heavily dependent users, not just those who have committed crimes.

In addition, everyone agrees that many drug users do themselves damage through ignorance. Harm reduction advice on dance drugs delivered as part of drugs education classes, and leaflets made available in clubs and pubs, can protect people against over-heating, dehydration and the potentially lethal effects of mixing different drugs with each other and with alcohol. The provision of information in police stations, prisons, surgeries,

⁵³⁶ *Drugscope Policy Briefing – Drug Consumption Rooms*, 2004. <http://www.drugscope.org.uk/wip/23/pdfs/polconsumption.pdf>

⁵³⁷ Joseph Rowntree Foundation, *Report of the Independent Working Group on Drug Consumption Rooms*, 2006.

⁵³⁸ T Kerr et al, 'Attendance at Supervised Injecting Facilities and Use of Detoxification Services', *New England Journal of Medicine*. 2006, 354.

pharmacies and clinics can help save people from overdose, infection and injecting in particularly dangerous sites such as the groin and neck. Outreach on the streets is a particularly effective way of taking this kind of information to otherwise hidden and hard-to-reach communities of chaotic drug users.⁵³⁹

The principal objection advanced against programmes of this kind – that is, programmes aimed primarily at reducing the harm associated with drug use and only secondarily at discouraging drug use itself – is that they encourage the spread of drug use by giving the appearance of condoning it. However, little research has been undertaken to test this contention, and it is largely unsupported by such evidence as exists. A report from the Beckley Foundation⁵⁴⁰ points out that:

Concerns remain that the existence, and public promotion, of these approaches create an atmosphere and environment that encourages higher levels of injecting drug use. We were not able to locate any evidence where such a link has been identified – indeed, the consensus statement issued by the World Health Organization, UNAIDS (the Joint United Nations Programme on HIV/AIDS) and UNODC (United Nations Office on Drugs and Crime) acknowledges this point specifically.⁵⁴¹

On the contrary, in Zurich, where harm reduction measures such as needle exchange, injecting rooms and the prescribing of methadone, buprenorphine and heroin have all been in existence for some years, the number of people presenting for heroin treatment has declined. Assuming, in the absence of evidence to the contrary, that the ratio remains reasonably constant between the number of people presenting for treatment and the number of people starting to use heroin, researchers concluded that the number of people starting to use the drug increased from around 80 people in 1975 to around 850 a year by 1990 but then dropped back to around 150 a year by 2002, which was at the height of the harm reduction programmes, including heroin prescribing. In the words of the Swiss team:

We can now quote reliable knowledge that in a modern western country which advocates and practises harm reduction in its most progressive form (apart from decriminalized cannabis) there are not more, but fewer, young people availing themselves of the opiate class of drugs. Indeed, we can now say with confidence that harm reduction measures do not “send a message” encouraging drug use. The authors believe that by ‘medicalizing’ addiction, an impression is created that [addiction] is unpleasant and undesirable, to be avoided, which is just what has happened.⁵⁴²

⁵³⁹ WHO review, *Evidence for Action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users*, 2004.

⁵⁴⁰ Beckley Foundation Drug Policy Programme, Report Four, *Reducing drug-related harms to health: an overview of the global evidence*, 2005.

⁵⁴¹ There are parallels here with the debate over sex education in schools and the claim by critics that the provision of information might be seen as undermining moral values and promoting sexual activity.

⁵⁴² C Nordt et al, 'Incidence of heroin use in Zurich, Switzerland: a treatment case register analysis', *The Lancet*, 367, 2006. 'Switzerland's' cantons' have registers of drug treatment approvals going back to the 1970s. It is therefore possible to derive statistically valid measures of the rate of addiction of its citizens over the period when needle services, injecting rooms, methadone, treatment, heroin prescription and most recently buprenorphine treatment were being introduced. Such data reflect the natural history of opiate use through interactions with treatment services such as methadone maintenance treatment (MMT), withdrawal from such treatments, mortality and other demographics.'

In the light of practical experiences like this one, the Commission supports the widest possible promotion of harm reduction measures as an integral component of a pragmatic drugs policy. We recommend that attention be given to improving and standardizing the services offered by needle exchange facilities, particularly those based in pharmacies. We also support the recommendation of the Independent Working Party on Drug Consumption Rooms that, in the absence of a centrally sponsored scheme for piloting drug consumption rooms, local authorities should seriously consider introducing such facilities where it is in the public interest to do so.

⁵⁴³ NTA, *Harm reduction: guidance notes to adult treatment plans 2006/7 and self-audit tool*, 3 October 2005.

Seeking to reduce harm is in no sense a soft or ‘liberal’ policy. It is a pragmatic and sensible one. Harm reduction is sometimes talked about as if it applied only to the health and hygiene measures employed to make injecting drug use safer. But there is no reason why the net of harm reduction should not be cast more widely. Harm reduction should not be seen as an alternative to interventions aimed at discouraging dangerous drug use in the first place, nor is it an excuse to under-perform in providing treatment and curing addiction. Harm reduction can perfectly well embrace residential rehabilitation treatment aimed at abstinence, thereby permanently reducing the amount of harm caused.

Policy on the use of drugs should be honest in its statement of aims

Policy makers who present themselves as pragmatic and hope to persuade people of the reasonableness of their proposals need to be frank about the problem they are attempting to solve. They need to be candid about the fact that drug use may have benefits – a lot of people use drugs because they find them pleasurable – even if any benefits are often short-lived and outweighed by disproportionately painful costs. Policy makers need to acknowledge the distinction between risk and harm and, if necessary, concede that, while all drug users are taking risks, many are suffering no harm. They also need to acknowledge that they are trying to prevent two kinds of harm: harms to drug users as well as the harms that drug users cause to society.

The National Treatment Agency (NTA) explicitly makes harm reduction measures part of the care that treatment providers are expected to offer. Guidance notes sent to all Drug Action Teams (DATs) and Crime and Disorder Reduction Partnerships insist that ‘a re-invigoration of harm reduction at all tiers of drug treatment is required.’⁵⁴³ The NTA urges DATs to produce strategies for harm reduction, with champions, targets, progress

reports and communications plans. DATs must seek to reduce needle sharing and drug-related deaths and promote screening, vaccination, counselling, advice on sexual health, dental health, primary healthcare and the misuse of alcohol and prescription drugs. Directors of Public Health must produce strategies for reducing blood-borne viruses. Ambulance crews should be encouraged to carry naloxone as an antidote to opiate overdose, and police too should be trained to deal with overdoses in custody. Specialist drugs clinics should be prepared to offer rapid access to substitute prescribing for released prisoners and those prematurely leaving residential treatment.

Much of the guidance that the NTA issues is designed to improve the quality of the treatment that is offered to drug users and thus the quality of their lives, and its guidance on harm reduction displays a proper concern that drug users should be spared pain, illness and premature death. At the same time the NTA is absolutely clear about the fact that the service provided to drug users is to some extent conditional on and subordinate to the service that drugs treatment provides to society. The Agency's Business Plan for 2006/7 states that 'maintaining current levels of funding of the drug treatment system during the next spending review period, and any future expansion, depends on continued delivery of the criminal justice agenda'.

Working to reduce the harms suffered by drug users is a worthwhile objective in its own right. In our view, it should not have to be justified in terms of crime reduction, desirable though crime reduction is. All those working in the drugs field, from the National Treatment Agency to outreach workers on the street and including a large number of people within the criminal justice system, would subscribe to this view. It is time that ministers did the same.

Policy on the use of psychoactive substances should be consistent.

It should have integrity in the sense both of being honest and of being coherent, without in any sense trying to impose uniform solutions. 'Drugs' – taken as shorthand for 'drugs currently classed as illegal' – tend to be regarded as a category distinct from other psychoactive substances, as if more set them apart than merely their legal status. 'Drug use' is treated in the media, and to some extent by public opinion, as if it were something uniquely dreadful. We have explored in the chapter on legal and illegal drugs the reasons why these attitudes bear little relation to the objective harmfulness of the substances in question. On the basis of the evidence – not just the scientific evidence on relative

toxicity and addictiveness but also society's past and present experience of the use of different substances – it makes more sense to view alcohol, tobacco, prescription medicines and currently illegal drugs as individual points on a single spectrum of substance use and abuse.

⁵⁴⁴ F Measham et al, *Dancing on drugs: risk, health and hedonism in the British club scene*, Free Association Books, 2001.

Along this spectrum, uses overlap. People often make use of more than one substance, sometimes without thought, sometimes as a means of modifying unwanted side-effects or enhancing desired effects. The abuse of one substance often coincides with the abuse of others. As we know, smoking tobacco makes smoking cannabis easier and more likely. Drinking alcohol often prompts and facilitates drug use and can enhance it as well as making it far more dangerous. One study has noted of clubbers' drug use: 'They classically blur the licit (tobacco and alcohol) with the illicit (cannabis, amphetamines, ecstasy and cocaine). Their before, during and after clubbing repertoires make them the ultimate post-modern consumers'.⁵⁴⁴ Alcohol is regularly used as a means of coming down from drugs or as a substitute during withdrawal from drugs. Benzodiazepines such as diazepam and temazepam, which are legally obtained on prescription, are often used by heroin users to help them sleep. One in four heroin-related deaths results from this particular combination.

Drug misuse is often stigmatized as self-inflicted harm, but abuse of alcohol and tobacco, risky sexual behaviour and overeating are all equally self-inflicted. Some drug use is unmanageable – but then so is some alcohol and tobacco use. Much alcohol and tobacco use is controllable – but so is much drug use. Many in the substance misuse field believe it would be more constructive to stop treating 'drugs' as a single category and segregating this category of psychoactive substance from all others. Every substance should be treated separately but viewed in relation to every other.

We believe that this single spectrum of substance use and abuse should then be viewed as part of a broader continuum of the health-related choices that people make. The choices of whether or not to use cannabis or cocaine, whether or not to smoke, whether or not to drink and, if so, how much and how often to drink, should not be regarded as wholly unlike the choices of whether or not to eat fast food and processed food, to avoid exercise or to have unprotected sex. Far more, of course, depends on some of those choices than others, at least in the short term, but the choices should be seen as being the same in kind if not in degree. Viewed in this light, major aspects of 'drugs policy' then become part of a public health policy that seeks to create

the conditions in which people make good choices and take responsibility for their own individual health – a duty which, according to the Prime Minister, we owe not simply to ourselves but to the state as a means of relieving the burden on the NHS: ‘We all now pay a collective price for the failure to take shared responsibility’.⁵⁴⁵

Placing drug use alongside drinking, smoking and diet in this way would have the additional effect of including drug users in society rather than excluding them. Under this rubric, drug use could more easily be regarded as ‘normal’, not, of course, in the sense of being something that everybody does or should do but as being within the range of ordinary human behaviour. Setting drug use in context would not entail trivializing it or pretending that there are no problems associated with it, which there undoubtedly are; it would simply mean recasting drug use as a social problem alongside others of the same type, such as heavy smoking and excessive drinking. This has been the approach in the Netherlands, where both cannabis and heroin use are lower than in Britain.⁵⁴⁶

Contextualizing drug use would have the dual effect of bringing drugs, alcohol and tobacco in towards to a policy ground where they could all be regulated in relation to one another. Associating alcohol and tobacco with drugs that have traditionally been illegal would help to present them as less acceptable and therefore easier to resist. Setting drugs in the context of the use of other potentially harmful substances would help to de-demonise them and bring them within the reach of mainstream public health policies. The logical solution, as suggested above at p.189, is the integration of drugs policy with alcohol policy, recently achieved in Northern Ireland.⁵⁴⁷ We agree with the Canadian Senate’s Special Committee on Illegal Drugs:

For public policy on psychoactive substances to adequately encompass the common dimensions of substance use, it must be integrated, yet flexible enough to allow for approaches that are adapted to different substances... An adaptable policy would be able to propose, define and develop tools suited to the various substances.⁵⁴⁸

Policy on the use of drugs and other substances should be assimilated into broader social policy, not ghettoised

Once policy on psychoactive substances is internally consistent and coherent, it needs to be assimilated into broader social policy. Policy on substance misuse needs to remain a high priority but in a different way: not singled out for separate treatment but absorbed into the policy mainstream, though

⁵⁴⁵ Tony Blair, end-of-term speech, July 2006.

⁵⁴⁶ ‘Social control is achieved through depolarization and the integration of deviant behaviour rather than isolation and removal, as is typical of the deterrence model. This paradigm also suggests that drug problems should be seen as normal social problems rather than unusual concerns requiring extraordinary treatment.’ Canadian Senate, *Report of the Senate Special Committee on Illegal Drugs. Cannabis: our position for a Canadian public policy*, Volume 3, p. 593, 2002.

⁵⁴⁷ *A Model for the Joint Implementation of the Drug and Alcohol Strategies* was launched in 2001. Regional and Local Action Plans were developed over a period of three years and reviewed in 2004. A six-stage approach to developing a fully integrated policy was initiated in 2005, resulting a year later in the *New Strategic Direction for Drugs and Alcohol 2006-11*.

⁵⁴⁸ Canadian Senate, *Report of the Senate Special Committee*, op.cit. Vol.3, p.591.

with careful guardianship in the early stages to make sure that it is not submerged.

In our view, there is no single undifferentiated ‘drugs problem’, nor should the misuse of drugs be thought of as *either* ‘a health issue’ or ‘a crime issue’: it is both, and it is also ‘a social care issue’, ‘a housing issue’, ‘an employment issue’, ‘an education issue’, ‘a foreign policy issue’, ‘an environmental issue’ and ‘a young people’s issue’. In the government’s own view, illegal drugs are a ‘cross-cutting issue’⁵⁴⁹, one of the relatively small number of issues where the relevant Public Service Agreements are shared between different government departments. The problems relating to drugs are part of the daily business of many agencies besides, of course, the NHS and the criminal justice system.

A role for other agencies

Local authorities are among the most important of these agencies. Besides their statutory duties towards young people and in connection with crime reduction, both of which necessarily involve tackling drugs issues, local authorities are likely in future to have further obligations to act on drugs as the prime movers in Local Area Agreements (LAAs).⁵⁵⁰ These agreements are set to be placed on a statutory footing if Parliament passes the Local Government and Public Involvement in Health Bill introduced in December 2006. Already, reducing the harm caused by illegal drugs is one of the eleven mandatory outcomes that must be included in any proposal for a Local Area Agreement.

The social services departments of local authorities have for some time had a range of responsibilities towards drug users under the National Health Service and Community Care Act 1990 (NHSCCA), as well as towards their children under the Children Act 1989. Local authorities have a statutory duty to assess the needs of drug users, like everyone else, for community care.⁵⁵¹ If the local authority decides that the person’s needs call for provision by them of such services, then the local authority must make arrangements for those services to be provided (though of course it can do so by purchasing provision made by third parties). The right to an assessment does not automatically imply a right to receive services. The local authority may decide that the need is not urgent enough or serious enough for services to be provided, and, if the decision is made that services should be provided, it is still up to the authority to decide what level of services to provide.⁵⁵² However, local authorities do have a specific duty to provide accommodation to meet the needs of persons who are drug dependent – in other words, they have

⁵⁴⁹ This was established by the 2000 Spending Review, where illegal drugs are identified as ‘cross-cutting’ alongside 14 other areas such as ‘Support for Older People’ and ‘Rural and Countryside Programmes’). http://www.hm-treasury.gov.uk/Spending_Review/Spending_Review_2000/Spending_Review_Report/spend_sr00_repchap22.cfm

⁵⁵⁰ Local Area Agreements are three-year agreements between central government, local authorities and their partners to deliver national outcomes in a way that reflects local priorities. Local authorities work with other local bodies – Primary Care Trusts, police services etc – to negotiate targets and outcomes with central government. In return they are given the freedom to pool budget streams and devise their own, locally appropriate strategies to achieve the agreed outcomes.

⁵⁵¹ Section 47(10) of the National Health Service and Community Care Act provides (subject to immaterial exceptions) that, where it appears to a local authority that any person for whom they may provide or arrange for the provision of community care services may be in need of any such services, the authority *shall* carry out an assessment of his or her needs for those services (the assessment decision) and, having regard to the results of that assessment *shall* decide whether his needs call for the provision by them of any such services (the service provision decision).

⁵⁵² c.f. Alyson Morley, *Mainstreaming mental health: an introduction for councillors*, Democratic Health Network, 2005.

a statutory duty to provide residential rehabilitation for drug users who are deemed to need it.⁵⁵³ They also have the power, though not the duty, to provide non-residential services for people who are drug-dependent.⁵⁵⁴

In addition, local authorities' housing departments are under pressure to provide for drug users even though the detail of their requirement to do so is not clear. Under the Housing Act 1996 local authorities have a duty to secure accommodation for applicants who are homeless, eligible for help, have a priority need and are not intentionally homeless. Priority-need categories initially included people with children and those classed as 'vulnerable', the young, the old and those with some physical or mental health problem, but were extended under the Homelessness Act 2002 to include 16- and 17-year-olds, care-leavers aged 18 to 20, people who are vulnerable because of time spent in care, the armed forces, prison or custody and people who are vulnerable because of violence. Drug users may fall under most of these headings but are not specifically named as having priority need nor explicitly classed as vulnerable.⁵⁵⁵ They are, however, one of the groups specified for inclusion under the Supporting People scheme, discussed above at pp.197–199. Drugs problems in an area are also a major barrier to regeneration and, as a 2004 Home Office research study pointed out, regeneration partnerships need to have a drugs strategy as part of their overall agenda, with good working relationships between regeneration agencies and specialist drugs services.⁵⁵⁶ Rowena Young, Director of the Skoll Centre for Social Entrepreneurship in Oxford, has argued that:

The Neighbourhood Renewal Unit should develop specific work on drugs... Given the overwhelming correlation between problem drug use and deprivation, and the relationship between drug use, crime, unemployment and poor public spaces, every area regeneration programme needs to be able to tackle the related problems of dealing, crime and ill-health associated with drugs.

However, critics have pointed out that drugs issues rarely rise as high as they should on the agendas of regeneration agencies. This may be in part because these agencies focus primarily on economic regeneration and on creating a positive environment for business. Conversely, 'often communities and particularly projects working with substance use, do not touch regeneration funding opportunities with a barge pole, mainly due to the high intensity of paperwork, bureaucracy and the need to match funding by at least 50 per cent', plus the fact that funding is quarterly in arrears, thus penalizing small projects.⁵⁵⁷

⁵⁵³ Under section 21 of Part III of the National Assistance Act 1948 (as set out in Appendix 1 paragraph 2(6) of Local Authority Circular 93 (10), a Direction from the Secretary of State).

⁵⁵⁴ Under section 29 of Part III of the National Assistance Act 1948 (as set out in Appendix 3 paragraph 3(g) of LA Circular 93 (10)). Where a person has a substantial or permanent handicap possibly linked to addiction, the duty to provide services may be triggered. Otherwise, whilst there is a duty to assess, and an expectation that a full range of services is available, there may be no specific duty to meet identified needs.

⁵⁵⁵ To be vulnerable, the applicant must be clearly less able to cope when homeless or in finding and keeping accommodation and must be at risk of harm in situations where a less vulnerable person could cope without harmful effects. Again, drug users would often fit this description well but, not particularly wanting them as tenants, local authorities do not necessarily accept problematic drug use, even of a severe and chaotic kind, as a reason for classing a homeless person as 'vulnerable', and many specifically exclude drug users.

⁵⁵⁶ R Lupton et al, 'A rock and a hard place: drug markets in deprived neighbourhoods', HO Research Study 240, 2002.

⁵⁵⁷ Kate Davies, 'Social regeneration: fitting drugs in', *Druglink*, Nov/Dec, 2001.

In addition, the Department of Work and Pensions is involved in tackling drugs issues through its commitment to the ‘Progress2Work’ scheme which seeks to help recovering drug users into jobs as part of their reintegration into society.

The need for a genuinely cross-cutting strategy

Thus the problems associated with drug use are already on the agendas of a wide range of agencies. However, outside the Home Office, the department that takes the lead in the drug strategy, there is often a sense at both national and local levels of a low priority being given to drugs issues and a general reluctance to ‘own’ them as core business, even when they abut onto or are woven into other agencies’ primary responsibilities. In consequence there is a real need for drugs policy to be integrated more effectively within the broader policy-making and implementation framework. In our view, issues relating to drugs should be tackled, so to speak, obliquely, in the context of other social policies, rather than being tackled head-on and in isolation. A cross-cutting issue requires a genuinely cross-cutting strategy, with explicit acknowledgement of a shared accountability and measurable targets for every department involved.

A model for this type of approach already exists in the work that is being done to promote the general interests and improve the well-being of children. The Children Act 2004⁵⁵⁸ provides a legislative spine for a wider strategy for improving children’s lives, both through universal services to benefit every child and more targeted services for those with additional needs. The overall aim, according to the Department for Education and Skills,⁵⁵⁹ is ‘to encourage integrated planning, commissioning and delivery of services’ as well as to improve multi-disciplinary working and increase accountability. ‘The legislation is enabling rather than prescriptive and provides local authorities with a considerable amount of flexibility in the way they implement its provisions.’

The Children Act 2004 requires ‘children’s authorities’ – in other words, the children’s departments of local authorities – to make arrangements to ‘promote cooperation’ between the authorities and a range of partners whose work affects or involves children. In each area this will include the police authority and police service, the local probation board, the Youth Offending Team, the Strategic Health Authority and Primary Care Trust and the Learning and Skills Council. These partners are legally obliged to cooperate with the children’s authority. They may ‘provide staff, goods, services, accommodation or other resources’ and they may contribute towards a pooled fund. Having arranged to cooperate, all these agencies are then legally required to ensure

⁵⁵⁸ A number of sections of the Children Act 2004 apply to Wales but the discussion above is only about those sections which apply to England.

⁵⁵⁹ DfES website, <http://www.dfes.gov.uk/publications/childrenactreport/>

that ‘their functions are discharged having regard to the need to safeguard and promote the welfare of children’. In other words, key local agencies now have an explicit duty to look after children. The children’s authority must set up a multi-agency Local Safeguarding Children Board, draw up a single Children and Young People’s Plan, appoint a Director of Children’s Services and a Lead Member for Children’s Services and set up a database containing basic information about children. Once in place, these partnership structures may be designated Children’s Trusts.

Provision is already being made for the national children’s strategy to be integrated with the National Drug Strategy, through a specific drug-related strand in the *Every Child Matters: Change for Children* initiative.⁵⁶⁰ *Every Child Matters: Change for Children – Young People and Drugs* details the changes that must take place to ensure that the children’s strategy supports the objectives of the drug strategy. All services dealing with children and young people must be prepared to tackle their problems with drugs as well as the other difficulties they may face. In 2005, when the *Young People and Drugs* paper was published, although the chairs of Drug Action Teams remained responsible for delivering a three-year strategy for preventing drug use by children and young people, the heads of Children’s Services were required to work with them on determining priorities within the strategy (targeting truants, say, or the children of drug users). Many areas of children’s services already have Key Performance Indicators on drug use that ‘reflect the contribution of mainstream services to delivering the strategy through education, interventions with vulnerable groups and access to treatment’.⁵⁶¹ In addition, *Young People and Drugs* continues, ‘consideration will be given to transferring accountability for children and young peoples’ drug misuse services to Directors of Children’s Services or their equivalents from April 2006’.

We believe that adult drugs services – integrated with alcohol services – require the same degree of integration into broader agendas as do children’s drugs services, both at the national strategic level and at the local service level. The Welsh drug and alcohol strategy clearly acknowledges this need:

Substance misuse does not occur in isolation. It is tied to the social context in which an individual lives... It is important to remember these connections and ensure that action to tackle substance misuse assumes a key role in wider policy agendas such as social inclusion, economic development, public health and crime and disorder.⁵⁶²

⁵⁶⁰ *Every Child Matters*, published in 2004, is the document setting out the national framework for local change through which the Children Act 2004 may be implemented. The framework’s full title is the National Service Framework for Children, Young People and Maternity Services. The Government has developed within *Every Child Matters* an Outcomes Framework to act as a basis for agreeing local priorities and planning local change. The Outcomes Framework details 25 specific aims, one of which is ‘Choose not to take illegal drugs’. (*Every Child Matters*, Section 2.4.)

⁵⁶¹ For example, monitoring drug use among children in care is a performance indicator for the DfES, whereas making sure that all young offenders are assessed for any need for drugs treatment is the responsibility of the Youth Justice Board.

⁵⁶² *Tackling Substance Misuse in Wales*, 2000.

Drugs policy and social exclusion

At the national level, policies relating to substance misuse should be seen as a facet of the government's wider policies on social exclusion. Substance misuse can both arise out of and also lead to social exclusion. As one component of social exclusion, it should be tackled alongside the other aspects – unemployment, homelessness, poverty, ill health, discrimination and family breakdown or vulnerability – with which it also often interlocks. For example, in some studies problems with substance use have been found to occur more frequently in single-parent families, not because this family structure in itself is a predictor of social problems but because it is likely to be associated with some of the other risk factors that influence drug misuse: more exposure to stress, for example, and more contact with 'deviant peers'.⁵⁶³

The Social Exclusion Action Plan published by the Department for Communities and Local Government in 2006⁵⁶⁴ identified a range of groups at risk of social exclusion: children in their early years in at-risk families, children in care, teenage parents, people with the lowest educational achievement and adults living chaotic lives. Virtually all of these groups include people notably affected by problems with drugs and alcohol: the young children of drug users, children in care, truants and excludees from school, homeless drug users and drinkers sleeping rough and persistently committing petty crimes. 'Tackling social exclusion and deprivation,' the Action Plan declares, 'promoting equality for all citizens and addressing the needs of vulnerable people are at the heart of this Government's agenda for public service reform.' Drug users are among these vulnerable people. They should explicitly be acknowledged as such and included in any initiatives designed to improve the quality of life of the socially excluded.

Similarly, the drug strategy should be more closely aligned with – or at least acknowledged in – strategies on homelessness, at both the national and local levels. As discussed above at p.73, one in three problematic drug users is homeless, and 80 per cent of homeless people have or have had problems with drugs. However, the Home Office observes that in England:

Homelessness and drug services have traditionally developed separately. They have tended to evolve a different culture and ethos supported by different national organizational structures. Until very recently drug agencies often did not address the specific drug needs of homeless people. Similarly the homelessness sector tended not to address drugs issues. This is changing rapidly now but the two issues are still covered by separate Government strategies.⁵⁶⁵

⁵⁶³ A Barrett and R Turner, 'Family structure and substance use problems in adolescence and early adulthood: examining explanations for the relationship', *Addiction*, Vol. 101, January 2006.

⁵⁶⁴ Department of Communities and Local Government, *Strong and prosperous communities: the Local Government White Paper*, 2006. Volume 2, p.21.

⁵⁶⁵ www.drugs.gov.uk Communities toolkit, 'Drugs and Homelessness'.

It is even more important to challenge this lack of articulation at the local level, as a 2005 document from the Office of the Deputy Prime Minister recognized: 'It is essential that, in addressing substance misusers with housing and support needs, DAT Treatment Plans, Homelessness Strategies and Supporting People Strategies are joined up locally.'⁵⁶⁶ Housing authorities have a duty under the Homelessness Act 2002 to publish homelessness strategies for their areas, just as Drug Action Teams are required to produce treatment plans that embrace all drug users, including those who are homeless. A small working group of representatives from the DAT, the housing authority, registered social landlords and other agencies working with homeless drug users, might operate as a sub-group to feed a unified strategy for homeless drug users into both the drug and the homelessness strategies.

⁵⁶⁶ Office of the Deputy Prime Minister/Home Office, 'Housing support options for people who misuse substances', March 2005.

⁵⁶⁷ This is discussed in detail at p.249 below.

Although there is still a great deal of work to be done in the practical implementation of the *Every Child Matters* initiative and its offshoot *Young People and Drugs*, they can be seen as pointing the way towards a far greater acknowledgement by other departments of their responsibilities towards the drug strategy. What is needed now is for departments to go beyond this enforced acceptance of responsibility and make dealing with drugs and alcohol issues a routine part of their day-to-day business.

Mainstreaming drugs policy

Isolating and ring-fencing the drugs issue, although it has enabled money to be poured into drugs policy, has enabled other agencies to abdicate their responsibilities. Linking drugs policy so closely with the Home Office and the criminal justice agenda has intensified the stigma surrounding problematic drug use and set it further apart from society's other problems. This process needs to be reversed. The government has already forced the reduction of crime and disorder onto the agendas of various agencies outside the criminal justice system through Section 17 of the Crime and Disorder Act 1998.⁵⁶⁷ This section requires each specified agency 'to exercise its various functions with due regard to the likely effect of the exercise of those functions on, and *the need to do all that it reasonably can* [our italics] to prevent, crime and disorder in its area'. Agencies must already have regard for gender balance and racial equality when they make their plans; now they must also have regard for crime and disorder. Arguably, since substance misuse is avowedly a cross-cutting issue, agencies should be required to take it into account in a similar way.

'Mainstreaming' has been defined as introducing a given way of thinking and acting into the administrative mainstream, letting

it develop into a natural behaviour in order to penetrate and change the way in which mainstream business is done. ‘Mainstreaming’ drugs policy means impressing on each department of government precisely how its own work is affected by the problems surrounding substance misuse and developing the contribution that each department can make to solving the shared problem. Partnerships, too, not just individual departments, should be encouraged to set targets that will further the objectives of the drug strategy, considering drugs issues when they are devising neighbourhood renewal schemes, say, or health education programmes or the siting of street lighting or the allocation of social housing. ‘Integration of drugs issues into the mainstream planning requirements of local partnerships would do more to drive up the quality of treatment in England and the outcomes of that treatment – individually and for communities – than ten years of treatment planning,’ writes one observer.⁵⁶⁸

It is tempting to suggest that in many connections what is needed is not a drugs policy at all but a closer and more determined focus on drug-related issues in amongst other social policies. In the context of policing, as we have already seen, it may be more productive to integrate drugs issues into other police business – the attack on organized criminal networks, say, or the Prolific and Priority Offenders scheme – than to devise a drugs strategy in isolation. Similarly, it may be more effective when seeking to discourage people from the harmful use of drugs and alcohol to embed these messages in the broader context of the entire series of choices to be made about individual health and well-being. Rather than ghettoizing drugs and alcohol education within Personal, Social and Health Education, such matters as the economics and geography of the drugs trade, the history of drugs policy and the philosophical issues surrounding the state’s regulation of personal behaviour could all be addressed elsewhere in the curriculum. ‘Our work with children and young people,’ remarks the Drug Education Forum, ‘indicates that they do not think about drugs in a vacuum but relate [the issue] to other issues and concerns in their lives.’⁵⁶⁹ Similarly, one children’s organization has suggested that attacking the sources of stress in children can do far more to forestall drug use than the imparting of drugs information. In general, tackling social exclusion effectively could do more to reduce the harms from drugs than any specific measure, even treatment, aimed at attacking drugs head-on.⁵⁷⁰

Involving local communities

Making drugs policy more ordinary and more a part of day-to-day business, one among many different concerns of social policy,

⁵⁶⁸ Sara McGrail, ‘More, better and fairer: the state of the nation’, *Druglink*, Nov/Dec, 2004.

⁵⁶⁹ Evidence to the House of Commons Home Affairs Select Committee, September 2001.

⁵⁷⁰ See, for example, Professor Peter Cohen, ‘The social and health consequences of cocaine use’, presentation held at the Nationale Designerdrogen- und Kokainkonferenz, 3-4 June 2004, CEDRO, 2004. ‘For all drug use and drug users, social exclusion and marginalization are the worst settings... In my view, daily and regular use, under certain circumstances also called addiction, is far less of a danger to people than social exclusion. Progressive policies confront drug related exclusion, more than they confront (intense) drug use per se’.

⁵⁷¹ 'Dealing with reality', *Guardian*,
June 21 2006.

would do much to de-demonize the issue in the eyes of the public, counteracting the stigma imposed by criminalization of drug use and making it easier for communities to handle. One aim of a new line of policy should be to spread the idea that substance misuse is just one of many problems that a community may have to handle. One of the characteristics of a *resilient* community is its capacity to manage a problem of this kind: not to deny it or try to eradicate it but to deal with it. Treating drug use as alien and drug users as somehow 'other' and exiled from the rest of the community is not only morally dubious but factually incorrect. People who use drugs are part of the community just as much as people who smoke or drink alcohol; the consumption of psychoactive substances does not entail forfeiting their membership of society. Nor should it be assumed, as we have seen, that drug dealers are always outsiders. Communities may well tolerate dealers who have grown up within them.

Occasionally they may even see them as providing a service. In June 2006 the *Guardian* reported the death of a 50-year-old woman from a cocaine overdose in the following terms:

The funeral of Lillian Taylor was like that of any other well-loved and respected figure. ... The funeral cortege was adorned with flowers spelling "Mum" and "Nan" ... Passers-by might have assumed that Taylor was a pillar of her community – and in a strange, mixed up way, she was... She was a well-loved grandmother and a respected community figure. She was also a drug dealer and addict.⁵⁷¹

The woman in question had been dealing in amphetamines and tranquillisers, partly to fund her own habit but also out of a confused sense of public service, with the aim of helping other women who, like her, had broken marriages, small children and little money and who felt they needed help to 'get through'. One of her neighbours commented following her death that the only thing that had changed subsequently in terms of drug use in their area was that most amphetamine and anti-depressant addicts were now going to 'proper' dealers, who used strong-arm tactics to recover debts and who also sold heroin and crack cocaine.

Communities should obviously be engaged in dealing with people who, whether they like it or not, are a part of them. If drug misuse is regarded not simply as a personal problem but a social problem, then it is a problem that is owned collectively. The trend in current policy is towards a greater level of public involvement in problem-solving at the local level. The key proposals of the Local Government White Paper published by the Department for Communities and Local Government

in October 2006 would, it was claimed, ‘extend the choice local people have over their services, either at the point of access or as a form of redress; increase the involvement of users and communities in commissioning decisions; enhance the right of local people to be heard, by extending the Community Call for Action to all local government services’. The White Paper is presented as imposing a duty on local authorities to ensure the participation of citizens, service users and community groups.⁵⁷² However, communities need to be willing to take up the rights and duties they are being offered.

⁵⁷² Department of Communities and Local Government, *Strong and prosperous communities: the Local Government White Paper*, 2006, Volume 1, p.8. ‘We will back this by a stronger legal framework to require local authorities and other best value authorities to secure the participation of local citizens and communities.’

We are clear that local communities should be encouraged to define and agree on their own priorities for action on drugs and alcohol. The patterns of drug use in a community will not necessarily emerge from statistics that are collated nationally. Only local people will be able to tell whether the problematic heroin use of a few people is the community’s major problem or whether, in fact, a more pressing priority might be an increase in the combined use of cocaine and alcohol, or the widespread use of cannabis without any awareness that there might be risks associated with it.

Communities should also be encouraged to develop strategies for implementing these priorities that will be appropriate to their own areas. A common priority might be, say, a zero-tolerance approach to drug use in public, but solutions might range from closed-circuit television and schemes for uniformed drugs wardens to drug consumption rooms, or a combination of all three.

Communities can be more closely engaged through community justice initiatives in the policing of drugs offences and in helping to determine what penalties should be imposed. Communities are also the natural focus for work with families, for a greater involvement of service users in their own treatment, for improvements in housing, for schemes for the employment of drug users and for public information campaigns geared to local interests rather the concerns of national politicians or media.

15 How policy is currently delivered

If the principle of bringing drugs policy into the mainstream is accepted, as we have argued in the last chapter that it should be, the challenge is to find the most effective mechanism for delivering prevention, education and treatment services that are both part of the daily business of all agencies and joined up coherently at the local level.

Our discussion of the translation of policy into practice falls into three parts, each the subject of its own chapter. This chapter describes how the National Drug Strategy is currently delivered, both at the national level and locally through Drug Action Teams. Chapter 16 then outlines weaknesses that we have identified in the system. Finally, Chapter 17 offers recommendations for improving delivery of the strategy at both central and local levels.

It should be noted, however, that we focus in these chapters primarily on England. Scotland, Wales and Northern Ireland each have their own substance misuse strategies, broadly similar in general outline to the English but tailored to their own circumstances.⁵⁷³ We do not attempt to describe in detail the parallel systems for delivering the drug strategy but simply pick out differences that have been seen to have a significant effect on the strategy's effectiveness.

The National Drug Strategy and central government

At present the organizational structure for delivering the drug strategy in England is dominated by the Home Office. Responsibility for illegal drugs is shared among several departments, as befits a cross-cutting problem, but for the last five years the Home Office has had the lead and has been able to gain priority for its objectives of reducing drug-related crime and restricting the supply of drugs.

The other key department is the Department of Health, responsible for boosting the number of problem drug users going into treatment and for progressively increasing the proportion of people staying there and completing their treatment. Under the Department of Health sits the National Treatment Agency (NTA), a special health authority whose job over the last five years has been to 'join together the drug agendas of the Department of Health and the Home Office'. The NTA was originally set up in 2001 specifically to ensure that the NHS gave appropriate priority to drugs treatment, but it has increasingly operated in the context of the government's increasing emphasis on the need to reduce drug-related crime.⁵⁷⁴ Thus, it has had simultaneously to promote, on the Home Office's behalf, the system for getting drug-using offenders 'out of crime and into treatment' (the Drug Interventions Programme) and also to ensure that the NHS picks up its general responsibilities for treating all drug users.

Three other departments are named in the Public Service Agreements on action against illegal drugs. The Department for Education and Skills currently has lead responsibility for

⁵⁷³ *Tackling Drugs in Scotland: Action in Partnership*, 1999; *Tackling Substance Misuse in Wales: a Partnership Approach*, 2000; *Drug Strategy for Northern Ireland*, 1999, updated in 2006 with *New Strategic Direction for Alcohol and Drugs 2006-11*.

⁵⁷⁴ Letter from Caroline Flint, Parliamentary Under Secretary of State For Public Health, and Paul Goggins, Parliamentary Under Secretary of State, Home Office, to Paul Hayes and Baroness Massey, Chief Executive and Chair of the National Treatment Agency, 11 January 2006.

drugs education and other measures designed to reduce ‘the use of Class A drugs and the frequent use of any illicit drug’ among young people under the age of 25, particularly the most vulnerable (those who are homeless, sexually exploited, truanting, refugees or asylum seekers, offenders or the children of drug-misusing parents). The Foreign Office is responsible for coordinating Britain’s international efforts against drugs and organized crime. Finally, the Treasury shares responsibility for restricting the supply of drugs into Britain.

⁵⁷⁵ This total included £88 million for the treatment of drug-using offenders in the community and £55.7 million for treatment in prison. The National Offender Management Service (NOMS): *Strategy for the management and treatment of problematic drug users within the Correctional Services*, January 2005.

Just as responsibility is divided, so funding for the implementation of the drug strategy in England comes from various sources:

- 1 the Pooled Treatment Budget – in 2006/7 a total of £385 million – combining funding from the Home Office and Department of Health;
- 2 mainstream NHS funding through Primary Care Trusts (PCTs), the local bodies in charge of commissioning overall health services;
- 3 mainstream social services funding through local authorities;
- 4 funding from probation and prison services (now combined in the National Offender Management Service), amounting in 2004/5 to almost £150 million;⁵⁷⁵
- 5 the Safer and Stronger Communities Fund, which brings together funding streams from the Home Office and Department of Communities and Local Government to tackle crime, anti-social behaviour and drugs;
- 6 separate Home Office funding for the Drug Interventions Programme; and finally
- 7 the Home Office’s Young People’s Substance Misuse Partnership Grant.

With so many different departments involved, coordination and leadership is needed at the ministerial level to give some coherence to the strategy. The Prime Minister currently chairs the Serious and Organised Crime and Drugs Cabinet Committee. Beneath it and reporting to it is the Drugs Working Group, which brings together ministers and senior officials from the Departments of Work and Pensions, Education and Skills and Communities and Local Government, under the chairmanship of the Home Secretary. It is this group that has primary responsibility for coordinating strategies on drug misuse: for deciding, for example, that particular emphasis should now be placed not simply on drugs treatment but on providing the ‘wraparound’ services that support treatment – employment, training and housing.

Below the Drugs Working Group sits the Drug Strategy Delivery Group, a cross-departmental steering group of officials with

practical responsibility for implementing the National Drug Strategy. It has agreed seven 'delivery indicators' against which local authorities and strategic partnerships can measure their progress in meeting drugs targets, including local perceptions of drug use in their areas and the number of people between 16 and 24 recorded locally by the British Crime Survey as using Class A drugs. All these groups are separate from the Advisory Council on the Misuse of Drugs. In Scotland, the Scottish Advisory Committee on Drug Misuse performs a comparable service for the Drugs Minister.

The National Drug Strategy and local organization

Providing effective solutions for individuals and communities experiencing problems with drug use requires robust local information. How many problematic drug users are there in the area? What are they using? Where are they getting their drugs? How many are committing crimes and how many are not? How many are involved in sex work? How many are homeless? How many have children? How many are in treatment and how many more need treatment? What are the existing treatment services? Where are they? How much capacity do they have? And how good are they?

Different agencies will have the data that might provide answers to these questions. The police, for example, will know where the principal drugs markets are and where crack houses are also used as bases for sex workers. The Primary Care Trust will know what and where the treatment services are. Individual treatment providers will know how many problematic drug users they have on their books.

An important challenge is to coordinate this information in order to assess the local need for services (treatment, housing, training, employment, social care), to draw up a local action plan, to fashion a budget from multiple pots of funding and to arrange for all of these services to be provided as effectively as possible by suppliers from the public, private and voluntary sectors.

It is worth repeating the point we have made earlier, that it is very difficult to collate statistics such as these and make them meaningful in the absence of a robust national framework within which all are collected on uniform bases. Be that as it may, the coordination of information and the development of a joint strategy is currently the responsibility of Drug Action Teams or DATs, local partnerships made up of representatives of all the different agencies with responsibility for drugs issues: the local police and probation services, voluntary agencies, the

NHS Primary Care Trust and the education, housing and social care departments of local authorities.

In Scotland and Wales, the drug and alcohol strategies are linked more closely and are delivered by joint teams: in Scotland, by Alcohol and Drug Action Teams or ADATs, and in Wales by Community Safety Partnerships, which have taken over the responsibilities of the former Drug and Alcohol Action Teams. Northern Ireland has four Drug Co-ordination Teams.

According to the Home Office website, there are 150 DATs in England. Because their areas are aligned with local authority boundaries, a single DAT can cover a large area like Lincolnshire or a smaller, more densely populated area like a London borough. Formally accountable to the Home Secretary, DATs are performance-managed by Drug Teams in the Government Offices for the Regions, who monitor their funding and expenditure and report to the Crime and Drug Strategy Directorate within the Home Office. (Scotland's ADATs have their own association to coordinate strategy and collate good practice.)⁵⁷⁶ In practice, while there may be 150 bodies in England that may be referred to as 'DATs', their status varies widely. Some exist as separate entities, as originally envisaged, while others have been largely subsumed within Crime and Disorder Reduction Partnerships (to be discussed below), where they may exist only as Substance Misuse sub-groups.

Each DAT has a chair and a coordinator. The chair is the most senior official within the team and will also have a senior position within one of the constituent agencies. He or she may, for example, be the Director of Healthcare Improvement at the Primary Care Trust or the Director of Social Services for the local authority. The coordinator is responsible for day-to-day management and usually leads a small team of people, which may include a commissioning manager, support workers and development workers, an information officer and administrative staff.

DATs are charged with delivering all four strands of the drug strategy: increasing the number of people going into treatment, reducing the supply of drugs, preventing young people from using drugs and reducing drug-related crime. A wide range of different responsibilities is implied by this basic brief. For example, the brief gives DATs oversight of the process for commissioning drugs treatment services. Commissioning involves assessing treatment needs in advance, setting targets to meet these needs and contracting services to meet these

⁵⁷⁶ In Scotland there are 22 Alcohol and Drug Action Team areas. In Greater Glasgow and Clyde the Alcohol Action Team and Drug Action Team have not been merged at the strategic level, although they are fully integrated below that in their service provision, meaning that effectively there are 23 teams for the 22 areas. There is a range of different staffing and structures from team to team.

projected targets rather than simply buying individual treatment as and when the occasion arises. Commissioning is meant to be carried out collectively by health, social care and criminal justice agencies, to avoid gaps and duplication. Working through their local DAT, the different agencies in an area are required to establish Joint Commissioning Groups on which each agency is represented, with a Joint Commissioning Manager to administer the commissioning process once decisions have been made. Until now, these managers have most often been employed by Primary Care Trusts (PCTs) as part of their general commissioning teams, and the Primary Care Trusts have done most of the commissioning on the DATs' behalf.

⁵⁷⁷ NTA Business Plan 2005-6.

⁵⁷⁸ Keith Hellawell, evidence to the House of Commons Home Affairs Select Committee, 30 October 2001.

16 The limitations of the current system

Our basic premise in considering how policy is delivered is that everyone should have equal access to, or be equally within the reach of, the people, agencies and information that can help them to avoid using drugs harmfully. Drug dependency, in the words of the National Treatment Agency, is 'a classic cross-cutting issue'.⁵⁷⁷ The support that problem drug users need is not just medical treatment but help with housing, employment, education and all the other services that enable people to take part in the life of society rather than remaining on its fringes. For such support to materialise, all the relevant agencies have to accept their responsibilities, and their activities have to be coordinated at ministerial level, at department level and at the local level.

Central coordination

At the level of national government, it is not clear at the moment how ministerial groups like the Serious and Organised Crime and Drugs Cabinet Committee, the Drugs Working Group or the Drug Strategy Delivery Group operate. Nor is it evident how effective they are.

There would seem to be scope for closer coordination of responsibilities for drugs policy at the inter-departmental level. The experiment of having a drugs czar charged with oversight of the drug strategy and with coordinating the efforts of different departments failed, in the opinion of the czar himself, Keith Hellawell, largely because he was not given the power to make these other agencies deliver:

Having someone who is seen as a neutral, a non-civil servant and a non-minister had its advantages. It had huge disadvantages, though, because there was no power base, there was no real support in terms of a strong Minister... [there were] very small teams of people.⁵⁷⁸

There is likewise scope for greater clarification of the responsibilities of each department and some explanation of the way in which they have been allocated. In the current Public Service Agreements, for example, there is no explicit reference to public health and no target directly related to individual health.⁵⁷⁹ The only reference to ‘health’ at all comes in the statement of the general aims of the Agreements on ‘Action Against Illegal Drugs’. These include ‘providing treatment for people with drug problems to help them live healthy and crime-free lives’. Health is not mentioned at all in the performance targets, by which departments are obliged in practice to set the greatest store. The Department of Health might feel more inclined to contribute wholeheartedly to delivering the drug strategy if one of its declared objectives was to promote health – and health as an end in itself rather than simply as a means to a crime-free life.

Local coordination

At the local level what is needed is an effective system that allows for multi-disciplinary, multi-agency planning on the basis of accurate information about local needs, gathered locally, with the involvement of service users as well as service providers and commissioners. These principles, broadly speaking, lay behind the existing system centred on local Drug Action Teams as it was originally devised. However, we consider that there are serious limitations in the functioning of the system as it has evolved and currently exists.

From their inception in 1995, Drug Action Teams have always faced stiff challenges in bringing local agencies together. The problem is not so much with the structure of the DAT system as with how it works in practice.

The commissioning of drugs treatment services provides a good example of the range of problems to be overcome in achieving a coordinated strategy. In theory, each member of a Joint Commissioning Group should be a budget-holder, in a position to commit funds to the integrated treatment plan that the DAT has devised. In practice, however, not all Joint Commissioning Managers now have shared budgets at their disposal, as it is quite common for individual agencies to default on their commitments to drugs services. This is at least partly because the commissioning managers’ influence on the commissioning strategy itself may be limited. A study carried out jointly by the Healthcare Commission and National Treatment Agency, as a pilot for the recent large-scale survey of commissioning standards within Drug Action Teams, reported that ‘substance

misuse commissioning posts were usually poorly resourced and isolated from strategic management'.⁵⁸⁰

Where a Joint Commissioning Group is weak, the DAT itself is not in a position to exert any extra authority. Some agencies are prone to commission services ad hoc and independently while others adopt an historic approach, commissioning what they have always commissioned, regardless of changing needs. Commissioning for the Home Office's Drug Interventions Programme for drug-using offenders, which is separately funded, may cut across other plans and take priority over them. There is also some confusion as to the effect that the reorganization of the NHS in England is likely to have on the DATs' commissioning system.⁵⁸¹ What will happen, for example, as a result of the merging in 2006 of 300-odd Primary Care Trusts into 150? What will be the effect of the creation of the ten over-arching Strategic Health Authorities? And how will the DATs be affected by the large-scale introduction of practice-based commissioning, which gives GPs far more say in the health services that are provided for their areas?⁵⁸²

Problems in partnership working

There is obviously nothing wrong in principle with the idea of partnership working, but in practice partnership working is notoriously difficult to implement successfully, and collaborating on the drug strategy is no exception.

Prompt and intelligent sharing of information is a particular problem. Sharing information takes time, forethought, compatible computer systems and a degree of consensus on what is permitted either by law or by individual organizations' attitudes to confidentiality. The Crime and Disorder Act 1998, for example, created a mechanism for agencies to exchange crime-related data, but the Act provided only a 'power' to disclose information rather than imposing a duty or compulsion to disclose it, and it did not offer any practical guidance on how information should be disclosed.⁵⁸³ Subsequently the Data Protection Act 1998, the Human Rights Act 1998 and the Freedom of Information Act 2000 have all had an impact, not always helpful and often confusing, on how data can be held and shared. Police services are reluctant to disclose operational information to other agencies, while social services and drugs agencies dislike sharing personal information about their clients that could interfere with care relationships that depend on trust.

In addition to the legal constraints mentioned above, the reluctance to share information may also sometimes be

⁵⁸⁰ Healthcare Commission/NTA, 'Pilot report of joint improvement reviews between the Healthcare Commission and the National Treatment Agency for Substance Misuse', 2004.

⁵⁸¹ The development of Community Health Partnerships in Scotland is similarly of relevance to Scottish Alcohol and Drug Action Teams.

⁵⁸² At the moment the bulk of NHS money is allocated to Primary Care Trusts which commission and reimburse hospitals (and other health care providers) for the services used by their local populations and pay GP practices for the services they deliver to patients. Under practice-based commissioning, GP practices are to be given their own 'notional' budgets with which to 'buy' health services for their patients, like attendances at Accident & Emergency departments, all referrals to hospital for outpatient and inpatient treatments, and drugs. The GP practices are accountable to their PCTs, which draft the contracts with hospitals and other providers and remain legally responsible for the funds. The idea is that GPs should come up with new ways of using the money, individually or in groups, to design services better suited to their particular circumstances. GPs who take up the scheme get payments and are allowed to keep any 'surpluses' they generate by better management of budgets. Practice-based commissioning will start in earnest in 2008.

⁵⁸³ As a result of its review of the partnership provisions of the Crime and Disorder Act 1998 in 2004-5, the government is considering taking measures to strengthen section 115 of the Crime and Disorder Act, which gives relevant agencies the power to disclose information, and to place a duty on responsible authorities to share depersonalised data which are relevant for community safety purposes and already held in a depersonalised format.

a symptom of damaging levels of suspicion between and among agencies. Treatment providers may mistrust the intentions of police and probation services; drugs workers complain about the ‘medicalization’ of drugs treatment and the arrogance of health professionals; and everyone apparently feels free to disparage social workers. Police and probation services tend to take the view that no other agencies understand offenders, and police officers are often irritated by what they see as the ‘soft’ social care approach to drug users that they believe undermines crime reduction.

Drugs issues impinge on the work of most of the agencies providing services in local communities, but they are never these agencies’ core business, and they generally appear nowhere in their key performance indicators. Individual agencies concentrate on the targets against which they are going to be measured, and they often believe that it can be more difficult to achieve these targets when drug use and drug users are involved.

Limits on the power of the DATs

DATs are often not strong enough to overcome these problems and to promote partnership working effectively. Constant structural changes to the various systems that they are supposed to be aligning and coordinating – the NHS, police services, local government – undoubtedly make their task harder. Nevertheless, it could be argued that they have rarely in any case had the power to perform the task effectively.

A loss of identity

Drug Action Teams first came into being in 1995, three years before the launch of the National Drug Strategy, almost as ‘virtual organizations’, without core funding, networks or formal systems. They were then based on NHS boundaries rather than local authority boundaries. For a short period in the early stages of the drug strategy, they enjoyed considerable freedom of action combined with generous funding. Staffing grew, DAT coordinators had good liaison with each other, every DAT had its Joint Commissioning Manager (in England at least), and these managers often had the power to bring money to the table. Individual DATs met monthly and were convened once a year in a national conference.

This halcyon period came to an end with the creation of the National Treatment Agency in 2001 and the introduction of tighter central controls and standardized performance targets. A critical Audit Commission report in 2002 was followed in 2003 by the decision that DATs should lose their separate

identity and be integrated with Crime and Disorder Reduction Partnerships (CDRPs).⁵⁸⁴ This move towards merger has tended to focus the DATs' attention on reducing drug-related crime and has had the effect of distracting attention from the task of commissioning treatment services for *all* drug users, not just those who have committed offences. A joint Healthcare Commission/National Treatment Agency report in 2004 remarked discreetly:

Issues have been identified arising from the crime and disorder reduction partnership (CDRP) and DA(A)T mergers. It is not always clear where the non-criminal justice element of treatment sits in the CDRP agenda priorities.⁵⁸⁵

A lack of support

With the erosion of the DATs' separate identity, DAT coordinators no longer have anywhere to go for help. There is no support unit, annual conference or forum and little in the way of institutional learning. One DAT often does not know what others are doing. Good practice, let alone best practice, is often not disseminated.

Poor positioning and ill-defined relationships

One of the Audit Commission's complaints in 2002 was that too often DATs lacked the power in real terms to be more than local talking-shops. In the absence of any kind of central DAT association to compare with the Scottish Association of Alcohol and Drug Action Teams, not enough is known about how many DATs across England actually work. However, anecdotal evidence would suggest that in many places DATs remain talking shops, as the Audit Commission suggested, because a wide range of factors limits their practical effectiveness.

For one thing, the relationship of DATs and other multi-agency regional partnerships is not always clear. The different partnerships are sometimes in competition for members, and possibly also for funding. As new local planning structures are put in place in order to coordinate regeneration, children's services, health and criminal justice, DATs have to work out and negotiate their relationships with each of these structures in turn or else risk becoming redundant. Thus, although DATs are themselves local strategic partnerships of sorts, it is not clear how they relate to the Local Strategic Partnerships formally established under the Local Government Act 2000.⁵⁸⁶

Unlike CDRPs, DATs do not automatically have representation on these bodies, which have considerable influence on local funding arrangements. It is also not always clear who has committed what resources to a DAT. Few DATs have managed

⁵⁸⁴ Audit Commission, *Changing Habits – the commissioning and management of community drug treatment services for adults*, (2002). Introduced under the Police Reform Act 2002, CDRPs are also local partnerships of police, local authority, health trusts, voluntary agencies, businesses and residents, in this case working together to reduce crime and disorder. The original intention was that all DATs should be merged with CDRPs, and in some areas drugs issues are now dealt with entirely through the local CDRP. In other areas DATs survive, either within the CDRP and subordinate to it, or alongside it.

⁵⁸⁵ Healthcare Commission/NTA, 'Pilot report of joint improvement reviews between the Healthcare Commission and the National Treatment Agency for Substance Misuse', 2004.

⁵⁸⁶ Local Strategic Partnerships are non-statutory, multi-agency bodies, co-terminous with local authority boundaries, that aim to bring together at a local level the different parts of the public, private, community and voluntary sectors in order to tackle multi-faceted local issues.

to formalise joint funding or performance measures, and many suffer from shortage of time and money. Many are constantly fearful that, in the present state of the NHS, with the resulting intense financial pressures on Primary Care Trusts, the trusts will not honour their commitments to drugs treatment. Some are already defaulting on their contributions to drugs treatment services. Kensington and Chelsea Drug Action Team, for example, reported in 2005, in answer to the question, ‘Have all mainstream funding commitments been maintained and inflation uplifted?’:

NO: the PCT are expected to put a financial recovery programme together owing to large financial deficit. There is a firm commitment to the DAT from the PCT; however, the pressures on their mainstream budget have resulted in a cut being made across all services including drug and alcohol treatment services.⁵⁸⁷

Problems in participation

While many individual DAT coordinators are experienced and effective, DATs themselves sometimes lack the dynamism that they need in order to impose their will on more permanent bodies with statutory powers. None of the individual members is paid for his or her participation in the DAT and all have full-time jobs elsewhere, in the organizations that they represent. Some DATs are able to command the attendance not only of senior figures but of the right senior figures: those who command budgets and possess the relevant knowledge both of local conditions and of drugs issues. However, attendance in others has been delegated to junior staff who are not in a position to make independent decisions and who lack the status to influence key decision-making bodies such as the Local Strategic Partnerships. Some agencies need to be persuaded to send representatives and support joint actions and on occasion the most important representatives are not there. The 2004 Healthcare Commission/NTA pilot study reported that ‘participation, at strategic level, of key partnership organizations such as local housing organizations has been lacking’. Many DATs complain in addition of the difficulty of engaging suitably senior representatives from the NHS. Logically, the participation of the local Director of Public Health, for example, should be indispensable to prevention and harm reduction initiatives in a DAT area, but such participation is by no means guaranteed. Finally, it is worth noting that few DATs have much institutional memory and that many of the members have had no structured learning about drugs issues. There are no formal induction procedures, no DAT-related training and often little continuity. Attendance is patchy and irregular.

Limits on local strategic thinking

One of the reasons senior local figures may be reluctant to commit time and energy to DATs could be a sense that they are simply mechanisms for executing policy that has been determined centrally, leaving little scope for independent strategic thinking or for adapting national policy to suit local requirements. It is a common complaint that DATs are so busy collecting performance and management statistics, in order to meet the demands of national strategies and also to provide evidence that targets are being met, that they lack the time to tailor local services to local needs.

The National Treatment Agency runs the National Drug Treatment Monitoring Service, the official method of monitoring the extent and nature of structured drugs treatment in England, (a function performed in Scotland by the Scottish Drug Misuse Database). Each DAT must supply the NTA every month with a 'core data set' – based on information supplied by the service providers – detailing its performance on how many people are receiving treatment and who they are, how long they have been retained in treatment, how long they have had to wait to get into treatment and so on. DATs complain that too much of this kind of detail is required, that the requirements change all the time and that the level of detail required about individual users is sometimes intrusive. In addition, data are often not sought in a form that is relevant to local conditions. For example, information on ethnicity may be requested under general headings that iron out detail which, locally, can be highly significant. Other information that could be valuable for treatment in practice is missed. The National Drug Treatment Monitoring Service tends to focus, for instance, on drug users in structured Tier 3 or 4 treatment – that is to say, in day care programmes or residential rehabilitation – but many of the early warning signs of problem use and trends in misuse are found in Tiers 1 and 2, in doctors' surgeries and police stations.

DATs need to be able to answer certain questions in order to provide the best service locally. For instance, are existing treatment services effective in helping drug users? Are there hidden groups of people having problems with drugs whose needs are not being met by existing services? The answers to these questions are different from the figures that DATs have to supply for central collating, and some coordinators object that they lack the resources to collect both sets of figures. Securing accurate data on the extent of drug use in an area is difficult. Different agencies (Primary Care Trusts, police, local authorities) supply figures that are inconsistent both with each other and with the DATs' own estimates. Even counting people in

treatment is hard: users may go (quite legitimately) to different agencies for different aspects of their treatment and be double-counted. Equally, they may give false names or change their names in order to be double-prescribed and go into treatment repeatedly in different areas.

The lack of statutory powers

DATs also face a near-impossible task in being required to coordinate NHS and local authority activities without the power and the influence that would enable them to do so effectively. Regular local structures are needed for commissioning the full range of services for people with drugs problems. But there is no simple statutory framework for assessing the need for treatment or other services at the local level and then providing or purchasing these services, and no single statutory body is responsible and accountable for it. While the Home Office drives the strategy and DATs are the main tool for implementing it, statutory responsibilities for the various activities it embraces remain respectively with the NHS/Department of Health and with local authorities/Department for Communities and Local Government.

The task of bringing health and social services together

This division of responsibility between the NHS and local authorities leaves a gap in the drugs treatment system that is very hard for non-statutory bodies such as DATs to bridge.

The NHS' responsibilities for providing drugs treatment services are clearly set out in the White Paper *Tackling Drugs Together* (1995) and are currently delegated to Primary Care Trusts. However, at a time when NHS budgets are under acute pressure, Primary Care Trusts are rarely able or willing to give drugs services a high priority.

Similarly, as we noted above on pp.222–223, local authorities have the sole statutory duty to assess people's needs for social care services, including residential rehabilitation for problematic drug users. But the authorities do not have a duty in every case to provide services to meet the needs that they have been told to identify, only a power.⁵⁸⁸ This power will only be exercised where budgets permit, and again drug users are competing with more obviously 'deserving' priorities such as the care of the elderly. Shortly after the NHS and Community Care Act came into force, the Scottish Office observed, with considerable prescience:

There has been concern in many quarters about the impact of the new community care arrangements on the provision of services for those who have alcohol and/or drug problems. This is due, in part, to the low priority which it is feared will attach in practice to this care group.⁵⁸⁹

⁵⁸⁸ Specifically, the NHS and Community Care Act 1990 requires local authorities to produce community care plans, to assess people whom they think may need community care and to arrange 'where appropriate' for the provision of this care. Drugs services must be included in the overall community care plans: 'Local authorities should, in cooperation with other agencies involved in the field, establish machinery to measure the prevalence of alcohol and drug use within their areas and identify and cost the services currently provided and resultant gaps or deficiencies.' As well as identifying the needs of the area, a local authority must assess the needs of individuals. It then has the power to provide appropriate packages of care but not the duty.

⁵⁸⁹ Scottish Office Circular SWSG14/93, July 1993.

It is asking a great deal of DATs to expect them to be the local bodies capable of exerting their managerial authority – or even their coordinating authority – over health and social services. That is especially the case given that health and social services are typically not at all keen to take the problems of drug abuse on board. Historically, inducing health and social services to work together has always been difficult. Partnership working has been required of them since the 1960s and 1970s in pursuit of the general policy objective of providing services in the community as an alternative to institutional care. However, twenty years on, in the mid-1980s, joint service provision was dismissed as ‘pedestrian and patchy’ by the Working Party on Joint Planning, and in 1986 it was described as ‘still overdue’ by the Audit Commission report *Making a reality of community care*.⁵⁹⁰

The NHS and Community Care Act 1990 put local authorities in overall charge of community care, and in the following decade they were frequently urged to combine their efforts with health services in their area to deliver comprehensive treatment to people with complex needs. The Scottish Office, for example, wrote in 1993:

It is important for local authorities to recognise the distinct role that NHS services have to play in the treatment of individuals who have alcohol and/or drug problems and, in particular, the scope which exists for joint working [of local authorities] with primary health care professionals and specialist staff within hospital or community settings.⁵⁹¹

However, the NHS and local authorities have distinct cultures and vertical management systems both of which make the lines of authority within these agencies far stronger than any lateral connections they may have to external agencies. Plans for joint working are often sabotaged by mutual suspicion, misunderstanding and bureaucracy.⁵⁹²

The National Treatment Agency’s *Models of Care* – published in 2002 and revised in 2006 – sets out procedures for securing integrated services and coherent treatment ‘pathways’ for individual drug users from health and social services.⁵⁹³ But without statutory powers DATs lack the influence to persuade these other agencies to deliver if they are reluctant to do so.

17 Improving delivery

Delivery from the centre

Central to the weakness of Drug Action Teams in recent years has been their lack of authority and of clear definition,

⁵⁹⁰ Jason Powell, ‘The NHS and Community Care Act 1990 in the United Kingdom: a critical review’, *Sincronia*, Autumn 2001.

⁵⁹¹ Scottish Office Circular SWSG14/93, July 1993. The initiative ‘A Joint Future’ was launched in 2003 precisely as a means of promoting better partnerships between health and social services to provide community care services, including those relating to addictions.

⁵⁹² The scheme in England and Wales to bring together services for the elderly in Care Trusts, for example, has so far resulted in the creation of only eight such trusts. The NHS website explains: ‘Care Trusts are set up when the NHS and Local Authorities agree to work closely together, usually where it is felt that a closer relationship between health and social care is needed or would benefit local care services. At the moment there are only a small number of Care Trusts, though [it adds hopefully] more will be set up in the future.’ <http://www.nhs.uk/England/AuthoritiesTrusts/Care/Default.aspx> Critics have pointed out that plans for several more Care Trusts have been abandoned and suggest that the scheme may ‘wither on the vine’ because of differences in funding structures and the reluctance of each service to take on the debts of the other: David Batty, ‘Q & A: Care Trusts’, *Guardian*, 2 April 2003, <http://society.guardian.co.uk/modsocialserv/story/0,,824261,00.html> and cf. <http://society.guardian.co.uk/modsocialserv/story/0,,609082,00.html>

⁵⁹³ The equivalent publication for Scotland is the Effective Interventions Unit’s guidance on *Integrated Care For Drug Users: Principles and Practice*, 2002.

following the move to subsume them in Crime and Disorder Reduction Partnerships. Once more, it would seem, the over-close identification of drugs policy with a criminal justice agenda has undermined its effectiveness and its ability to deliver against the wider range of targets that it must also achieve in the fields of health and social policy.

⁵⁹⁴ For instance, a 2001 Liberal Democrat policy paper called for the Department of Health to take the lead, a stance supported by the campaigning organization Transform in its Policy Paper 47, *Honesty, Realism, Responsibility: Proposals for the Reform of Drugs Law*, 2001.

The lead in drugs policy should leave the Home Office

Accordingly, our principal recommendation on the organizational structure for delivering drugs policy is that the Home Office should be deprived of its lead role. Its leadership of the strategy has intensified the stigmatization of drug use as being first and foremost a criminal matter and it has promoted the branding of drug users as criminals. The heavy emphasis in its publicity on the campaign against drug-related crime has overshadowed its work on reducing health harms to the point where, as we have noted above, any good it is doing in this area is having almost to be done by stealth.

Additionally, as far as the National Drug Strategy is concerned, the Home Office has tended to favour national, centralized solutions that hold back the kind of devolved and localized planning and initiatives that are needed in order for drugs services to be effective.

So where should the policy lead lie, if not with the Home Office?

The lead should pass to the Department for Communities and Local Government

Whenever the suggestion has been made previously that another department should take the lead in drugs policy, the Department of Health has been put forward as the prime candidate.⁵⁹⁴

Obviously, the Department of Health has qualifications for the task. We ourselves have argued above that problematic drug use should be characterized as a health issue and drugs treatment should be explicitly located within a framework of public health – indeed, that it should be treated as a public health priority.

The Department of Health could and should take more responsibility for ensuring that young people are provided with the information that they need about drugs when, for one reason or another, they are beyond the reach of school drugs education. The Department of Health's qualifications for leading on drugs might seem to be strengthened by the fact that it leads on alcohol which, we have argued, is simply a different point on a single spectrum of substance use.

On the other hand, one might point precisely to the way in which the Department deals with alcohol as an argument against

its claims. The overall budget for alcohol treatment is a tiny fraction of the overall spending on illegal drugs and it is left to the discretion of individual Primary Care Trusts to decide how to use what funding they do get to provide alcohol services at the local level. In 2006 the Department's own Alcohol Needs Assessment Research Project revealed that only one in eighteen people with alcohol problems receive the treatment they need.⁵⁹⁵ Similarly, we have noted the particular difficulty that some DATs experience in securing the participation of appropriate representatives of local health bodies. Although we have suggested measures for moving drugs up the health agenda, it could be a slow process amidst severe budgetary restrictions and sweeping structural change within the NHS.

Most importantly, just as drugs are not simply a crime issue, nor are they purely a health issue. Drug users should not be regarded simply as patients any more than they should be labelled as criminals. Drugs policy is not concerned – and certainly should not be concerned – solely with health and crime. The problematic use of drugs is also a social issue, both for individuals and for the communities in which they live. It is this aspect of the many-faceted 'drugs problem' that this Commission – the RSA Commission on Illegal Drugs, *Communities* and Public Policy – would wish to emphasise most strongly.

Specifically, drug misuse plays a large part in social exclusion. It is often itself a symptom of exclusion, and it also plays a part in the process of becoming excluded: failing at school, being unable to find a job, being unable to pay for a place to live and at the same time being presented with opportunities to make easy money on the fringes of the illicit drugs market as 'runners' and low-level dealers.⁵⁹⁶ In our view, the delivery of the drug strategy is clearly a serious part of the core business of the Social Exclusion Unit in England and its counterparts in Scotland, Wales and Northern Ireland.⁵⁹⁷ In 2004 the Social Exclusion Unit issued a report on mental health and social exclusion, recommending a full range of measures for attacking the cycle of deprivation linked to mental health. The recommendations in that report could all be applied with virtually no change to policy on illegal drugs.

For this reason, among others, we recommend that primary responsibility for drugs policy be given to the department in which the Social Exclusion Unit lies, the Department for Communities and Local Government (DCLG). (It is worth noticing that in Wales it is the Minister for Social Justice and Regeneration who has lead responsibility for drugs, a responsibility

⁵⁹⁵ <http://www.alcoholconcern.org.uk/servlets/doc/1086>

⁵⁹⁶ Mike Trace, memorandum 65 to House of Commons Home Affairs Select Committee, op.cit., September 2001.

⁵⁹⁷ In Scotland, social exclusion is dealt with in the Department for Communities in the Scottish Executive.

that was transferred to him from the Minister for Health and Social Services in 2003.)

DCLG's stated objective is to play a strategic cross-government role in forwarding social justice. On its agenda are several objectives that would have a direct impact on the problems associated with drug misuse:

- improving the quality of life of children, young people and families at risk;
- promoting healthier communities and narrowing health inequalities by targeting key local services to match need and by encouraging healthy lifestyles;
- creating safer and stronger communities by working with the police and other local agencies to reduce crime and anti-social behaviour, to strengthen community cohesion and to tackle drug abuse; and
- transforming the local environment by improving the quality, cleanliness and safety of public spaces.

DCLG is tasked not only with combating social exclusion but more specifically with many of the 'wraparound' services that the government itself considers indispensable to the success of treatment and the reintegration of drug users into society: housing, planning, the siting of facilities and oversight of the local authorities that provide the bulk of social care. In addition, DCLG is the department responsible for implementing the policy on devolved local government that would give greater responsibility to communities for tackling their own drugs problems.

A single forum for the discussion of substance misuse

Whichever department takes the lead in the strategy, there will still be a need for better coordination with other departments and greater coherence and transparency in the discussion of substance misuse at the national level. We have proposed in Chapter 13 that at the tactical level, in the field, drugs treatment services should be integrated with alcohol services and that the strategies for alcohol and drugs should be integrated when they come up for review in 2007 and 2008. We would add here that there should be a similarly coherent approach to overall policy on substance misuse. Even if there is no desire to repeat the experiment with a single substance misuse czar, there is clearly a need for a single high-level forum where policy on *all* psychoactive substances, whatever their current legal status, can be treated as part of a single conversation. The Advisory Council on the Misuse of Drugs has recommended that its own brief should be extended to include alcohol and tobacco as well as illegal drugs. We would strongly endorse this suggestion, adding only – observations that will be developed below in Chapter 19 – that there is

a need both for the ACMD's proceedings to be more open to public scrutiny and for its authority as an independent expert body to be taken more seriously by government.

Delivery at the local level

Communities and drugs

We argued above that, like the other components of social exclusion, drugs are an issue for whole communities. Communities are where the impact of drug use is felt. They are where users and dealers live, where drugs markets and treatment facilities alike operate and where social housing is or is not provided. They are the natural focus for work with drug users and with their families, for harm reduction measures such as needle exchanges, the serving of Drug Rehabilitation Requirements and other community sentences and the provision of employment and training schemes. It is at this local level that local needs should be identified and local priorities set.

When the current drug strategy was first launched in 1998, one of its four strands was headed 'Communities'. It made much of enabling and empowerment and the need to regenerate neighbourhoods. The Home Office put large amounts of money into a grant scheme entitled 'Communities Against Drugs' and tasked one of its teams specifically with promoting community engagement in the fight against drugs.

However, it was clear virtually from the start that the communities strand of the strategy was really an off-shoot of the dominant crime-reduction strand. Although it was headed 'Communities', the strategy's 'Aim (ii)' turned out to be 'To protect our Communities from Drug-Related Anti-Social and Criminal Behaviour', and its key target turned out to be to 'reduce levels of repeat offending amongst drug misusing offenders'. There was no reference to drug users in general and, in fact, little mention of communities. The two proposed actions that included the idea of communities at all were both crime-related, couched in the language of threat and counter-attack.⁵⁹⁸

In the words of the then drugs minister, Bob Ainsworth, addressing the House of Commons in January 2003, 'The new communities target was simplified to focus it on what matters most – reducing drug-related crime.' The 'Communities Against Drugs' money went almost entirely into projects designed to 'disrupt local drugs markets and drugs related crime', and little ever reached the families of users, groups of drug users pushing for improved services or local prevention initiatives. This was partly because a lower level of drug-related crime was an

⁵⁹⁸ The two actions were to 'ensure community support in achieving a consistent application of the drugs laws, including compatibility in dealing with low level possession offences amongst different prosecution agencies' and to 'energise and involve local communities through collaborative responses to local drug problems – with imaginative use of existing and planned community safety/estate action /drug network partnerships – so that positive outcomes, *focused on the drugs and the people that cause most damage and danger*, are achieved.'

intelligible and relatively measurable objective. Other aspirations – to develop ‘community resistance’ to drugs – were ill-defined and few potential grant applicants had much idea of how they might be either achieved or measured.⁵⁹⁹ Precisely because there are so many different components in the working of a successful ‘community’, evidence is hard to gather and harder to evaluate.

The Commission recommends that in any new drugs strategy the Communities strand should be reinstated, albeit in a new guise, one that spells out what is meant by community and describes more clearly what successful community engagement or community resilience would look like. The list might include support for the families of drug users, properly funded and well-run networks for involving service users, local businesses committed to schemes for helping drug users back into employment and social marketing campaigns aimed at particular local groups on issues of particular concern to the community.

So how would community engagement work in terms of organization at the local level?

More effective local multi-agency working

Under the new Local Government Bill, there will be a number of policy areas in which, although the desired outcomes will be specified, it will be left to local authorities to devise the precise administrative structures and to design their own processes for achieving these outcomes. We believe that substance misuse should be one of these policy areas.

We do not seek to prescribe a single uniform model for delivering drugs services locally, and we recognise that structures and terminology in Scotland, Wales and Northern Ireland will differ somewhat from those pertaining in England, which we mostly cite. All that is required is that in every area of Britain there should be a single body tasked specifically with identifying the scale of the local drugs problem and organizing a multi-agency solution: measuring the scale of existing substance misuse, encouraging individual agencies to accept their responsibilities, coordinating these agencies’ efforts and monitoring the effectiveness of the systems that are devised.

There are various means by which collective responsibility might be encouraged and partnership working might be improved at the local level. More local bodies could be obliged by law to take account in all their planning of the implications of problematic drug use. For example, the Home Office now wishes to hold the members of Crime and Disorder Reduction Partnerships to

⁵⁹⁹ The Lancashire DAT complained to the House of Commons Home Affairs Select Committee in its memorandum of September 2001: ‘The “Communities” related targets in the National Strategy are difficult to quantify... The DAT would recommend the development of community models that highlight the characteristics of local communities to which the DAT would aim.’

a higher standard of performance in partnership working to tackle crime, disorder and substance misuse. 'Responsible authorities' within CDRPs (which include police services, local authorities and Primary Care Trusts) are already required under the Crime and Disorder Act 1998 to work together to identify not just the extent of crime and disorder but specifically the extent of drugs problems in their areas and to develop strategies to deal with these problems.⁶⁰⁰ Under Section 17 of the 1998 Act a smaller number of agencies are required to go further and translate strategies into action, doing 'all that they reasonably can' to prevent crime and disorder. In the Police and Justice Act 2006, the Home Office proposes to bring more agencies under the scope of the more rigorous Section 17 and to extend the definition of Section 17 to require agencies to tackle substance misuse in particular as well as crime and disorder in general. If Primary Care Trusts were brought under the scope of Section 17 and if Section 17 were broadened in this way, then Primary Care Trusts could be explicitly bound by law to take account of drugs problems in all their planning and to do all that they reasonably could to remedy them.

It is likely that the National Treatment Agency will also continue to be tasked with keeping Primary Care Trusts up to the mark in their funding of treatment both for general drug users and for drug-using offenders. Under the Department of Health's Arm's Length Bodies Review, it has been decided that the NTA's central functions (making policy, monitoring treatment standards and coordinating efforts) should continue after 2008.⁶⁰¹ Its regional officers are intended eventually to become part of the staff of the new Strategic Health Authorities but for the time being they will be absorbed directly into the regional Government Offices, where part of their job will be to make sure that the Primary Care Trusts fulfil their obligations to the drug strategy.⁶⁰²

However, rather than imposing control from the outside, we believe it would be far more effective to find ways of making local partnerships work better from the inside. Some critics have suggested that the only solution would be to start from scratch and devise a different kind of local partnership. Others have suggested 'promoting' drugs policy and formally locating responsibility for it with the premier local partnership – that is, the Local Strategic Partnership (LSP) that is tasked with bringing together the work of all other partnerships in the area.⁶⁰³ At present it is unusual for drugs issues to feature high on the agendas of LSPs, as they are generally delegated to Crime and Disorder Reduction Partnerships. Now, however, in order

⁶⁰⁰ The Crime and Disorder Act 1998 was amended by the Police Reform Act 2002, which extended the requirement to identify impact from 'crime and disorder' in general to include substance misuse. In being identified as 'responsible authorities', Primary Care Trusts were bound to 'be aware of the extent of drug misuse in their areas and the implications this is having on health outcomes and inequalities and on NHS costs' and then 'identify methods of tackling it and deploy resources accordingly'. Department of Health/Home Office, 'Guidance for Partnerships and Primary Care Trusts (PCTs): Commencement of PCTs as Responsible Authorities from 30 April 2004'.

⁶⁰¹ Arm's length bodies (ALBs) are a key part of the health and social care system. Their work ranges from regulatory and advisory functions, to ethical and clinical-related roles. They were subjected to a review in 2003/4 with the aim of reducing their number, the number of posts in them and their expenditure, to 'maximise resources for front line delivery in the NHS. The review's goal was an ALB sector fit-for-purpose in the context of devolution and a smaller centre.' Measures for implementing the review's recommendations were announced in April 2006.

⁶⁰² In a letter to the NTA in January 2006, ministers involved in the drug strategy set out their concerns that the impetus already achieved should not be lost and drugs treatment should not be allowed to slide back down the agenda: "While delivery of drug treatment performance needs to be in the NHS mainstream, it will also be vital that any new role for Strategic Health Authorities is formally linked to effective Government Office involvement, to ensure that all partners – health, criminal justice and local government – are held to account and that there is a balance between health and criminal justice issues."

⁶⁰³ In Scotland, Community Planning Partnerships are similar in composition to Local Strategic Partnerships, bringing together key agencies under the leadership of local authorities. In general, they perform similar functions and could have a similar strategic role in relation to drug strategies.

to allow CDRPs to perform their operational functions more effectively, the Home Office proposes to transfer their strategic responsibilities, including the responsibility for developing strategies on drug misuse, to Local Strategic Partnerships.⁶⁰⁴

Strengthening the DATs

We believe, however, that there is nothing wrong with the basic principle underlying Drug Action Teams and that there is much that could be done to make the existing system work more effectively.

Statutory powers

We recommend, for example, that serious consideration should be given to making Drug Action Teams statutory bodies. This would remove many of the actual or perceived legal obstacles to data-sharing that currently exist.

Independent identity

In addition, we believe that every Drug Action Team should be represented on its Local Strategic Partnership in its own right and not just by virtue of its relationship with the local Crime and Disorder Reduction Partnership (CDRP). In fact, we recommend that this relationship should be dissolved and DATs disentangled from CDRPs altogether.

Many observers feel that the effectiveness of DATs has been compromised by their attempted assimilation into CDRPs. Although the association with CDRPs has failed to make drugs issues part of the mainstream of CDRP work, as far as DATs are concerned it has obviously brought with it a heavy emphasis on crime issues that threatens to submerge their other roles. DATs are now often chaired by Community Safety managers, the equivalent within CDRPs of the DAT coordinator, usually drawn from the police or probation services. They are far less often chaired by representatives of the health services, whose participation in DATs has generally declined, apparently since the rise to prominence of the criminal justice agenda within the national drug strategy. DATs have also become entangled in some of the organizational problems facing CDRPs, which the Home Office review found to be frequently ineffectual, weighed down by bureaucracy and either out of touch with, or invisible to, the communities they are supposed to be protecting.⁶⁰⁵

Freedom to implement a population-based strategy

We believe more emphasis should be placed on the local DAT's role as the principal gatherer of information about local drug use and the need for services in the area as well as the

⁶⁰⁴ Regulatory Impact Assessment of 'Policing and Justice Bill – amendments to partnership provisions of Crime and Disorder Act 1998 as amended by Police Reform Act 2002', January 2006.

⁶⁰⁵ Review of the partnership provisions of the Crime and Disorder Act 1998: report of findings, 2005.

body best placed to represent the interests of drug users. To this end, DATs should be given more freedom from performance management against central targets in order to be able to give more time and depth to this local information-gathering. If they were given more freedom, they could then become centres for local, population-based planning rooted in good local data, in accordance with the NHS's own 'Improvement Plan: Putting People at the Heart of Public Services':

Local services will set their own targets reflecting the local circumstances, ethnicity and inequalities of the communities that they service and the local priorities of the people who use them.

Centralised data collection in the service of national targets often fails to measure the problems that most concern local communities.⁶⁰⁶ These data consequently generate a strategy that fails to meet local needs. DATs could play an important role as brokers for the service users in their areas, responsible for ensuring a choice of relevant services, for informing users of their options and for helping them make sure their voices were heard. Given time and scope to concentrate on local research, DATs could identify more precisely such key features as the range of drugs being used in an area, the number of deaths that could more accurately be attributed to the use of drugs, the existence of drug-related crimes going unreported, the levels of truancy from school that might be contributing to risky drug use, and so on. DATs could also monitor the effectiveness of local services in meeting these local needs rather than national targets.

A leading role for local authorities

DATs might well be strengthened by explicitly giving the lead within them to local authorities. This would accord with the vision of local councils not simply as 'place shapers', in the words of the Secretary of State for Communities and Local Government, but as the guardians of the most vulnerable people in society:

Councils ... have the right powers and relationships to make sure that all local services – whether they are the responsibility of local authorities or not – work together to meet citizens' needs... Local government is ...in a unique position to provide joined-up, targeted and innovative services for vulnerable people.⁶⁰⁷

In some ways local authorities would already seem to be best placed to ensure the provision of coherent drugs services at the local level. Arguably, the introduction of Drug Action Teams, superimposed on an already existing community care system, gave the impression of relieving local authorities of the burden

⁶⁰⁶ See, for example, H Loughran and M McCann, 'A community drugs study: developing community indicators for problem drug use', University College Dublin, 2006.

⁶⁰⁷ Ruth Kelly, speech to Local Government Association Conference, July 2006. Department of Communities and Local Government, *Strong and prosperous communities: the Local Government White Paper*, 2006. Volume 2, p.24.

of organizing drugs services. At the moment, local authority funding for drugs (in the form of grants from mainstream community care funding) is relatively small in comparison with the Pooled Treatment Budget, and in practice it tends to be limited to the ‘spot purchasing’ of places on detoxification or residential rehabilitation schemes and, to a lesser extent, with providing day care provision. However, local authorities, as well as leading Local Strategic Partnerships, sit on health and social care partnership boards, so are in a good position to advance drugs issues on the agendas of those bodies.

In addition, local authorities are best placed to promote drugs services effectively through the Local Area Agreements that are a mechanism (soon to be statutory mechanism) for pooling the resources of different agencies in order to address complex and interconnected local problems.⁶⁰⁸ The current priority areas for which Local Area Agreements may be negotiated are ‘safer and stronger communities’, ‘healthier communities and older people’ and ‘children and young people’. Drug misuse is obviously a key area of concern under all of these headings.

Again, local authorities control many of the ‘wraparound’ services that are crucial to supporting people who are tackling their own problems with drugs. They may also be in a better position to identify local needs for treatment with the introduction of the Local Involvement Networks or LINKs that are to replace Patient Involvement Forums in every local authority area. The aim of the LINKs scheme is to help people engage with health and social care organizations, which would make the scheme a potential channel for the concerns that constituents – including drug users and their families – might have about existing drugs service provision.

Local authorities’ performance in helping to deliver good drugs services is likely also to be improved by the development and extension of the overview and scrutiny function. Backbench councillors have been tasked with scrutinizing the performance of the local executive, both on its own and in work it undertakes jointly with other organizations. This scrutiny can cut across organizational boundaries, looking at the effectiveness of council services, their relevance to local needs, the access to these services for particular groups and the implications of mainstream policies and practice for other more specialized services.⁶⁰⁹ In terms of drugs services, scrutiny procedure could be used to ask whether treatment services meet the needs of local users, whether they are accessible to men and women equally and to different ethnic groups, and how they might be affected

⁶⁰⁸ The Local Government and Public Involvement in Health Bill, introduced to Parliament on 12 December 2006, seeks to create a statutory duty on named partners and the local authority to cooperate with each other to agree the targets within the Local Area Agreement.

⁶⁰⁹ Department of Health, ‘A stronger local voice: a framework for creating a stronger local voice in the development of health and social care services’, July 2006.

by the reconfiguration of NHS services in the area. It could be seen as one of the responsibilities of a DAT Chair to trigger this overview and scrutiny function, where appropriate, as a means of ensuring that all the relevant agencies are meeting the needs of the service users whose interests the DAT represents.

Overview and Scrutiny Committees are already entitled to examine health and social care services. In many authorities, they have already brought about improvements, in mental health provision, for example: 'Health scrutiny has been a major driver in improving mental health services, identifying the contribution of mainstream services to the mental well-being of local people and reconnecting elected members with their communities.'⁶¹⁰ The government will soon be extending the scope of scrutiny to include the work of Crime and Disorder Reduction Partnerships.⁶¹¹

The government will also be introducing, as part of the Police and Justice Bill, the Community Call for Action. This allows members of the public who are dissatisfied with service provision to ask their local councillor to call for action from the local authority and its partners. If an issue cannot be resolved through normal council channels, it can then be referred to Overview and Scrutiny Committees for consideration. Initially the proposals related only to crime and disorder, but have become more wide-reaching with the publication of the Local Government White Paper. In other words, local authorities could increasingly be involved in calling service providers to account on behalf of the public on a range of issues that could well include drugs services. The Community Call for Action is expected to be introduced by April 2008.⁶¹²

With this range of relevant interests and powers concentrated within local authorities, it would seem to make sense to propose a drug strategy delivered through Drug Action Teams or other local agencies in which local authorities have a carefully defined leadership role, and headed by DCLG, the department to which local authorities are accountable and the department with overall responsibility for ensuring the smooth and effective running of local partnerships nationwide.

Whichever model of delivery is adopted, however, its over-riding objective should be the existence of clear lines of statutory power and explicit accountability. Every organization and every person involved in delivering the drug strategy at the local level should know where they stand, what powers they have and what their obligations are when it comes to identifying the need for drugs

⁶¹⁰ A Morley, *Mainstreaming mental health: an introduction for councillors*, Local Government Information Unit, 2005.

⁶¹¹ Home Office, *Review of the partnership provisions of the Crime and Disorder Act 1998 – report of findings*, 2005. This will be achieved by amending Section 21 of the Local Government Act, as part of the review of local government.

⁶¹² Tony McNulty, Written Answer, House of Commons, 7 December 2006.

services at the community level, commissioning those services, evaluating their effectiveness, and assessing and providing for individual drug users.

Part IV Drugs and the Law

18 The law at present

A policy that sets drugs in context and seeks above all to reduce drug-related harm needs a new legal framework to reflect these objectives. In our view, the Misuse of Drugs Act 1971 and the classification system it embodies achieve neither of these aims.

The Act, and all the later legislation following on from it, should be repealed and superseded by a new Misuse of Substances Act that:

- sets drugs in the wider context of substance misuse alongside alcohol and tobacco;
- is linked directly to a scientifically based index that makes clear the relative risks of harm from individual substances;
- seeks to punish harmful behaviours stemming from drug use rather than the simple possession of drugs.

Regulating alcohol, tobacco and illegal drugs all within the same framework would have an integrity and credibility that the present system lacks. Centring the framework on a harms index that can be changed in order to reflect the latest developments and the most recent research would give it both authority and flexibility.

A framework of this kind would be a neutral instrument.

It could be used either to relax or to tighten the regulation of individual substances. Some drugs that are currently illegal could be brought under the same kind of regulation that is now used to control comparably harmful but legal substances; for example, milder forms of cannabis might be regulated in much the same way as tobacco. Conversely, some drugs whose current regulation is elastic and discretionary might be more strictly controlled alongside substances that inflict similar amounts of harm; for example, the stronger forms of 'skunk' cannabis might be regulated alongside amphetamines instead of Valium. Not all members of the Commission, like many in the arena of drugs policy, are agreed on whether or not any particular drug should be legalized, or even on whether the possession and use of any drug should be treated as a civil rather than a criminal offence. But they have refrained from trying to settle these narrower issues in order to advocate the broader principle of a new legal framework to replace one that is manifestly failing in its aims.

What is the legal framework regulating illegal drugs at the moment?

Most readers of this report will already be familiar with the current state of the law and with the main recent developments

in the field, but for those who are not the next sections outline the current position.⁶¹³

The UN Single Convention on Narcotic Drugs 1961 requires its 180 signatories to declare illegal the cultivation, manufacture, export, import, distribution, sale and possession of the major plant-based drugs – heroin, opium, cocaine and cannabis – other than for scientific and medical purposes. There are wide variations in the way in which the Convention is interpreted by its signatories, but it remains the framework within which drugs policy makers are on the whole constrained to operate.

The 1971 UN Convention on Psychotropic Substances adds LSD, ecstasy and other psychoactive pharmaceutical drugs to the list of substances to be controlled. The 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances strengthens existing provisions against money laundering, directs signatories to cooperate in tracing and seizing drug-related assets and inserts the requirement that they should impose criminal penalties for all drug offences, including possession of drugs for personal use.

The Misuse of Drugs Act 1971

Britain fulfils its obligations under these UN Conventions mainly through the Misuse of Drugs Act 1971 (MDA), which makes it unlawful to produce, import, export, supply or possess anything designated as a controlled drug unless an exception or exemption applies. Controlled drugs are listed in Schedule 2 to the Act. Beside the best known illicit drugs, the list includes a large number of drugs that are used mainly for medical purposes but that may also be used recreationally: Ritalin, for example, which is prescribed in order to dampen down hyperactivity but abused for precisely the opposite reason. The idea of controlling these commonly prescribed drugs is to protect their licit use (in the interests both of public health and of the pharmaceutical industry) while at the same time restricting their illicit use. To enable doctors, dentists, pharmacists, researchers and others to prescribe and handle these drugs for medical purposes, the Home Secretary makes exemptions to the Act under the Misuse of Drugs Regulations 2001.

⁶¹³This section does not purport to be a thorough-going technical review of current drugs law. The Commission's brief is more general than that of the Police Foundation, which set out in 2000 to review the effectiveness of the Misuse of Drugs Act 1971. Its terms of reference were to:

- a describe the purpose and intention behind the existing relevant legislation and place them in their historical context including the U.K. obligations under the United Nations drug conventions and to the European Union.
- b review and assess the current goals of drug misuse control.
- c assess the adequacy of the existing relevant legislation in meeting current needs.
- d compile a list of possible revisions to the existing relevant legislation pointing out agreement, conflicts and possible compromises if current legislation is found to be inadequate for some or all of the needs identified.
- e select the most cogent proposals for revision of the existing relevant legislation and examine the implications of their implementation.

The Foundation's report, commonly referred to as the Runciman Report, can be found at <http://www.druglibrary.org/schaffer/library/studies/runciman/default.htm>

Principal drug-related offences

- Production, manufacture or cultivation
- Transportation or storage
- Importation or exportation
- Supply – distribution or dealing
- Offering to supply
- Possession with intent to supply
- Possession
- Permitting premises to be used for production, consumption or supply
- Keeping or controlling the proceeds of drug trafficking by another

Possession of any drug contained in the Misuse of Drugs Act 1971 is illegal. Simple possession is distinguished from possession with intent to supply, which is treated as a supply offence. In addition, 'supply' covers both professional dealing and 'social supply': sharing with friends or buying on their behalf. A person can be convicted of supplying drugs if the prosecution can prove that they passed or intended to pass a controlled drug to someone else, even if they made no profit and received no benefit. In theory, handing a cannabis joint on to someone else could be treated as supplying. A person can be convicted of possession if the drug is found in their house as long as the prosecution can prove that they knew about it and had some control over the drug (which need not be direct control). A person can be convicted of past possession if they admit to past use – the fate of singer Boy George in 1986. They can also be convicted of attempted possession if they buy oregano believing it to be cannabis or if they buy glucose under the impression that it is cocaine.

Trafficking offences (which include producing, exporting, importing and supplying – i.e. distributing and selling – controlled drugs) are punished much more severely than possession, though in practice the distinctions are often blurred by the fact that many users also supply or 'deal' on a small scale to pay for their own drugs.

Controlled drugs are divided into three classes, A, B and C, which determine the maximum criminal penalties that can be imposed for related offences. These penalties are set out in Schedule 4 to the 1971 Act.

The three classes and their associated maximum penalties are set out in turn.

Class A drugs

(heroin, cocaine, crack, ecstasy, LSD, magic mushrooms, methadone, methamphetamine, amphetamine prepared for injection)

Trafficking:

The maximum penalty is life in prison and/or an unlimited fine. Since 2000 there has been a minimum sentence of seven years for anyone convicted a third time, but judges have exercised discretion in imposing it. (In February 2005 a Private Member's Bill was put forward to make this minimum sentence mandatory, but too few MPs participated in the vote to decide the issue.)

Possession:

A summary offence, tried in a magistrates court, can result in

a maximum sentence of six months imprisonment and a fine of up to £5,000. For an indictable offence, tried before a jury in a Crown Court, the maximum penalty is seven years in prison and/or an unlimited fine.

⁶¹⁴ Production is also “drug trafficking” for the purposes of the Proceeds of Crime Act 2002.

Class B drugs

(amphetamines, barbiturates, Ritalin, codeine and other weaker opiates)

Trafficking:

The maximum penalty is fourteen years in prison and/or a fine.

Possession:

A summary offence can result in three months in prison or a fine of up to £2500. Conviction for an indictable offence may result in five years in prison and/or a fine.

Class C drugs

(cannabis, tranquillisers such as temazepam and Valium, anabolic steroids, ketamine, GHB)

Trafficking:

A conviction for trafficking may result in a maximum sentence of fourteen years in prison and/or a fine. A separate clause in the 1971 Act – Section 6 – specifically prohibits cultivation of cannabis and sets the maximum sentence at fourteen years (or, if the case is tried in a magistrates court, six months or a fine of up to £5,000). However, Section 6 has become virtually a dead letter, and growers are more usually prosecuted under Section 4 for ‘production’. Unlike ‘cultivation’, ‘production’ counts as a trafficking offence under the Drug Trafficking Act of 1994 and enables the grower’s assets to be seized.⁶¹⁴

Possession:

The maximum sentence for possession is two years in prison and/or a fine. The possession of cannabis could have become a non-arrestable offence when cannabis was downgraded from Class B to Class C in 2004. (Until 1 January 2006 police could only arrest for offences that carried at least a five-year prison sentence.) This would have denied police the means of arresting (without a warrant) large numbers of cannabis-using offenders and searching their premises. Under pressure from one wing of the Association of Chief Police Officers, the Police and Criminal Evidence Act 1984 was amended to retain powers of arrest for cannabis possession. All possession offences, like all other offences of any sort, are now arrestable in accordance with the provisions of Section 24 of the Police and Criminal Evidence

Act 1984 as amended by the Serious and Organised Crime and Police Act 2005.

⁶¹⁵ Though this upgrading was not carried out by an Order in the usual way – see p.272 below.

The lists of drugs within each class may be amended by Orders, which have to be approved by both Houses of Parliament. The Home Secretary may draft the Orders but may not lay the drafts before Parliament without consulting or receiving a recommendation from the Advisory Council on the Misuse of Drugs, set up under the Misuse of Drugs Act in 1971. The most significant changes to the Act since it was passed have been the inclusion of ecstasy as a Class A drug in 1977 and thirty-five ecstasy-like drugs in 2001, the tightening of controls on the tranquilliser temazepam in 1995, the inclusion of anabolic steroids in Class C in 1996, the addition of GHB to Class C in 2003, the downgrading of cannabis to Class C in 2004, the inclusion of ketamine in Class C in 2005, the upgrading of fresh magic mushrooms to Class A in 2005⁶¹⁵ and the reclassification of methamphetamine from Class B to Class A in 2007.

Other relevant legislation

Various other laws have a bearing on the control of illegal drugs. The Medicines Act 1968 identifies some drugs that may only be supplied or possessed with a prescription. It is an offence, for example, to possess temazepam without a prescription; it is legal to possess anabolic steroids without a prescription but not to supply them, which is why many change hands unobtrusively at health clubs or over the Internet. The Road Traffic Act 1972 makes it an offence to drive while under the influence of drugs. It does not distinguish between illegal or prescribed drugs – driving under the influence of Night Nurse is as much an offence as driving while impaired by cannabis – and there is no defined limit for drugs as there is for alcohol. The Customs and Excise Management Act 1979 provides for heavy fines to be imposed for importing or exporting controlled drugs without authorization, based on the value of the drugs seized. The Drug Trafficking Offences Act 1994 gives police the power to seize the assets and income of anyone found guilty of trafficking. The court may make the assumption that, unless the defendant can show otherwise, any property or money received or any expenditure made by him during the six years prior to his prosecution represent the proceeds of drug trafficking. This 1994 Act was consolidated by the Proceeds of Crime Act 2002 which created the Assets Recovery Agency.

The main pieces of drug-related legislation passed since the beginning of the ten-year National Drug Strategy in 1998 reflect an emphasis on drugs as a crime issue rather than primarily as

a health or social care issue. The Crime and Disorder Act 1998 made it legal to drug-test alleged offenders who have been charged with certain types of drug-related crime (mugging or burglary, for instance) and then to compel them to be assessed for drugs treatment. The Drugs Act 2005 has taken this approach one step further, by allowing alleged offenders to be tested on arrest, even before any decision has been made to charge them for their trigger offences.

⁶¹⁶This fact is mentioned in a review of international drugs policies by the Canadian Senate Special Committee on the Misuse of Drugs in *Cannabis: our position for a Canadian public policy*, Vol. 3, September 2002.

How is the law enforced?

For reasons to be explained later, it is arguable that only a substantial degree of discretion in the way in which Britain's current drugs laws are implemented makes them workable. (It should be said at this point that Scotland has its own legal system, with its own courts system and legal profession. Thus, although the Misuse of Drugs Act is equally binding in Scotland, the ways in which it is implemented and policed are sometimes different. This section focuses primarily on the implementation of the law in England and Wales, only picking out features that are unique to Scotland where they are significant in terms of the effectiveness of any of the countries' drugs strategies.)

The UN Conventions themselves, by which our drugs laws are shaped, allow for considerable flexibility in the way they are applied. The 1988 Convention, for example, qualifies its demand that each signatory should impose criminal penalties for drug possession with the words 'Subject to its constitutional principles and the basic concepts of its legal system'. Some countries' constitutions enshrine principles of personal freedom, including the freedom to harm oneself; these provisions release them from the obligation to criminalise the possession of drugs for personal use. In Germany, for example, the constitutional court has ruled that prosecution for possession of small quantities of cannabis contravenes basic rights and is unjustified.⁶¹⁶ It is this let-out that has enabled countries like Portugal and Australia to remove criminal penalties for drug possession and to substitute civil administrative ones.

As for the actual taking of drugs, as distinct from the possession of them, although the Conventions state that this should be limited to 'medical and scientific uses', they do not expressly require that it be made an offence. There has been confusion on this point since the first Convention was written in 1961. In 1977 the UN's *Bulletin on Narcotics* tried to clarify the issue:

It is clear that use of drugs and their possession for personal consumption has... to be limited by legislation and administrative measures exclusively to medical and scientific

purposes. Consequently, “legalization” of drugs in the sense of making them freely available for non-medical and non-scientific purposes... is without any doubt excluded and unacceptable under the present international drug control system... [But] it is a fact that “use” (or “personal consumption”) is not enumerated amongst the punishable offenses.⁶¹⁷

This statement obviously has far-reaching consequences in allowing people to be tested for drug use as a prelude to treatment or as part of treatment without their necessarily being threatened with criminal sanctions. Again, the use of drugs for ‘medical and scientific purposes’ that the Conventions permit can be interpreted very broadly to give some latitude for harm reduction strategies such as the prescribing of heroin to serious addicts for whom other treatments have failed.

In Britain, as in most EU countries, the laws against trafficking are enforced rigorously and fairly consistently. Supply offences – which in 2004 accounted for 14 per cent of all drug offences – are most commonly punished by immediate custody; in 2004, 61 per cent of cases were disposed of in this way. In the cases of heroin, cocaine and crack, over 80 per cent of convictions resulted in immediate prison sentences. Fines are seldom imposed for trafficking; the most usual alternative to prison, generally for cannabis dealing, is a community sentence.

When it comes to possession, however, a good deal of discretion is exercised at every level: by the police in deciding whether to arrest, the prosecution services in deciding whom to charge and the courts in determining appropriate punishments.

The constitutional position of the British police service allows discretion by every officer, meaning that, even if a law is in place, an officer may effectively choose not to enforce it.⁶¹⁸ Local policing priorities and resources will also do much to determine how strictly the law is enforced. Consequently, the taking of ecstasy and other ‘dance drugs’ such as amphetamines and ketamine may well be tolerated in venues such as night-clubs though, in other more exposed public spaces, drugs laws are usually more strictly enforced. Commander Brian Paddick told the House of Commons Home Affairs Select Committee in 2001 that he would consider his officers to be wasting their time if they went out looking for cases of possession of ecstasy: ‘I would say to them, and I would say publicly, that they are wasting valuable police resources.’⁶¹⁹

The current policy towards cannabis is particularly open-ended. When it was a Class B drug (i.e. before January 2004), its policing

⁶¹⁷ http://www.unodc.org/bulletin/bulletin_1977-01-01_4_page004.html

⁶¹⁸ Keith Hellawell, evidence to House of Commons Home Affairs Select Committee, 30 October 2001.

⁶¹⁹ in his evidence to the House of Commons Home Affairs Select Committee on 20 November 2001.

was variable.⁶²⁰ Large numbers of people were arrested; cannabis possession accounted for the arrests of one in seven known offenders in England and Wales, and many police officers considered this offence a useful tool for gaining access to suspects' homes. However, there was no coherent policy and little consistency. Many arrests were incidental to the policy of stop-and-search or to other investigations, and a small number of officers accounted for a disproportionate number of arrests, while others simply turned a blind eye or gave informal warnings. Their reactions depended a good deal on whether they themselves had ever used cannabis, their previous experience with drug users and the suspect's attitude or previous record.⁶²¹

⁶²⁰ T May, H Warburton et al., *The policing of cannabis as a Class B drug*, Joseph Rowntree Foundation, 2005.

⁶²¹ H Warburton, T May and M Hough, 'Looking the other way: the impact of reclassifying cannabis on police warnings, arrests and informal action in England and Wales', in *British Journal of Criminology*, 45 (2), 2005.

⁶²² The ACPO guidelines were reviewed during 2006. The revised version, published in January 2007, extends the presumption against arrest to people under 18.

After the reclassification of cannabis, the Association of Chief Police Officers in England issued guidelines stating that there is now a presumption against arrest: police officers should not normally arrest someone for possession of a small amount of cannabis unless that person is flouting the law (e.g. smoking in public), is under 17, is near a school or is caught repeatedly.⁶²² The preferred penalty now is a formal warning. This involves the police officer checking suspects' personal details against central police records, confiscating their cannabis and searching them for other drugs, questioning them under caution, requiring them to sign an official notebook and issuing them with encounter forms marked 'formal warning cannabis'. Formal warnings are entered onto local police intelligence systems. No one is entitled to more than two. A third offence, however long the interval between second and third offences, will lead to arrest. Formal warnings do not leave offenders with a criminal record in the sense that they are not entered on central records and therefore cannot be checked by potential employers – or indeed other police forces. Although they are recorded locally, it is rare for this information to be shared between forces.

Paradoxically, although the formal warning is itself a less stringent measure than the arrests and prosecutions that it was introduced to replace, its introduction may in practice be having the effect of taking some flexibility out of the system. In the year immediately following the reclassification of cannabis, arrests for possession fell by one third, from 68,225 to 43,590. However, this was followed in 2005/6 by a 21 per cent rise in recorded crime that the Home Secretary attributed almost entirely to the introduction of the formal warnings for cannabis offences. Formal warnings are a good deal quicker and easier to process than arrests, and they have the advantage over an informal ticking-off of counting as a clear-up for the police. What seems to be happening is that a large number of cannabis users who previously might have been

arrested but equally might have been let off completely, at the discretion of the individual police officer, are now being caught by the formal warning scheme. This means that, rather than reducing the administrative burden, the scheme may be resulting in a greater and not a lesser number of police actions being taken in cases of cannabis possession.

In addition, a recent study has raised concerns that there are still inconsistencies in the policing of cannabis possession and the issuing of formal or ‘street’ warnings:

The decision by the Home Office to include street warnings as ‘sanction detections’ seems to have prompted some senior police managers to encourage their officers to issue street warnings, simply to increase their overall sanction detection rates and thereby meet important Treasury targets. Whilst a degree of variation in policing cannabis is inevitable, in the study, people from black and minority ethnic groups were over-represented in the statistics for cannabis possession. If the public view the approach of their local police as inconsistent, confidence in low-level police work will be affected and the ability of patrol officers to police by consent will be weakened.⁶²³

Not all of those who are arrested for possessing cannabis or other drugs are charged or prosecuted. The police may eventually decide not to charge and may caution or discharge the offender, and the Crown Prosecution Service may decide not to prosecute someone whom the police have charged, taking the circumstances of the case and the character of the defendant into account. In 2004, only about 60 per cent of drug offenders of all types, and a much smaller percentage of offenders accused of possession, were taken to court. Of 73,010 people stopped for possession of drugs, 27,520 were given a formal warning, 22,530 were cautioned and 22,960 were charged and prosecuted.⁶²⁴ Not all of those who are prosecuted are convicted. In 2004, of around 56,000 drug offenders dealt with by the courts, about 6,500 were found not guilty – approximately 13 per cent. Of those arrested for possession offences, 11 per cent – about a quarter of those who were taken to court – were given absolute or conditional discharges.⁶²⁵

There is elasticity, too, in the sentencing of those who are convicted. The guidelines issued to judges and magistrates by the Sentencing Guidelines Council⁶²⁶ list factors based on case law to take into account when sentencing and provide for distinguishing between different kinds and degrees of drug use and misuse. It is rare for the maximum penalties set out in the Misuse of Drugs Act to be imposed. They are usually reserved for

⁶²³ T May et al, *Policing cannabis as a Class C drug: an arresting change?*, Joseph Rowntree Foundation, 2007.

⁶²⁴ Paul Goggins responding to Written Parliamentary Question, 5 December 2005.

⁶²⁵ L Mwenda, ‘Drug Offenders in England and Wales 2004’, *Home Office Statistical Bulletin* 23/05.

⁶²⁶ An independent body established under the Criminal Justice Act 2003 to take over responsibility for developing comprehensive sentencing guidelines from the Court of Appeal and the Magistrates’ Association. It is advised by the already existing Sentencing Advisory Panel.

repeat offenders involved in serious offences concerning supply for commercial gain. The majority of those sent to prison for drug offences are sent there for importing or supplying drugs. For possession offences, even those involving heroin or crack, community sentences are more common than imprisonment or fines. Where custodial sentences are imposed, no more than five or six per cent of offenders receive the maximum term, and the maximum fines are imposed in no more than one or two per cent of cases. When people do go to prison in relation to possession offences, they often do so as a consequence of failing to pay the fine that was originally imposed, perhaps coupled with repeated shoplifting.

In other words, while current British policy formally toes the general prohibitionist line enshrined in the UN Conventions, in its implementation it has avoided adopting the moralistic and retributive attitudes towards people found guilty of possessing drugs that are commonly found in the United States.

19 What is wrong with the law at present

The current law is out of date, unwieldy and peppered with anomalies, an agglomeration of miscellaneous provisions adopted to address situations that in many cases no longer apply. It causes some social harms while limiting others. It acknowledges no parallels and no relationships between the use of illegal drugs and the use of alcohol and tobacco. We need a new Misuse of Substances Act that will achieve a better balance between punishing those who inflict harm on others for profit, reducing the damage done to those who harm only themselves and moderating the penalties for activities that harm no one at all.

The Misuse of Drugs Act 1971 is out of date.

The Misuse of Drugs Act was drafted nearly forty years ago at a time when drug use was very much lower than it is now. It is very much a product of its period, a fact signalled by the large amount of space the Act devotes to countering the mis-prescribing of controlled drugs by doctors and others – a direct reflection of the alarm caused in the 1960s by some well-publicized cases of over-prescribing of heroin by a small number of GPs. The Act also singles out cannabis as one of only two drugs mentioned by name in the body of the Act as distinct from the schedule (the other being opium). This emphasis probably reflects the furore over cannabis that occurred in the late 1960s immediately preceding the drafting of the 1971 Act. Much other drugs-related legislation has been enacted since 1971, but this ageing law remains the basic statute. It is clearly time it was looked at again.

Cannabis and the 1968 Wootton Report

The Times of 24 July 1967 carried a full-page letter paid for by the Beatles and signed by a wide range of public figures, including Francis Crick, Graham Greene, Peter Brook, Jonathan Miller and David Dimbleby. It argued that the penalties for cannabis use (which then routinely involved imprisonment) were disproportionate and unfair. It prompted a wave of debate in Parliament and the press and led to a sequence of reports, most notably by the National Council for Civil Liberties⁶²⁷ and by a subcommittee of the Advisory Committee on Drug Dependency chaired by Baroness Wootton of Abinger. The Wootton Report, published in 1968, largely supported *The Times* letter-writers in pointing out that the dangers of cannabis had been exaggerated:

In terms of physical harmfulness, cannabis is very much less dangerous than the opiates, amphetamines and barbiturates, and also less dangerous than alcohol. ... We believe that the association of cannabis in legislation with heroin and the other opiates is entirely inappropriate... We are also convinced that the present penalties for possession and supply are altogether too high.

This general distinction was acknowledged when cannabis was put in a different class from opiates under the 1971 Act.⁶²⁸

The Misuse of Drugs Act does not include alcohol and tobacco.

Alcohol and tobacco do more overall harm than the most damaging of the drugs that are currently illegal but are saved from stigma by centuries of habit. Alcohol, more than tobacco, not only harms individuals but frequently inflicts terrible damage on alcohol abusers' families, friends and neighbourhoods.

The law embodies classifications and a system of classification that is crude and ineffective, a tool being used for purposes for which it was neither designed nor intended.

The original purpose of the three-tier classification was simply to indicate the scale of penalties that should apply in connection with individual drugs, reflecting their harmfulness.⁶²⁹ It was intended for the benefit of sentencers and to assist the police and prosecutors in deciding when to arrest individuals, when to charge them and when to take them to court.

Beyond this practical guidance for use in the criminal justice system, the ABC classification was not designed to send messages to anyone. That was not its purpose. However, successive governments, in deciding or declining to classify or re-classify

⁶²⁷ NCCL, *Drugs and Civil Liberties*, 1967.

⁶²⁸ The aim of the Wootton Report was to ensure that possession of small amounts of cannabis should not be punished with imprisonment. Its recommendation was that the maximum penalty on summary conviction should be reduced from one year to four months (offences with a maximum sentence of six months or less rarely incurring prison sentences). In 1970 James Callaghan introduced new legislation to implement the main proposals of the Wootton Report. This legislation was reintroduced by the incoming Conservative government and became law as the Misuse of Drugs Act 1971. The maximum penalty for cannabis possession was reduced from one year to six months and when the law gained royal assent, the Lord Chancellor instructed magistrates to 'reserve the sentence of imprisonment for suitably flagrant cases of large-scale trafficking'.

⁶²⁹ The ACMD's 1979 *Report on a review of the classification of controlled drugs and of penalties under section 2 and 4 of the MDA 1971*, the only review of the classification system to have been carried out since its introduction, states that the three-fold classification 'exists solely to determine which scale of penalties shall be applicable to individual drugs'. Quoted in Police Foundation, *Drugs and the Law: report of the Independent Inquiry into the Misuse of Drugs Act 1971*, 1999, p.40.

particular drugs, have repeatedly justified their decisions on the grounds of wanting to ‘send the right messages’ to the public or to avoid sending the wrong ones. Sadly, all the evidence indicates that, when the classification system is used in this way, it either fails to transmit the desired message at all or else sends signals that are garbled and likely to bounce back.

The idea of sending messages on the comparative dangers of different drugs is presumably to deter people to a greater or lesser degree from using them. Placing a drug in Class A is assumed to act as more of a deterrent than placing it in Class B. However, the authorities have done very little research on why a formal classificatory system of this kind should deter in this way or whether in practice it actually does. Most of the empirical evidence suggests that it does not deter and that the majority of people who take drugs do so with little or no regard to which class it is in. In a YouGov survey of drug users that we commissioned,⁶³⁰ 80 per cent of respondents considered that people’s knowledge of the ABC classification had little or no impact on their choice of which drugs, if any, to use. Categorizing ecstasy as a Class A drug, for example, makes little difference to whether a clubber will or will not use it, and the only message its ranking alongside heroin might send to the average user is either that the authorities do not know very much about ecstasy or that heroin is less dangerous than they had previously imagined.

The media’s reaction to changes or suggestions of changes in the classification of particular drugs may send messages of sorts to the public:

- ‘Soft laws spark boom in hard drug use’
- ‘Cameron Rocked by Row over Drug Call’
- ‘Clarke stays soft on cannabis’
- ‘Cannabis, conspiracy, and how the liberal elite made a dope of Blunkett’.⁶³¹

But the messages usually have more to do with politics, politicians and the prejudices of newspaper editors than with the realities of the illegal substances themselves.

The simple fact of a drug’s position within the existing classification system is often either uninformative or, on occasion, actively misleading. The then Home Secretary Charles Clarke acknowledged as much in January 2006 when he said:

- Decisions on classification... too often send strong but confused signals to users and others about the harms and consequences of using a particular drug and there is often disagreement over the meaning of different classifications.⁶³²

⁶³⁰ Surveys conducted by YouGov for the RSA in association with *The Daily Telegraph* on the attitudes, knowledge and experience of drug use among the general public and drug users, June 2006.

⁶³¹ *News of the World*, 6 August 2006, after a leaked Strategy Unit report suggested that rises in cannabis consumption and the use of hard drugs might be linked. *Daily Mirror*, 5 November 2005, after David Cameron suggested on television that ecstasy should not be in the same class as heroin. *Daily Mail*, 19 January 2006, after Charles Clarke accepted the ACMD recommendation not to reclassify cannabis as Class B. *Daily Mail*, 27 January 2004, on the reclassification of cannabis from Class B to Class C.

⁶³² Speech to House of Commons, 19 January 2006.

The classification structure set out in the Misuse of Drugs Act does not contain any of the information that would enable it to function satisfactorily as an indicator of the relative harms that different drugs can cause. The Misuse of Drugs Act offers no explanation whatever of why particular substances are in particular classes or even what the classes themselves are based on or what they are supposed to signify. It acknowledges none of the nuances in drug-using behaviour of which drug users are aware: that in terms of risk and harmfulness it matters a good deal how much you take, how often you take it, whether you take it in company or alone, whether you combine it with drink or with prescription medicines, whether you have a pre-existing mental illness or are currently unhappy, anxious or under stress. A Class A drug used in a relatively safe way may pose less risk than a Class C drug used in an unsafe way. The Act suggests by implication that all drugs in the same class are equally harmful and are equally harmful under all circumstances. Most drug users will know that they are not. Some may even reason that if they have used one drug in a class with no ill effects – ecstasy or LSD in Class A, for example – they are just as likely to emerge unscathed if they use another drug in the same category: heroin, say, or methamphetamine. The opacity of the classification system and the over-simplifications built into its workings not only reduce its value as a sentencing tool but undermine a prevention strategy that depends on official information about drugs being accurate and plausible.

The current classification system, in the words of Professor Colin Blakemore, head of the Medical Research Council, ‘reflects the prejudice and misconceptions of an era in which drugs were placed in arbitrary categories with notable, often illogical, consequences’.⁶³³ Besides the omission of alcohol and tobacco, it incorporates several striking anomalies.

LSD

In 1971, although psychedelic substances had been the object of media fascination for a decade, there was still little accurate information about how they worked on the brain and what their long-term effects might be. It therefore seemed a sensible precaution to place LSD in Class A. Consequently, case law that is still used as a precedent in sentencing states firmly, ‘Any idea that those who import or deal in... LSD should be treated more leniently [than heroin] [is] entirely wrong’⁶³⁴ – this despite the fact that research over the past thirty years suggests that LSD’s toxicity is low, that it is not addictive and that its potential for harm or public disorder is strictly limited. It is consumed less frequently than most other recreational drugs and in far lower doses than were customary in the 1960s. It generally causes little harm.

⁶³³ Quoted by Chairman Phil Willis MP during the Science and Technology Committee evidence session with Joan Ryan MP and Vernon Coaker MP, Wednesday 14 June 2006, as part of the committee’s enquiry into drug classification, 5th Report, 2005/6.

⁶³⁴ Sentencing Guidelines Council, ‘Guideline Judgments Case Compendium’ – *Rex v Aramah* (1982) 4 Cr.App.R.(S) 407.

Magic mushrooms

Two hundred times less potent than LSD⁶³⁵, magic mushrooms look even more incongruous alongside heroin as a Class A drug. Between 1993 and 2000 there was one case of a death in connection with which mushroom poisoning was listed as the underlying cause of death. The corresponding figure for heroin was 5,737.⁶³⁶ The classification of magic mushrooms is the more curious because it was carried out, not thirty-five years ago but in 2005. The hallucinogenic chemical they contain, psilocin or psilocybin, was placed in the highest category in 1971 under the Misuse of Drugs Act, but the mushrooms themselves were left unclassified. They were seen as a natural product growing wild, being subject to control only if they were dried or otherwise prepared for use. No further scientific evidence of their harmfulness has come to light, but in recent years the media have begun to draw attention to the fact that sellers were avoiding penalties by offering mushrooms in their raw state and a clause was inserted into the Drugs Act 2005 to include in Class A ‘fungus (*of any kind*) which contains psilocin or an ester of psilocin’.

Coca leaves

The inclusion of coca leaves alongside crack cocaine in Class A flies in the face of the World Health Organization’s finding that it is not the chemical composition of cocaine that is harmful but the way in which the drug is formulated. The chewing of coca leaves in their raw state cannot be shown to be harmful and may even be beneficial.⁶³⁷ Nevertheless, the Misuse of Drugs Act makes the sale and possession of the leaves as much subject to the full force of the law as the sale and possession of crack. This curiosity is made the more puzzling by the fact that elsewhere the Act does show itself capable of taking account of how a substance is prepared and taken. Amphetamines are more dangerous when they are injected than when they are swallowed because they reach the bloodstream and the brain faster, and this is reflected in the classification of injected amphetamines in Class A, but all other amphetamines in Class B.

Ecstasy

However, it is the Class A ranking of ecstasy that probably does most to undermine the credibility of our drugs laws in the eyes of that section of the population that is most likely to use drugs: namely, the hundreds of thousands of people for whom ‘dance drugs’ are a routine feature of a good night out. Ecstasy is in a higher class than the amphetamines to which it is closely related for no good scientific reason. It was added to the list of controlled drugs in 1977, shortly after the success of Operation Julie which broke up the largest LSD manufacturing business in the world in

⁶³⁵ R M Julien, *A Primer of Drug Action*, (W H Freedman, 1998), cited by R Levitt, E Nason, M Hallsworth, *The evidence base for the classification of drugs*, Technical Report, RAND Europe, March 2006.

⁶³⁶ Len Cook, National Statistician, in a letter to Paul Flynn MP 31.1.05 – cited by RAND study, op.cit.

⁶³⁷ A World Health Organization survey in 1995 whose publication was blocked by the United States. *Drugscope* submission to House of Commons Science and Technology Committee, March 2006.

a remote farmhouse in Wales. During that operation, evidence was discovered suggesting that ecstasy might have been about to be produced in the UK on a large scale, and it may be that it was then given a Class A classification as a precautionary measure on the basis of its believed potential links with crime rather than its inherent chemical harms.⁶³⁸

Reasonable as that may have seemed to those in the know at the time, ecstasy's position in Class A has looked debatable ever since. Both major reviews of drugs policy in the last ten years – the Police Foundation Report in 1999 (widely referred to as the Runciman Report) and the Home Affairs Select Committee enquiry in 2002 – have recommended downgrading ecstasy to Class B to sit alongside amphetamines. Such research as there has been continues to indicate that, while it is impossible to rule out long-term damage to mental functioning, the health effects of ecstasy are not comparable to those of heroin, crack or cocaine.

The procedures for classifying drugs are slow and far from transparent.

Part of the problem with the existing system is the ambiguous role of the Advisory Council on the Misuse of Drugs (ACMD), a body that might be supposed to be responsible for devising and operating the classification system. The first section of the Misuse of Drugs Act 1971 is devoted to bringing the Council into being. The members' function is defined as being 'to keep under review the situation in the United Kingdom with respect to drugs which are being or appear to them likely to be misused and of which the misuse is having or appears to them capable of having harmful effects sufficient to constitute a social problem'. The Council's members are expected to offer advice on restricting supply, providing treatment, devising education, promoting research and facilitating collaboration between all the different agencies involved in dealing with the social problems caused by drugs. They may do any or all of this either at the request of the Home Secretary or any other relevant Minister or when the members themselves 'consider it expedient to do so'.⁶³⁹

The Act makes it clear that the ACMD's advice may involve 'alteration of the law'. In practice, altering the law is likely to mean recommending adjustments to the classification system. The Council's members are certainly entitled to suggest changes in the current classification of specific drugs 'where they consider it expedient to do so'. However, over the years, they have been largely reactive rather than proactive in this area, as the Commons Science and Technology Committee has recently pointed out.⁶⁴⁰ The actual procedure for classifying drugs remains unclear, even

⁶³⁸ See Harry Shapiro, 'Operation Julie: the day acid reigned', *Druglink*. Nov/Dec 2004.

⁶³⁹ The Act lists 'The Secretary of State for the Home Department, the Secretaries of State respectively concerned with health in England, Wales and Scotland, the Secretaries of State respectively concerned with education in England, Wales and Scotland, the Minister of Home Affairs for Northern Ireland, the Minister of Health and Social Services for Northern Ireland and the Minister of Education for Northern Ireland.

⁶⁴⁰ House of Commons Science and Technology Committee, Fifth Report of Session 2005–06, *Drug Classification: making a hash of it?* 31 July 2006.

muddled. There is no formula for determining which drugs should be reviewed or when. The government, in its response to the Science and Technology Committee's criticisms, has claimed that the process should begin with the ACMD:

The classification system provides an established means (through the Council) for revisiting and revising the classification of a drug. When there is evidence of a new drug being misused the Council will take the first step in the 'knowledge inputs' and make a thorough assessment of its harms and how and where it should be reflected within the three-tier classification system. ... The Government is content that this is a satisfactory mechanism by which classification, as well as other aspects beyond the single issue of legal status, of an individual drug is considered.⁶⁴¹

In practice, however, investigations give the impression of having been largely ad hoc and usually at the request of the Home Secretary. There is little evidence of the ACMD taking the initiative in this regard.

Once a change in classification has been made, there is also no set process for monitoring the results. No research has been done, for example, on the consequences of making ketamine a controlled substance, although research on this topic might have made a valuable contribution to the debate on whether or not to classify khat, which remains legal.

The ACMD may well never have been intended to be a fully independent agency. According to one of the Home Office officials in charge of drugs when the Council was formed, it was established as 'a waste paper basket to deal with awkward questions about drugs that the government hadn't thought of', a body that could safely be relied upon to do nothing. If that was the intention, it was not entirely fulfilled. Between 1984 and 1998 the Council on its own produced ten reports on some of the most pressing of the social problems that the Misuse of Drugs Act had tasked it with covering: the relationship between drugs and AIDS, the environmental roots of drug misuse and the links between drugs and crime. In 2003 it produced the influential *Hidden Harm* report on the problems facing the children of drug misusers.⁶⁴²

On the appropriate classification of individual drugs, however, the ACMD has been slow to take the initiative. Possibly it was never intended to. If so, this ambivalence about its function may be what has affected its structure and organization and limited its influence. The Council only meets in plenary session twice a year (though its sub-committees are convened more often),

⁶⁴¹ The Government Reply to the Fifth Report from the House of Commons Science and Technology Committee, Session 2005-06 HC 1031, October 2006.

⁶⁴² Harry Shapiro, 'A question of balance', *Druglink*, July-August 2006.

and its proceedings are not made public. Its own researches are limited to exhaustive reviews of the existing evidence and interviews with key figures in drugs research; it does not have a budget with which to commission fresh enquiries. Its secretariat is supplied by the Home Office, and a significant proportion of its time is taken up with meeting the Home Secretary's specific requests. The suggestion is made increasingly often – most recently by the Science and Technology Committee – that the ACMD avoids conducting enquiries whose results might challenge the general trend of government policy. It does perhaps seem odd that the ACMD has conducted no enquiry into cocaine even though the World Health Organization concluded as long ago as 1995 that moderate and occasional use of powder cocaine may not, in fact, be especially harmful.

The Science and Technology Committee explicitly criticized the ACMD for failing to draw attention to perceived weaknesses in the classification system. Its report comments on the fact that the ACMD's Technical Committee, whose job is to make recommendations to the full council about classification, has for some years been working on an alternative method for assessing the harmfulness of drugs. This, it argues, might suggest dissatisfaction with the existing method – or lack of method, since a specific set of criteria for 'harmfulness' has never been formally defined:

We understand that the Advisory Council on the Misuse of Drugs operates within the framework set by the Misuse of Drugs Act 1971 but, bearing in mind that the Council is the sole scientific advisory body on drugs policy, we consider the Council's failure to alert the Home Secretary to the serious doubts about the basis and effectiveness of the classification system at an earlier stage a dereliction of its duty.

It might equally be argued, however, that the Advisory Council on the Misuse of Drugs is not being consulted as it should be. On occasion it has been ignored or bypassed altogether. For example, when cannabis was finally downgraded to Class C in 2004, it was at the third time of asking. The Wootton Report's suggestion in 1968 that cannabis be set apart from other drugs was echoed in 1979 when the ACMD specifically recommended downgrading cannabis to Class C. The Police Foundation reiterated the recommendation in 1999, and the ACMD repeated it in 2002. Its advice was finally accepted two years later. In 2005, on the strength of new research into potential links between cannabis use and mental illness, Charles Clarke invited the ACMD to review its position on the drug with a view to moving it back up again into Class B. Having conducted the review, the

Council duly advised the Home Secretary in January 2006 that the new evidence did not justify a higher classification than Class C: ‘Although [cannabis] is unquestionably harmful, its harmfulness does not equate to that of other class B substances both at the level of the individual or society.’ There were strong suggestions in the press that the Home Secretary had definitely been minded to restore cannabis to Class B and that he would ignore the ACMD’s advice. Such a move would seriously have undermined the Council’s position, and it was reported that more than one of its members had threatened to resign if he took this step.⁶⁴³ He subsequently drew back, and cannabis remains in Class C.

⁶⁴³ e.g. *Guardian*, 14 January 2006, ‘Expert advisers threaten revolt against Clarke’. <http://www.guardian.co.uk/drugs/Story/0,,1686310,00.html>

⁶⁴⁴ *Response of the Advisory Council on the Misuse of Drugs (ACMD) to the House of Commons Science and Technology Committee’s report*, 13 October 2006.

While the cannabis review was going on, the Home Secretary was also considering the upgrading of fresh magic mushrooms. He did not, however, choose to do this by the usual route: a review of the evidence by the ACMD, followed by a Modification Order laid before Parliament for its approval. Instead he made use of a new piece of legislation, a clause in the Drugs Act 2005; or, in the words of the Government’s response to the Science and Technology Committee’s report, he expedited matters ‘by taking the legislative opportunity that arose with the introduction of the Drugs Act’. The reason given was that this was not a full reclassification but simply a clarification of an ambiguity in the existing law that had been requested by the judiciary.

The Misuse of Drugs Act requires the Home Secretary to consult the ACMD when he proposes to lay an Order before Parliament to change the classification of a specific drug. Because in this case he had chosen not to lay an Order before Parliament, the Government seems to argue, he was not required to consult the ACMD. The procedure that was followed may therefore have been within the letter of the Misuse of Drugs Act. Nevertheless, the stratagem was certainly against the spirit of the Act, which presents the ACMD as having a key role in decisions on the appropriate classes for psychoactive substances. The ‘clarification’ has been as effective as an Order would have been in altering the legal status of a substance and consequently the penalties to which a user would be subject. In our view, the ACMD should therefore have been involved to the same degree as it would have been had the Home Secretary followed the procedure prescribed in the 1971 Act. The Council was asked to comment informally and is reported to have said that the move ‘seemed sensible’. It has since confirmed its support for ranging fresh mushrooms alongside dried ones in Class A on the grounds that they have the same hallucinogenic effects.⁶⁴⁴ However, this episode set an unfortunate precedent for sidestepping an expert body specifically set up to provide scientific evidence on drugs.

In January 2006, largely in response to his travails surrounding the correct positioning of cannabis, Charles Clarke announced that he was concerned by the ‘limitations’ of the current arrangements and that he would in due course be calling for a review of the entire classification system. The role that the ACMD was to play in this review was never mentioned. In the event, that did not matter, because in October 2006, John Reid having succeeded Charles Clarke as Home Secretary, the Home Office announced that it had decided ‘after careful consideration, not to proceed with a review of the classification system at this time’. Home Office Minister Vernon Coaker said:

I have spent the past few months⁶⁴⁵ meeting frontline police, victims of crime, drug addicts and others involved in the criminal justice system. None of them have raised the classification system as a concern that affects them with me.

I believe it is vital that we focus our energies on tackling drugs supply, getting more drug users into treatment and educating young people about the dangers of drugs.

So, no review.

The current classification system is vulnerable to political and media pressure.

Ecstasy, for example, would seem to have been retained in Class A only by political and media pressure centred on a series of deaths, most notably that of Leah Betts, which were used by the press as a means of condemning youth culture in general. Treating ecstasy as a scourge has largely become a totem for being ‘tough on crime’.

The ACMD might have been expected to conduct a review of the evidence on ecstasy when, in the space of three years, first the Police Foundation Report and then the House of Commons Home Affairs Select Committee report called for its downgrading. The Chairman of the ACMD, Professor Michael Rawlins, explained to the Science and Technology Committee during its enquiry that there had not been enough significant new research to warrant such an enquiry. The Committee challenged this suggestion and called for ‘an urgent review of the classification of ecstasy’. In response, the Advisory Council agreed to ‘undertake an assessment of the level of available evidence in order to establish whether a review is appropriate’.⁶⁴⁶ The Council subsequently resolved that it would undertake a review. Arguably, however, the members will be wasting their time, as the government’s response to the Science and Technology Committee’s call for a review was unequivocal:

The Government has *no* intention of reclassifying ecstasy.

Ecstasy can and does kill unpredictably; there is no such thing as a “safe dose”. The Government firmly believes that ecstasy should remain a Class A drug.⁶⁴⁷

⁶⁴⁵ Vernon Coaker replaced Paul Goggins as Drugs Minister in May 2006.

⁶⁴⁶ *Response of the Advisory Council on the Misuse of Drugs (ACMD) to the House of Commons Science and Technology Committee’s report*, 13 October 2006.

⁶⁴⁷ Science and Technology Committee, *Drug Classification: Making a Hash of It? – Follow-Up*, evidence session with Vernon Coaker MP, Professor David Nutt and Professor Sir Michael Rawlins, 22 November 2006.

In this particular case, it would seem, scientific evidence is not the government's primary concern.

Current legislation is driven more by morality than by the practical desire to reduce harm.

The Misuse of Drugs Act fails to acknowledge the fact that the use of drugs in all three divisions of the classification system in practice often produces no harm at all. In consequence, penalties designed for the small proportion of drug users who commit crimes or suffer health problems are applied to a much larger group who harm neither themselves nor anyone else. The imposition of these penalties may well have the effect of producing harms where previously none existed. The conclusions of the 1999 Police Foundation report *à propos* of cannabis remain relevant: 'The evidence strongly indicates that the current law and its operation creates more harm than the drug itself.'

In law, the seriousness of an offence is usually defined both according to the degree of culpability of the offender – did he or she intend to cause harm? – and by the amount of harm that the offence actually caused. Whom can drug users be accused of intending to harm? And whom – providing they have not burgled, shoplifted or assaulted anyone in order to finance their habit – have they actually harmed, if their drug taking does not lead to their damaging their own health, disrupting their family lives or neglecting their jobs?

According to the Sentencing Advisory Panel, there are some kinds of conduct that may do no harm but are made criminal 'purely by reference to public feeling or social mores'. The examples that the Panel gives relate mostly to social taboos on sexual behaviour: 'sex with an adult relative', 'intercourse with an animal' and 'sexual activity in a public lavatory'. But, the Panel continues, this tendency to criminalise on the grounds of custom and public feeling 'may also be true of *possessing* dangerous drugs [their italics], since people are free to harm themselves in other ways (for example through alcohol abuse) without committing a criminal offence. ... Public concern about the damage caused both to individuals and to society as a whole by drug addiction has influenced the public perception of the harm caused by this offence'.⁶⁴⁸

Here the moralistic roots of twentieth-century drugs policy and its continuation into the twenty-first century are laid bare. Using drugs, it would seem, is an offence because it offends 'social mores' even if the harms it causes cannot be identified.

⁶⁴⁸ Sentencing Advisory Panel, 'Advice to the Sentencing Guidelines Council on *New Sentences – Criminal Justice Act 2003*', 20 September 2004. Foreword by the Chairman, Professor Martin Wasik.

The possibility that this is so raises the question of how far society really does perceive certain kinds of drug use as deserving to be a crime. The British Crime Survey, for example, categorizes it as a 'victimless crime'.⁶⁴⁹ Repeated public opinion surveys over the last twenty years would seem to suggest that there is an increasing public acceptance, particularly among younger people, of the appropriateness of the moderate social use of drugs such as cannabis and ecstasy. In our 2006 YouGov survey, one of the largest so far undertaken, a clear majority of people indicated that they would be happy to see the personal use of 'soft' drugs such as cannabis either made legal or the penalties for their possession lowered to the status of a parking fine.

Too much reliance should not be placed on the findings of such surveys. The same people who give liberal answers in the context of an abstract debate on legalization or decriminalization are capable of giving very different responses when drugs appear to present a threat to their own children. Equally, many people would react strongly against trivializing drugs laws by equating them with parking restrictions, a brand of law that is widely despised and flouted by many who would not consider defying any other legal control. Nevertheless, it has also been found that people who fear and condemn 'pushers' and 'junkies' in the abstract often react with more compassion to individual drug users who are known to them. The North West Drug Treatment Commission public attitude survey, for example, found that 'the general public in the North-West are understanding about drug users as individuals. Whether that individual is a friend, a neighbour or someone in treatment, the message from this survey is that the public see the person not the drug use.'⁶⁵⁰

The law relies too heavily on discretion in its implementation.

Britain currently has laws that only serve the stated purpose of the National Drug Strategy – to reduce harm – if they are implemented with discretion: that is, if all the people who could theoretically be prosecuted in accordance with them are *not* so prosecuted and if all those who are prosecuted are *not* penalized in the ways that were originally envisaged. Laws are generally designed to be applied with discretion as to whether to prosecute at all, and as to the penalties to be applied. However, there must be a case for saying that a law that requires such a perverse degree of discretion on the part of its enforcers in order to work is an unsatisfactory law.

Where the control of illegal drugs is concerned, discretion is exercised by a wide variety of people – police officers,

⁶⁴⁹ The bulk of the British Crime Survey is devoted to information on 'victimisation' – respondents' experience of crime. Drugs offences are specifically excluded from this part of the survey as 'victimless'; the information on drug use has been gleaned since 1996 through the insertion of a supplementary and optional self-completion module.

⁶⁵⁰ North-West Drug Treatment Commission, *People like us: drugs and life in the North-West, 2002*. A more recent Irish study confirms the impression that 'there [is] a lot of community commitment to helping drug users'. H Loughran and M McCann, 'A community drugs study: developing community indicators for problem drug use', University College Dublin, 2006.

prosecutors, magistrates, judges – and it is exercised inconsistently from area to area, police station to police station, court to court. At every turn there is scope for individuals' personal beliefs about drugs and their harmfulness to influence how drug users are treated. A law that is not universally and equally applied gives rise to the perception, and possibly the reality, of unfair discrimination in its application to different groups of people. This was an issue that gave the Police Foundation inquiry particular cause for concern seven years ago and the problem has not been resolved – or even addressed. In the field of drugs, it seems, difficult issues are not ones to be tackled: they are ones to be run away from.

Our current drugs law criminalizes people who are not otherwise criminals.

The worst consequences of a blanket prohibition of drugs may clearly be seen in America where more than half a million people – more than the entire prison population of Western Europe – are incarcerated for drug offences carrying mandatory minimum sentences. A large proportion of these offences are possession offences. Our relative pragmatism and the way in which our criminal justice system exercises its wide discretion avoids the incarceration of many thousands of people – possibly even hundreds of thousands – for acts that lack criminal intent and have no direct victims other than the perpetrators themselves. In 2005, for example, some 120,000 people in England and Wales were stopped for cannabis possession. To have arrested and prosecuted each of them would have absorbed something like 600,000 police hours and would have cost a total of well over half a million pounds.⁶⁵¹ Instead, 63,635 of them, the majority of them first offenders, were given formal warnings. This outcome compares with what happened during the 1990s when the number of arrests for cannabis possession increased steadily year on year, doubling over the decade as a whole.

The power of discretion, however, imposes a burden on the individual police officer. It is open to abuse and it is liable to lead to inconsistency between different areas and separate commands. In addition, discretion is not allowed as explicitly in the policing of other drugs as it is in the case of cannabis. As it stands, the enforcement of our current drugs laws in other areas still imposes considerable social costs. Relatively minor possession offences for drugs other than cannabis can mean cautions and criminal records for significant numbers of otherwise law-abiding people, debarring them for life from entering most countries outside the European Union including America or from entering the armed forces.⁶⁵² Recreational users buying cannabis and ecstasy to share with friends at no profit may still be punished as drug dealers.

⁶⁵¹ Tiggey May et al., *Times they are a'changing: policing of cannabis*, Joseph Rowntree Foundation, 2002.

⁶⁵² In addition, anyone wishing to work with vulnerable groups, including children, would have to declare a record of drug possession on all such applications forever, as the offence of drug possession is not exempt from the Rehabilitation of Offenders Act in those circumstances.

The law sends people to prison who should not be there.

Although the flexibility with which our drugs laws are implemented does keep many minor offenders out of prison, many people are still sent there who will not be deterred from taking drugs by the experience and may well be disproportionately harmed by it, partly *because* the sentences involved are usually short. In a consultation paper issued in September 2005, the Sentencing Advisory Panel remarked that short custodial sentences are 'long enough to cause sufficient disruption to increase the likelihood that the offender [will] re-offend after release whilst being too short for any effective rehabilitation to take place... Short custodial sentences are followed by high rates of reconviction.'⁶⁵³ 'Nonetheless,' the Panel continues, 'large numbers of short custodial sentences are imposed,' and a table annexed to the consultation paper gives details of the custodial sentences allocated in 2003 for, among other offences, the possession of drugs. Of all 897 prison sentences handed down for possession of Class A drugs in 2003, well over half the total (541) were for less than three months and 77 were for less than fourteen days.⁶⁵⁴

⁶⁵³ Sentencing Advisory Panel, 'Custody Plus discussion paper', 30 September 2005.

⁶⁵⁴ <http://www.sentencing-guidelines.gov.uk/docs/Custody%20Plus%20Annex%20B%20for%20seminars.xls>

⁶⁵⁵ Judge Patrick Harrington QC, quoted on the BBC Wales programme, 'Week In, Week Out', 3 October 2006.

If offenders need drugs treatment, such short sentences hardly allow time for it. Clearly, a custodial sentence of this sort is about punishment, not treatment, and is highly likely to interrupt any treatment that the offender was receiving outside prison. Nor is it likely to have the deterrent effect it is presumably supposed to have. On the contrary, it will probably increase the risk of people re-offending by disrupting their lives, damaging their relationships with their families and prejudicing their prospects of getting a job. A judge has recently said that giving prison sentences to non-violent drug addicts is futile: 'A sentence of four months on a drug addict is utterly pointless – it achieves nothing whatsoever, but the judge has his options reduced... a custodial sentence becomes the inevitable'.⁶⁵⁵ Since drug use is common in most prisons, a short spell in prison is arguably as likely to aggravate an existing drug problem or even to present opportunities for acquiring a new one as it is to provide a route into treatment.

A recent international study on the impact of imprisoning drug offenders has concluded that the fear of arrest and sanctions is not a major factor in an individual's decision on whether or not to use or deal drugs. In addition, there is little correlation between incarceration rates and drug use prevalence in particular countries or cities; and the impact of enforcement action, including incarceration, on the price of drugs is much less powerful than other market factors:

Given the significant costs of incarceration as a way of reducing drug problems, (in budget terms, but also in terms of the

negative impact on community relations, social cohesion and public health), it is hard to justify a drug policy approach that prioritizes widespread arrest and harsh penalties for drug users on grounds of effectiveness.⁶⁵⁶

The law forces people into treatment who may not need it.

As we noted earlier, the current legal framework may have the effect, through the operation of testing and assessment on arrest under the Drugs Act 2005, of forcing into treatment a large number of people who neither want it nor really need it (occasional users of cocaine, for example) and then punishing them with imprisonment if they fail to take up the opportunity being pressed upon them. (The Act states that anyone who has tested positive for a Class A drug should be referred for an initial assessment to see if he or she is suitable for treatment and, if suitable, for a follow-up assessment. Failure to attend and remain for the duration of either of these assessments is an offence punishable by imprisonment for a term not exceeding 51 weeks or a fine of up to £2,500.⁶⁵⁷)

The Drugs Act 2005 is open to challenge on grounds of both principle and practicality.

The Drugs Bill which brought the Drugs Act into being was a controversial piece of legislation, pushed through at speed in the ‘wash-up’ prior to the 2005 General Election. The Bill was criticized on human rights grounds as an invasion of privacy, and it was also open to the charge of violating medical ethics on the ground that patients acquiescing to treatment under legal pressure were not consenting to their treatment in a free and informed way.⁶⁵⁸ More to the point, it is not all clear that coercing drug users into treatment is actually an effective way of treating them. On the contrary, as we also noted earlier, independent research shows that coercion may well reduce the likelihood of keeping people in treatment, of improving their condition and of reducing the chances of their re-offending.⁶⁵⁹

The coercive character of the Drugs Act also manifested itself in the unproductive attempts by the government to introduce a new presumption of ‘intent to supply’ for people found in possession of more than certain specified amounts of controlled drugs.

The Act left the precise amounts to be determined by the Home Secretary at a later date. The aim was to achieve more consistency in charging for ‘possession with intent’ and to make it harder for drug dealers to avoid conviction on the grounds that their stocks were for personal use. The setting of this type of threshold for personal possession had been proposed and rejected at intervals for at least thirty-five years on both legal and practical grounds.⁶⁶⁰

⁶⁵⁶ D Bewley-Taylor, M Trace and A Stevens, *Incarceration of drug offenders: costs and impacts*, Beckley Foundation 2005.

⁶⁵⁷ Drugs Act 2005, Part 3, Section 12 (4) and Section 14 (4).

⁶⁵⁸ The parliamentary Joint Human Rights Committee observed that the Bill claimed to comply with European human rights requirements but that no evidence had been produced to support that claim. This does not inspire confidence that human rights compatibility has been a matter of central concern in the formulation of the policy and the drafting of the legislation. Seventh Report, Session 2004-05, Section 3, *Drugs Bill*.

⁶⁵⁹ C Beynon, M Bellis and J McVeigh, ‘Trends in drop out, drug free discharge and rates of re-presentation: a retrospective cohort study of drug treatment clients in the North West of England’, *BioMedCentral, BMC Public Health* 2006, 6:205, <http://www.biomedcentral.com/content/pdf/1471-2458-6-205.pdf>

⁶⁶⁰ For example, it was considered – and rejected – by the Wootton Enquiry in 1969. Report by the Advisory Committee on Drug Dependence, *Cannabis*, 1969, paras. 84-6.

On legal grounds, critics objected that such a measure would reverse the burden of proof by making it the defendant's responsibility to adduce evidence that he was *not* intending to supply rather than the court's responsibility to prove that he was. From a practical point of view, the then Director of Public Prosecutions, David Calvert-Smith, pointed out in a letter to the House of Commons Home Affairs Select Committee in 2002 that determining the precise amounts of drugs that make someone a dealer rather than a user will always be 'extremely problematic', given the range of different circumstances that might lie behind the possession of quantities of drugs. In due course the Select Committee specifically recommended against setting thresholds for possession.

⁶⁶¹ The amounts proposed as being the maximum that might be considered as being for personal use were: half a kilo of cannabis leaf, 4 ounces of cannabis resin, 10 ecstasy tablets, 14 grams of amphetamines, 7 grams or 10 wraps of heroin or powder cocaine and 7 grams or 10 rocks of crack cocaine.

⁶⁶² By the *Guardian*, 6 June 2006.

⁶⁶³ 5 rather than 500 grams of cannabis leaf, 5 ecstasy tablets and 2 grams of heroin, cocaine and crack, though the recommended amount of amphetamines remained the same, at 14 grams.

But the Home Office pressed on regardless, whereupon it ran into precisely the difficulties that the Director of Public Prosecutions had foreseen. An initial set of figures produced in November 2005 was hailed with some glee by the media as being unreasonably generous.⁶⁶¹ 'Cannabis possession limits to be 500 joints,' wrote *The Times*. The Home Office was then reported⁶⁶² to be considering a second set of figures that went to the other extreme⁶⁶³ and was greeted with dismay by drugs workers on the ground that it was far too restrictive. They feared that large numbers of people who simply use drugs (usually punishable by a warning, caution or fine) would become liable to prosecution for dealing drugs, as a result of which they could theoretically be sent to prison for a maximum of fourteen years. The heaviest users, those already most vulnerable to health harms, would be the most vulnerable to punishments that could only have worsened these harms. In October 2006, with a different Home Secretary in place, the Home Office announced that the Government would not be proceeding 'at the present time' with the proposal to set thresholds, not through any consideration of public health but because the scheme 'might increase the burden on [police] forces and affect their performance'.

The law is not cost-effective.

Prosecuting and imprisoning large numbers of drug users and spending large amounts of money on mostly unsuccessful attempts to stop trafficking is a waste of public money that could be better invested in harm reduction, prevention and treatment.

In an earlier chapter, we discussed the monetary costs of the drugs policy and considered the budgets for 2003/4, 2004/5 and 2005/6. These budgets reveal that the amounts of money allocated specifically to 'reducing supply' remained static during this period, while the amounts allocated to drugs treatment

increased significantly.⁶⁶⁴ We strongly support the change in government attitudes that this shift in funding priorities would seem to indicate and we urge policy makers to display the same adaptability in their attitudes to the existing law.

⁶⁶⁴ See pp.67–68 above.

⁶⁶⁵ Report of the Senate Special Committee on Illegal Drugs, *Cannabis: our position for a Canadian public policy*, September 2002, Vol. 3, p.610.

⁶⁶⁶ Alaskans voted to recriminalise marijuana possession in 1991 and that remained the law until 2004, when the Supreme Court reaffirmed its 1975 decision. In the spring of 2006 a Republican majority in the Alaska House approved a bill to recriminalise possession again, but the state is currently being sued by the American Civil Liberties Union for an unconstitutional invasion of privacy.

20 ‘To legalize or not to legalize’

If the present state of the law is, as we maintain, radically unsatisfactory, then one possible response would be to say that all or some of the drugs that are now illegal should be ‘legalized’. That word can mean almost anything, from legalizing the mere possession of one or more drugs to legalizing the growth, production and sale, as well as the possession, of all drugs. In this chapter, we rehearse the arguments for and against legalization in the most general terms. Suitably adapted, these general arguments can be used for or against the legalization of any given drug or of any activity – such as growth, sale or possession – related to any given drug.

It is worth setting out these for-and-against arguments in some detail, partly for the sake of intellectual clarity but partly also because those who take up both of the extremes in the on-going debate often seem not to appreciate the full implications of what they are saying.

The arguments for legalization

One of the principal arguments in favour of legalization is that the individual’s use of drugs is a matter for personal choice, not paternalistic interference based on covert moral prescription. ‘Health and happiness cannot be forced on a person, especially not by criminal law based on a specific concept of what is morally right.’⁶⁶⁵ Everyone should have the right to govern his or her own conduct if it harms no one else. It was this kind of respect for the individual that led the Alaska Supreme Court to rule in 1975 that the state constitution’s privacy provision should take precedence over drugs legislation and that anyone should be allowed to possess up to a quarter pound of cannabis in their own home.⁶⁶⁶

Even if drug use were a matter for state policy, the argument continues, that policy need not take the form of criminal legislation. ‘When it comes to illegal drugs, criminal legislation occupies a symbolic and determinative place in public policy. It is as if this legislation is the backbone of our public policy,’ complained the Canadian Senate’s Special Committee in its report proposing the legalization of cannabis in 2002. The report went on to bemoan:

the increasing juridicization of social relations, a situation in which legislation is the central, sometimes the only, tool of government policy... Public policy cannot be reduced to adopting legislation, the more so since laws rarely contain clearly stated guiding principles setting out aims and objectives.... Public policy must be equipped with a set of tools designed to deal with the various issues that drugs represent to societies. Legislation is only one such tool.⁶⁶⁷

⁶⁶⁷ *Cannabis: our position for a Canadian public policy*, Report of the Senate Special Committee on Illegal Drugs, Vol. 3, September 2002.

Those who object to the kinds of drugs laws there are at present point out that a majority of the people who use drugs do so without harm; drugs policy should be geared to this majority, not to the minority who do experience harm. We know that alcohol can damage our health and that it may sometimes be linked with violence and anti-social behaviour, but for the sake of the large majority of drinkers who do not abuse it we are willing to accept these risks and attempt to manage them. Similarly, although the health harms and social costs of smoking have been established beyond any doubt, we choose to regulate it heavily and make it less socially acceptable rather than attempting to eradicate it altogether.

That is the argument from freedom: members of a free society should be left free to make their own choices unless their own choices harm others.

In addition, considerations that combine the moral and the practical are also brought into play. One is that the drugs market, being an illegal market, is also an untaxed market. The sales of alcohol and tobacco are heavily taxed and bring substantial revenues into the Treasury, revenues that can be spent on, among many other things, dealing with the harms that alcohol and tobacco undoubtedly cause. But sales of illegal drugs, even though they run into hundreds of millions of pounds, go completely untaxed and therefore bring in no revenue. Drug dealers pay nothing at all towards alleviating the enormous harms that their activities can cause. Moreover, it is on the face of it unjust that, while alcohol concerns and tobacco companies, along with all kinds of other legal enterprises, pay their taxes like ordinary citizens, the producers and purveyors of illegal drugs do no such thing. Suppose two companies make identical gross profits. But if one is a tobacco company, it pays heavy taxes and its net profits are much smaller than its gross profits, while, if the other is a drugs cartel, it pays no taxes and its net profits are as great, or almost as great, as its gross ones. Inequity and injustice are thus added to the loss of revenue to the state.

On top of being an untaxed market, the market in illegal drugs is also an unregulated market. The market in alcoholic drinks is heavily regulated. Alcohol cannot legally be sold to minors or to people who are clearly drunk. There are limits on the amount of alcohol that alcoholic beverages can contain, and the amount of alcohol that they do contain must clearly be indicated on the bottle or can. Alcoholic beverages must not contain contaminants or other illegal substances. In the case of tobacco, many of the same stringent requirements pertain, and smoking in public places is already banned in the UK or shortly will be. All cigarette packages have stringent health warnings printed on them. The upshot of such regulation is that, while alcohol and tobacco cause great harm, they do not cause nearly as much harm as they would if they were wholly unregulated. But illegal drugs, being illegal, are wholly unregulated. As a consequence, drugs sold on the street may, and often do, contain dangerous contaminants. Their strength and other chemical properties will usually be unknown to the purchaser, and they contain no health warnings. Many of the harms caused by illegal drugs are not caused by the chemical properties of the drugs themselves but by their being too strong and by the other substances that have been used to adulterate them. The upshot of the total lack of regulation is that, unlike alcohol and tobacco, illegal drugs cause even more harm than they would if they were regulated. Those who advocate legalization point out that that particular outcome is, to say the least of it, somewhat paradoxical.

These kinds of considerations are known to have influenced the Advisory Council on the Misuse of Drugs when it recommended in 2005 that khat, though known to have harmful health effects if over-used, should remain legal. The ACMD pointed out that in America, where khat is banned, prices are more than ten times as high, making it necessary for users to raise ten times as much money by legal or criminal means in order to continue a habit that is deeply entrenched in most users' cultural tradition. In addition, keeping khat legal also makes it possible to keep the trade in it entirely separate from the trade in other drugs. Why, the legalizers ask, are we not prepared to take a similarly realistic approach towards, say, cannabis?

The critics of drugs prohibition have additional objections to the present legal regime.

- 1 Drugs prohibition criminalizes very many otherwise law-abiding citizens and clogs up the criminal justice system, at great cost to the individuals concerned, to society and to the economy.

- 2 The black market in drugs breeds corruption and violence and is the major source of income for criminal networks. Taking drugs out of the hands of criminals would weaken and reduce organized crime.
- 3 The illegal drugs trade is associated with tax evasion and money laundering on a grand scale, carried out at least in part through the legal financial system.
- 4 Making drugs legally available would reduce the need for users to rob, shoplift and burgle in order to pay for them.
- 5 Keeping drugs illegal makes the environment in which they are bought more dangerous. Young people are drawn into criminal subcultures in order to get their drugs. In having to approach criminal dealers for cannabis, relatively inexperienced users are exposed to a range of more dangerous drugs.
- 6 Illegality also makes the environment in which drugs are used both more unpleasant and more hazardous. Users of more dangerous drugs such as cocaine and heroin frequently feel forced to take them furtively, often in squalid conditions and with little regard for safety. It is often the setting in which heroin is used rather than the drug itself that causes harm. If standard doses were administered in a safe and sterile place, and if users took routine steps to protect their health, they would not become ill or die at a rate any different from the population as a whole.⁶⁶⁸
- 7 As we noted above, illegality rules out quality control. Neither experimental nor dependent users have any foolproof means of gauging the strength or purity of what they are buying or identifying the substances with which their purchases may have been cut. Removing legal prohibitions would make it possible for government to regulate the quality and guarantee the dosages of the drugs supplied and provide the safest equipment with which to administer them, backed up with advice on health and harm reduction.
- 8 A blanket prohibition on drugs that includes cannabis and ecstasy cripples the credibility of drugs education programmes. Far more effective programmes could be designed around the principle of 'Know' not 'No'.
- 9 The stigma of illegality deters people who need treatment from seeking it. In the YouGov survey of drug users organized by this Commission in 2006, almost ten per cent of respondents said they had held back from seeking treatment for this reason.
- 10 With the threat of prosecution in the background, surveys about drug use are likely to get fewer respondents, who are also less likely to tell the truth. With more accurate statistics, government could assess the results of its policies against a solid basis of evidence and evaluate them against the stated aims, focusing on what the policies have actually

⁶⁶⁸ E Goode, *Between Politics and Reason: The Drug Legalisation Debate*, St Martin's Press, 1997.

achieved rather than measuring how far they have merely been implemented.⁶⁶⁹

It might be worth paying the costs of prohibition if the policy were achieving its stated objectives of reducing drug use and the incidence of drug-related crime but, the proponents of legalization argue, it patently is not. The illegality of drugs may put some people off using them – possibly those least likely to do so in the first place – but it is only one among many possible deterrents and may not be the strongest.

The Police Foundation Inquiry, for example, commissioned a MORI survey of public attitudes to drugs in 1999. It revealed that ‘the public sees the health-related dangers of drugs as much more of a deterrent to use than their illegality, the fear of being caught and punished, availability, or price... All the evidence suggests to us that the law plays a minor part in deterring demand.’⁶⁷⁰ Restrictions on the availability of drugs and rises in their price, changes in music and fashion, the stability of a person’s background and their access to alternative ways of spending their time have all been found to have more influence in discouraging drug use.

In any case, critics of the current arrangements maintain, the total number of people using drugs is less important than the ways in which they are using them. Looked at in a non-moralistic way, the practical objective should be to reduce the overall sum of drug-related harms. Having more people using drugs less harmfully would probably have less drastic consequences than the current situation in which fewer people use drugs but use them in more dangerous ways.

What if drugs were legalized? What then? Would the state intervene at all? In practice, very few proponents of legalization argue for a drugs ‘free for all’, with no restrictions on the production, sale or consumption of drugs. Most prefer to devise regulatory systems through which drugs could be made legally available.

Several variants have been advanced over the years, most of which contain the same elements. According to the proponents of these schemes, the state would need first of all to secure the sources of supply, building a chain of licensed producers, importers and distributors, presumably on the same model as the current trade in legally produced opiates and other drugs used for medicinal purposes. In the case of cannabis, the government would also have to gain control of domestic cultivation and then, if necessary, expand it to help meet the demands of the market.

⁶⁶⁹ Transform, *After the War on Drugs*, 2004.

⁶⁷⁰ Police Foundation, *Drugs and the Law: report of the Independent Inquiry into the Misuse of Drugs Act 1971*, 1999. Overview. This is a view shared by P Reuter and R McCoun, *Drug War Heresies, Learning from other Vices, Times & Places*, Cambridge University Press, 2001, p. 83. They note that most of the research in this area has focussed on cannabis use and conclude that the deterrent effects of the law are ‘quite modest in size, generally accounting for 5 to 10 percent of the variance in marijuana use reported in perceptual deterrence surveys’.

Different drugs could be made available to different groups of users in a variety of ways. Dependent heroin users could be supplied through an extension of the current system for prescribing diamorphine or medical heroin. For those using 'harder' recreational drugs like cocaine, a network of licensed specialist pharmacists or 'druggists' could be created⁶⁷¹, making drugs available only to licensed users. 'Softer' recreational drugs could be made available much as alcohol and tobacco are sold now, at off-licenses and tobacconists, with licensees made responsible for preventing sales to children and limiting the amounts that people could buy at any one time. In addition, specific premises could be licensed for the sale and consumption of drugs, for all-comers (as in pubs) or for members only (as in casinos). New users might be managed with permits similar to provisional driving licences controlling the times, places and conditions under which they could consume drugs, perhaps giving them different levels of access to various substances according to their training and previous experience of use.

⁶⁷¹ Transform, op.cit.

⁶⁷² Quaker Action on Alcohol and Drugs, Memorandum to House of Commons Home Affairs Select Committee, September 2001.

Most advocates of legalization concede that any system of legal supply would have to be underpinned by an extensive campaign of public education and a ban on advertising and marketing, rather as the Betting and Gaming Act 1968 allows gambling only with 'unstimulated demand'. A ban of this kind would theoretically make it possible to control the size of the market and limit the commercial pressures that promote excessive use.⁶⁷²

The regulation of gambling might be seen as a model for a regulated drugs trade. Gambling, like drug use, can be expensive, addictive and linked to the criminal underworld. Most religious authorities disapprove of it to a greater or lesser extent, and most legal jurisdictions limit it. However, tight restrictions have proved impossible to enforce and in recent years policy has been to expand the trade but under a government-controlled licensing system. The Betting and Gaming Act 1960 allowed commercial bingo halls to be set up as members-only clubs, the Gaming Act 1968 allowed commercial casinos to operate, and the Gambling Act 2005 has paved the way for 'super-casinos' on the American model. The new Gambling Act has three stated objectives, which could be applied to the drugs trade with very little modification:

- preventing gambling [the selling and taking of drugs] from being a source of crime or disorder, being associated with crime or disorder or being used to support crime;
- ensuring that gambling [the selling and taking of drugs] is conducted in a fair and open way [a safe way];
- protecting children and other vulnerable persons from being

harmed or exploited by gambling [the selling and taking of drugs].

If we feel that controls of this kind are sufficiently stringent to keep gambling within acceptable limits, legalizers argue, why do we not apply the same standards to drug use?

The contention is that turning the supply of drugs into a legal trade of this kind would create a safer environment for drug use, reducing or even eradicating the dangers that controlled use of drugs, it is alleged, can bring. It might well lower levels of acquisitive crime. It would therefore have the most benefits in relation to the most seriously problematic drug users, among whom both drug-related death and drug-related crime are most common.

But for society as a whole, would it create more harms than it eliminates?

The arguments against legalization

The most emotive argument against legalization is undoubtedly the argument from morality. It is none the less powerful an argument for being emotive. Those who support the broad thrust of today's prohibitionist policies and oppose any moves in the direction of legalization maintain that drug use impairs rationality, alters personality and interferes with the individual's relationship with other people, with society and with God.⁶⁷³ (The same concerns have been voiced in the past, and are still voiced today, about the consumption of alcohol.) In evidence to the Commons Home Affairs Committee in 2001, Baroness Greenfield expressed essentially this view in secular terms:

I believe that a society composed of citizens who, even if not physically at peril are, nonetheless, over- or under-stimulated because of drugs would not constitute a desirable society...

These same chemicals could literally change or even "blow" the mind... Anyone who takes drugs will run the risk of changing their personality and their view of the world.

Society's legal arrangements should reflect its moral concerns, and on this argument the law should forbid behaviour that would compromise individuals' moral individuality and integrity. Criminal penalties symbolise society's moral abhorrence of drug use. To remove these penalties would be morally objectionable in itself and would send a morally abhorrent message to society at large.

Moral considerations aside, legalizing drugs would be fraught with risk. The protagonists of change usually argue that, if drugs were legalized, the number of people using them would not

⁶⁷³ Peter Cohen, Testimony before the Canadian Senate's Special Committee on Illegal Drugs, 28 May 2001. 'The Reformation[']... new ideology was that people had an individual relationship to God. They were now able to seek salvation for themselves, rather than through the church... Within the Protestant tradition, force like sexuality, alcohol and drugs came to be seen as powers that threatened this autonomy and damaged the relationship with God.'

increase significantly and that, even if the number using them did increase, the fact that they would probably be using them more safely would mean that the total amount of harm caused would be reduced. But what if they were wrong? What if, in the event, it turned out that the number of drug users increased substantially and/or that people continued to use them unsafely, just as tens of thousands of people use alcohol and tobacco unsafely? The total amount of harm caused by drugs, far from diminishing, might increase or even soar. No one knows. The downside risks of legalization are incalculable. If people had known in the seventeenth century what we now know about the harms caused by tobacco, it is at least possible that the use of tobacco would have been prohibited from the outset. The fact that we failed to prohibit tobacco then is no argument for legalizing illegal drugs now.

People's concerns about the dangers of taking unknowable risks are increased by the limited evidence available on the experiences of other societies. Few governments in other countries have conducted experiments that would provide relevant evidence and, even where they have conducted them, there is disagreement about the results. In the Netherlands, for example, following the introduction in the 1970s of the famous 'coffee shops', where cannabis can be bought and used in small quantities without penalty, there was no immediate rise in the use of cannabis and levels of use in the Netherlands are still lower than they are in either America or Britain, despite their stricter controls.⁶⁷⁴ Against that, however, a significant increase in consumption took place in the Netherlands between 1992 and 1998, during which time the number of coffee shops increased and cannabis became to some extent an ordinary commercial product. Similarly, the proportion of 12–17-year-olds in Alaska reported to have used cannabis increased after it was legalized in 1975 at a faster pace than it did in the nation as a whole, prior to its recriminalization in 1990 (although others note that the rise in use was even steeper in some other states where strict prohibition continued in place).⁶⁷⁵

In any case, a rise in the number of people using cannabis is one thing; a rise in the number of people using heroin or crack cocaine is quite another. It is at least possible that, if drugs of all types were made legal and became more easily available, even with an intensive campaign warning of their risks, more people would use them and, in particular, more young people would experiment with them. In Britain in the 1950s, when dependent heroin users were to be counted in dozens rather than hundreds, a significant proportion of them were doctors, who alone had easy access to heroin. Similarly, large numbers of American GIs

⁶⁷⁴ One Dutch study has compared cannabis use in San Francisco, where it is illegal, with Amsterdam, where it is illegal but de-penalised: 62 per cent of those surveyed in San Francisco reported having used it at one time or another as compared with 34.5 per cent in Amsterdam. P. Cohen and H. Kaal, 'The irrelevance of drug policy: patterns and careers of experienced cannabis use in the populations of Amsterdam, San Francisco and Bremen', CEDRO 2001. A more recent European study found that 15.8 per cent of young men in Britain were reported to be using cannabis at least once a month, as compared with 9.7 per cent in the Netherlands. EMCDDA Statistics 2005, <http://stats05.emcdda.europa.eu/en/elements/gpstab08a-en.html>

⁶⁷⁵ Supplementary memorandum submitted by the Home Office to the House of Commons Home Affairs Select Committee, 2001. <http://www.publications.parliament.uk/pa/cm200102/cmselect/cmha/318/318ap02.htm>

were found to have taken up heroin use in Vietnam, where again supplies were easy and cheap. Heroin use in Britain now is relatively uncommon, confined to little more than one per cent of the population. Anything that altered this situation and increased its use would be inherently risky. The same obviously applies to crack cocaine and methamphetamine.

⁶⁷⁶ Professor David Nutt, in evidence to the House of Commons Home Affairs Select Committee in 2001.

The argument that legalization would, however, make heroin use safer depends on the assumption that all problematic heroin users would come out into the open if the drug were legally supplied and that they would be within the reach of the services that could help them. However, it is equally likely that many of the factors that cause them to stay out of sight now – the deterioration in their health, their often chaotic daily lives, the stigma attached to injecting drug use – would continue to apply and the result of the experiment would simply be to increase the already unacceptable number of people experiencing serious problems with drug abuse.

It would almost certainly be the case that, if any or all of the drugs that are now illegal were legalized, a market of the kind that now exists for alcohol and tobacco would at once spring into being. It would probably be a regulated market, as in the case of alcohol and tobacco, but, for better or worse, it would come into existence. Instead of drugs being ‘pushed’ illegally, they would be marketed – i.e. pushed – legally, by one means or another. If cannabis were legalized, cannabis farms would quickly appear in the Home Counties and elsewhere in the UK, and legal outlets would be established – as the proponents of legalization freely acknowledge – in this country’s high streets and shopping malls. It is claimed that multinational tobacco companies have already acquired licences for names such as ‘Morocco Black’ and ‘Acapulco Gold’ that might be used as names for brands of cannabis if cannabis were legalized.⁶⁷⁶ At the very least, the physical face of Britain – and, so to speak, its ‘cultural texture’ – would be changed irrevocably.

This last point, about irrevocability, is worth pausing over as it, too, counts as part of the case against legalization. If cannabis and other illegal drugs were ever legalized, it would almost certainly not be possible to de-legalize them, any more than it is possible now to contemplate the de-legalization – i.e. the legal banning – of tobacco and tobacco products. The deed would be done; there would be no turning back. Thousands, possibly millions, of people would have got used to the idea of having access to one or more of the drugs that are now illegal. They would have come to believe that they had a legal right to access such drugs, and they

would be right: they would have acquired such a legal right. And legal rights, once given to people, become very hard to deny them. In addition, there would come into being powerful vested interests in the drugs industry, vested interests that, unlike their counterparts in the illegal drugs industry, would be entitled to, and would, hire PR agencies and public affairs agencies and would lobby governments for, say, wider access to drugs and lower taxes to be levied on them. Any radical change in policy would not be politically neutral: it would lead to a radical change in the associated politics.

Moreover, according to those who oppose legalization, there is no reason to think that legalizing one or more of the drugs that are at present illegal would eliminate the criminality associated with such drugs. It might not even reduce it substantially. Existing criminal networks would simply move on to other crimes; here and in other countries organized criminal networks have proved themselves almost infinitely adaptable. Under a regime of legalization, the government would almost certainly want to tax drugs heavily, as it taxes alcohol and tobacco. It would want to do so in order to raise revenue, in order to discourage excessive use and also, in this particular case, to fund the new regulatory mechanisms and institutions that would have to be put in place. The prices of drugs, far from falling or remaining stable at their present low levels, would almost certainly increase. Drugs that are now illegal but cheap would almost certainly be legal but more expensive.

The consequences would be predictable. In the first place, a black market – probably a large-scale black market – in drugs would quickly develop. This market would deal not only in cheaper supplies of drugs but also in counterfeit and, almost certainly, contaminated drugs. Criminal gangs would dominate this black market just as they now dominate the existing black market, and they would import legal drugs illegally just as they now import illegal drugs illegally. Smuggling would be rife. Not only that, but there is a distinct possibility that criminal gangs would be more likely to fight among themselves – possibly violently – because the amount of turf available in the new black market would be diminished.

Secondly, if legal drugs turned out to be no cheaper than illegal ones, the seriously drug-dependent would almost certainly continue to steal in order to finance their habits. Many of those who are seriously dependent on drugs are very poor, live chaotic lives and, quite apart from their drug-related behaviours, are already engaged in other forms of criminal activity. For many

people, persistently stealing to fund their drug use has become a way of life. Especially because, in the absence of successful treatment and rehabilitation, their employment prospects would not have improved, they would be most unlikely to stop committing crimes. In the view of those who oppose legalization, the notion that criminality would somehow disappear or be greatly reduced post-legalization is, to put it mildly, somewhat optimistic.

The opponents of change make another point, one that is more mundane, perhaps, but no less serious. The debate about making Britain's drugs trade legal does not take place in a vacuum and there are powerful political constraints, both foreign and domestic, on an experiment of this kind. Most obviously, though there may be room to manoeuvre around possession and use of drugs⁶⁷⁷, legalizing production and supply would almost certainly involve challenging the internationally agreed UN Conventions.⁶⁷⁸ These are held firmly in place by the influence of the United States – ‘the Taliban of drugs policy’, in Peter Cohen's phrase – which largely funds the International Commission on Narcotic Drugs (ICND) and brooks no opposition, at least in public, to the ‘war on drugs’. Any state has the right to ask for a review of a UN convention on a focus point, but it is a simple matter for opponents to block such a move. Equally, any state can denounce or disregard the drugs conventions, which have no binding force of law. However, the political will to take this drastic step unilaterally is simply not there. Work is going on to build the kind of international consensus that would be needed in order to achieve a more open discussion of options for the future, and in the fullness of time possibly a full-scale review of the Conventions, but it is a slow process.

As must be evident, powerful arguments can be advanced on both sides of this long-running debate. No one in this field has a monopoly of truth. The fact that choices are difficult – as well as the fact that in this field, as in so many others, difficult choices have to be made – is obvious. It is against that background, and in that spirit, that we set out our proposals for changes in the law in our next chapter.

21 A new legal framework for the regulation of drugs

For all the reasons given in chapter 19, we regard the present legal framework for the regulation of drugs in the United Kingdom as unsatisfactory. We believe it should be scrapped almost in its entirety. Its faults are manifold. The law as it stands is incoherent and out of date. It is based far more on prejudice and folk myth

⁶⁷⁷ See for example N Dorn and A Jamieson, *Room for Manoeuvre: Overview of comparative legal research into national drug laws of France, Germany, Italy, Spain, the Netherlands and Sweden and their relation to three international drugs conventions*, Drugscope for the Police Foundation Inquiry, March 2000.

⁶⁷⁸ Specifically, Article 3(2) of the Trafficking Convention 1988 which unambiguously requires signatories to attach criminal penalties to production and sale.

than on reason. It makes no mention of the UK's two most death-dealing drugs: alcohol and tobacco. It leaves far too much discretion in the hands of the authorities, especially the police, who want and need clearer guidance for purposes of enforcing the law. The law as it stands criminalizes people who are not otherwise criminals. It probably makes a positive contribution to causing violent crime. It certainly increases the chances that people who do use drugs do so in an unsafe manner. It embodies a classification system that is full of anomalies. Not least, changes to the existing law owe as much to the exigencies of the on-going combat between the major political parties as to careful consideration of the available evidence. As we stated earlier, we believe that the Misuse of Drugs Act 1971 and much of its attendant legislation – the Drugs Act 2005 in particular – should be repealed and replaced by a consolidated Misuse of Substances Act.

The new Misuse of Substances Act should have the following properties.

- 1 It should acknowledge that, whether we like it or not, drugs are a fact of life – and have been for millennia. They are not going to go away. The notion of a completely or almost completely drug-free United Kingdom is a chimera.
- 2 Given that drugs may, and often do, cause significant harm to individuals, their family, their friends and their communities, the main aim of the law should be to reduce the amount of harm that they cause.
- 3 The use of criminal sanctions should be confined to the punishment of those offences connected with drugs that cause the most harm.
- 4 Only the most serious drugs-related offences should attract custodial sentences – and those sentences should be long rather than short.
- 5 The law should encourage those dependent upon harmful drugs to seek or accept treatment but should not – as the law does now – actually make it easier for drug-using offenders who have committed other crimes to receive appropriate treatment than it is for users who have not committed other crimes.
- 6 The focus of the law should not be on individual drugs as such (as in the existing ABC classification) but on the harms that drugs cause.
- 7 The law should acknowledge that alcohol and tobacco, in addition to drugs, may, and often do, cause significant harm. Drugs should not be 'ghettoized' as being peculiarly abhorrent.
- 8 The law should be flexible. It should be capable of being readily adapted to take account of new drugs, of changes

in the properties of existing drugs and of new scientific findings in relation to drugs.

- 9 The law should require ministers to take into account the best available scientific evidence relating to drugs and their use. If ministers reject the advice of their scientific advisers, the law should require them to state publicly and formally why they are doing so.

It is beyond the competence of this Commission to draft an actual Misuse of Substances Bill, but we believe the new Act should be framed along the lines indicated below.

An index of substance-related harms

At the heart of a new framework should be an index of substance-related harms. The index should be based on the best available evidence and should be able to be modified in the light of new evidence – and also in the light of the coming onto the market of new substances. It should be intelligible to lay persons as well as to scientists and lawyers, and the evidence on which it is based should be made readily available to the public. There should be no mystery about it, as there is about the present ABC classification, which often appears to be arbitrary, confused and haphazard. When the Chairman of the Advisory Council on the Misuse of Drugs, was asked by the House of Commons Science and Technology Committee why psilocin (the hallucinogenic component in magic mushrooms) is categorized as Class A, he replied: ‘I have no idea what was going through the minds of the group who put it in Class A in 1970 and 1971 ... It is there because it is there.’ The same could be said of the present classification system as a whole: it is there because it is there. In our view, that is not good enough.

We recommend the adoption of an index of harms that takes fully into account not merely the substances themselves (and the present classification system is crude even in that regard) but the people using them, the ways in which they are used and the kinds of crimes, if any, that are associated with them. The index should underlie not merely the law itself – and the choice of penalties to be imposed for drug-related offences – but also other aspects of government policy relating to drugs, including drugs education, the determination of policing priorities relating to drugs and the allocation of funds for different kinds of drugs treatment and harm reduction programmes.

The principal question is how an index of this kind should be related to the law itself. The Science and Technology Committee recommended that any revised classification system should

be based on ‘a more scientifically based scale of harm’.⁶⁷⁹ This scale, it added, should be somehow ‘decoupled’ from criminal penalties, to allow the relative harms of different drugs to be assessed objectively, without regard to the practical implications for the criminal justice system. However, the committee offers no explanation of how complete this ‘decoupling’ should be. Should the objective harmfulness of a drug be related at all to the penalties imposed for its supply or possession? And if so, how?⁶⁸⁰

A new legal framework

The Commission proposes a new legal framework for the control of dangerous substances in four parts: (1) a statute and (2) a schedule, comprising the Misuse of Substances Act itself, supported by (3) an index of substance-related harms and (4) a table setting out precisely to what degree and by which methods each substance is currently to be regulated:

- (1) The statute should be drafted in broad and general terms, expressing the state’s intention of controlling substances whose use involves an unacceptable level of risk of harm, either direct harm to users or indirect harm to other people through crime, environmental damage, financial burdens on the taxpayer or distress to families, friends and communities. It should define in general terms the activities that will be considered offences, such as the cultivation or manufacture of dangerous substances and their trafficking. It should also make clear the circumstances in which the supply and use of controlled substances will *not* constitute offences.
- (2) A schedule should then set out a graduated list or gradient of all specific offences related to the production (growing or manufacture), supply, purchase and possession of potentially harmful substances, in descending order of seriousness. Each offence should be accompanied by a range of penalties attached to it, the precise choice of penalty to be decided, as now, by the sentencer.

The main difference from the present classification system would be that neither the statute nor the schedule themselves would determine the absolute criminality of any individual substance by name nor allocate specific penalties to its supply or possession in isolation from the circumstances of the individual case. The schedule would rank *offences*, not substances, in order. Individual substances would be named neither in the statute nor in the schedule of offences.

⁶⁷⁹ *Drug classification: making a hash of it?*, op.cit., pp.45-46.

⁶⁸⁰ The Science and Technology Committee would seem to have placed a great deal of weight on a remark made in his oral evidence by Deputy Assistant Commissioner Andy Hayman to the effect that the police do not pay much attention to the minutiae of the classification system when taking action against drug offenders. The somewhat drastic inference the committee draws from this is that the classification system (a rough ranking of harms) is of no use to the police and that therefore any other index of harms should be ‘decoupled’ from the system for imposing criminal penalties through the courts.

- (3) The gravity of any offence, and therefore the penalties to be attached to it, would be determined by reference to the third element in the new framework: the harms index. The index would rank substances in the order of their harmfulness as currently assessed on the basis of scientific and sociological evidence.

The index, a simple list of substances set out in descending order of harmfulness, could be generated by a matrix mapping the various types and degrees of harm associated with each of the substances in question. These harms would be related to, among other things, the substances' chemical properties. Thus it would be possible to differentiate, say, between different grades of cannabis according to their levels of THC or tetrahydrocannabinol, allowing skunk and the many other varieties of high-strength cannabis to be ranked higher than the most common street-level varieties.

But the catalogue of harms would not be restricted to the substances' chemical characteristics. It would also – and this is critically important – incorporate the context, the circumstances and the ways in which the substances might be used, for example (a) the effects that a substance may have on people with particular characteristics – high blood pressure, for example, or a tendency to depression; (b) the risks inherent in particular methods of taking substances – injecting crack, say, rather than chewing coca leaves, combining heroin with alcohol, snorting ketamine, injecting in the groin; (c) the links between individual substances and particular types of crime – between crack and violent behaviour, heroin or cocaine and shop-lifting, alcohol and domestic violence, GHB and (allegedly) date-rape; (d) the propensity for some substances to be used in binges; and so on.

The matrix would set out each of the categories of harm that substances may cause, and each individual substance would then be scored in each category. Its mean score would be used, but only as a guide, to help determine its relative position on the harms index. Some method would have to be found of making allowance for the fact that drug use is not uni-dimensional but multi-dimensional. People use the same substances in different settings and different circumstances, and the resulting harms will also differ.

The Metropolitan Police Service's matrix for prioritizing the criminal networks it seeks to disrupt offers an interesting parallel. The Prioritisation Matrix lists the various categories of crime in which criminal networks may be involved: social crimes such

as murder, kidnap, paedophilia and people smuggling, economic crimes such as substance importing and distribution, money laundering and fraud, and political crimes such as the funding of terrorism. It then matches individual criminal networks against each of these categories, scoring them ‘high’, ‘medium’ or ‘low’ according to the degree of their involvement in the particular crime and allocating numerical values to these scores based on proportions of the maximum sentence available for each crime. (A high score for a crime such as money laundering would equate to the total maximum sentence available for it, that is, twenty years; a medium score would be ten and a low score five.)

The position of a substance on our new harms index would determine the gravity of offences relating to it and the consequent penalties. It might be decided, for instance, that the most serious offences on the gradient should be related only to, say, the substances in the top three positions on the harms index, whatever these three substances happened to be. Large-scale trafficking is likely still to be considered the most undesirable activity related to controlled substances. The first entry on the gradient of offences would therefore read:

‘Trafficking in substances in the range 1-3 on the index’

Trafficking in substances lower down the harms index would come lower down the gradient of offences and penalties, as would less serious activities involving substances in the range 1-3: small-scale manufacture, for example, or simple possession. Below them would come, say, small-scale dealing involving substances in the range of 4-6 on the harms index. Then would come perhaps possession of substances in the range of 4-6. And so on.

The Blakemore/Nutt hierarchy of harms

A model already exists in work done by the Advisory Council on the Misuse of Drugs itself for the construction of such a harms index. An unofficial matrix of drug-related harms is already the informal mechanism on the basis of which the ACMD’s Technical Committee has made some of its recommendations.

The matrix used by the ACMD’s Technical Committee would seem to have its roots in the Police Foundation report. The Chair of the Technical Committee is Professor David Nutt, who was also a member of the Police Foundation inquiry. As the basis for its recommendations on reclassifying certain substances, the inquiry made its own assessment of the relative harms of drugs, using nine separate criteria. The ACMD undertook in 2001 to consider the development of a rather similar-sounding risk assessment framework ‘which could be used by Council members as part of wider considerations of appropriate classification of

individual substances’. ‘Over a series of our meetings,’ David Nutt told the Commons Science and Technology Committee, ‘we have evaluated across the whole range almost every drug in the Act in a systematic way, given the current level of evidence, so we have set up a system where we can be proactive in terms of individual drugs and also we have reviewed the relative harms and risks of all the drugs.’

Professor Colin Blakemore has also been making the case for including alcohol and tobacco in any harms index of this kind, because they are the psychoactive substances most frequently used throughout the world and those with the most damaging results. Recently Professors Blakemore and Nutt have worked⁶⁸¹ on what David Nutt has described as ‘a matrix in which numerical values could be given to assessments of harm in order to rank drugs, not just illegal drugs but also including the familiar, acceptable, legal drugs as a kind of calibrator for the scale as a whole’.⁶⁸² It is this matrix that has presumably been the informal basis of the harm assessments that have been made by the Technical Committee in recent years.

⁶⁸¹ With William Saulsbury of the Police Foundation and Leslie King of the Forensic Science Service.

⁶⁸² In his evidence to the Science and Technology Committee, 1 March 2006.

The matrix, devised primarily by Professors David Nutt and Colin Blakemore, uses nine criteria for determining harmfulness, grouped under three headings.

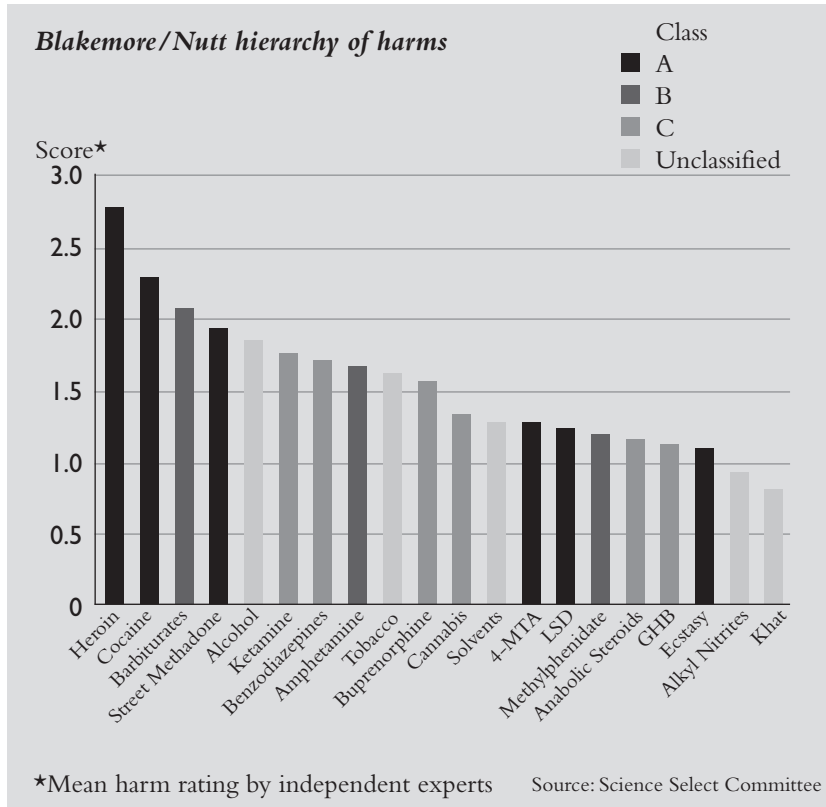
- 1 *Physical harms*, which include (i) a substance’s acute toxicity; (ii) its chronic toxicity; and (iii) its ability to be ingested by the more rapid and dangerous means of injecting and smoking rather than swallowing.
- 2 *Likelihood of dependence*. This includes (iv) the intensity of pleasure derived; (v) psychological withdrawal symptoms; and (vi) physical withdrawal symptoms.
- 3 *Social harms*, which include (vii) the damage done to others by drug users’ intoxication; (viii) the likely healthcare costs of drug misuse; and (ix) ‘other social harms’ such as child neglect, acquisitive crime and the erosion of family relationships.

Each drug is scored on a four-point scale, with a 3 in any category suggesting that it poses an extreme risk, 2 a moderate risk, 1 some risk and 0 a negligible risk, and the overall harm rating is then achieved by taking the mean of all nine scores. Heroin, for example, has an overall rating of approximately 2.8, the highest of any drug, scoring 3 for dependence and between 2 and 3 for both physical and social harms. Ecstasy has a rating of around 1.2, scoring not much more than 1 (“some risk”) in any category.

Applied to twenty of the most commonly used drugs, the Blakemore/Nutt matrix has produced a hierarchy of harms that

differs in some conspicuous respects from the one implied – and legally enforced – by the current classification system.⁶⁸³

⁶⁸³ Since the chart's publication in this form in 2006, methamphetamine has been classified as Class A.



Most obviously, the authors of the harms hierarchy have chosen to include the legal drugs alcohol and tobacco, taking the view that it is illogical to omit from any reckoning of harms the two substances that cause more damage to human health than all the other drugs put together. The two most harmful drugs according to this ranking (heroin and cocaine) are illegal and in Class A, and the two least harmful ('poppers'/amyl nitrites and khat) are legal; but in between those extremes the ordering of substances is very different from that in the current classification system. Alcohol – which of course does not feature in the Misuse of Drugs Act at all – is ranked as being more dangerous than amphetamines, cannabis, ecstasy, ketamine and GHB, all illegal. Cannabis is ranked as less dangerous than the tobacco with which it is usually smoked. Of the eight substances rated as least harmful, three (ecstasy, LSD and 4-methylthio-amphetamine) are currently in Class A, though on the Blakemore/Nutt ranking they are less harmful than glues and lighter fuels that can be bought in most tobacconists.

Alcohol and tobacco

Like the Blakemore/Nutt hierarchy above, the harms index that we propose would include alcohol and tobacco. Equally, the gradient of offences would incorporate the considerable body of law that already exists regulating the manufacture, sale and use

of alcohol and tobacco: driving under the influence, supplying to people who are already intoxicated, selling to children, using in a confined space and so on. By including alcohol and tobacco as familiar benchmarks against which to judge the absolute harms of other drugs, the index would locate drug taking quite precisely on a spectrum of health choices alongside drinking, smoking and taking tranquillisers. The index would also include steroids, volatile substances such as glues, solvents and aerosols, prescription drugs such as benzodiazepines, ‘legal highs’ like *salvia divinorum* and piperazines, and the many over-the-counter medicines that are susceptible to abuse.

If alcohol and tobacco are to be included in the harms index, should alcohol and tobacco therefore be regulated in the same way as every other substance listed in the index? Law makers starting with a blank sheet would find themselves obliged, if they adhered strictly to the index, to penalize a wider range of offences related to alcohol and tobacco and to punish them more severely than they are punished at the moment. The Blakemore/Nutt calculations suggest that the harms they cause would place both of them relatively high up the harms index – alcohol, for instance, would be likely to appear in the top six most harmful substances – with the consequence that a consistent application of our penalty system would lead to the supply and use of alcohol being viewed as seriously as the supply and use of, say, ketamine and more seriously than the supply and use of amphetamines.

Social attitudes to smoking have already changed significantly under the influence of health warnings, bans on advertising and restrictions on smoking in public places, and there are signs that attitudes to heavy drinking are also likely to alter when subjected to the same kinds of pressures, particularly when these pressures are reinforced by rises in price. At the same time, among some younger age groups at least, the recreational use of ‘soft’ drugs is increasingly viewed in very much the same light as drinking alcohol or smoking tobacco. To some extent, public attitudes are thus converging, becoming less tolerant of alcohol and tobacco and more tolerant of some drug use. The time may come when it will seem illogical to regulate alcohol and amphetamines differently, and the tendency may be to regulate alcohol more strictly rather than to regulate amphetamines less strictly. But for the time being the cultural roots of drinking and smoking are too deep for this to be practical. Fully conscious of being moved by pragmatism rather than rigorous logic, the Commission does not recommend that alcohol and tobacco should be regulated as strictly as their objective harmfulness might seem to indicate.

That being so, it would be necessary within the new legal framework to limit the number of offences that would be considered applicable to alcohol and tobacco. Alcohol and tobacco would have to be specifically exempted from consideration under many of the offences listed in the schedule to the new Misuse of Substances Act. 'Small-scale dealing involving substances in the range of 4-6 on the harms index', for example, would have to be amended to read 'Small-scale dealing involving substances in the range of 4-6 on the harms index, with the exception of alcohol'. Nevertheless, including drugs that are currently legal in the harms index to constitute a benchmark, and incorporating offences related to them in the same overall catalogue, that is, providing for them to be regulated within the same legal framework and by the same agencies as other drugs if under a different set of conditions, would be a means of confronting more honestly the inconsistencies and apparent double standards in our attitudes to different forms of substance use and abuse. It is this inconsistency that undermines much otherwise valuable prevention work.

⁶⁸⁴ 'Business Ethics and Company Law',
Institute of Business Ethics,
http://www.ibe.org.uk/teaching/new_be_law.htm

We are clear that the harms index should not form an integral part of the new Act itself. Putting some distance between the Act and the harms index allows more freedom for individual drugs to move up or down the index in response to new evidence without each move requiring a full-blown change to the Act. The index could stand in the same relation to the Act and the penalty system as sentencing guidelines currently do. Courts already take account of the circumstances of individual cases when deciding on sentences, assisted by guidelines that set out the various factors that may be relevant. Under the new framework, prosecutors and sentencers would use the harms index to determine the gravity of any particular offence and thus the severity of the penalty. Attitudes to drugs and drug users still vary considerably between judges and magistrates, and an objective tool like a harms index would be a means of achieving greater consistency in sentencing.

The index could have the same kind of quasi-legal status as the Highway Code, which is not itself law but is taken into account by the courts when they are dealing with offences under the Road Traffic Acts. Another quasi-legal model would be the 'Combined Code' on corporate governance that was drawn up by the Hampel Committee in 1998. The Code was attached to the listing rules of the stock exchange with the requirement that, in order to be listed, companies must either declare their adherence to its provisions or explain any deviation from them: what is now called the 'comply or explain' approach.⁶⁸⁴ Without itself being

part of the new Act, the harms index could be recognized in a similar way as part of an overall regulatory framework.

It will be essential for the substances harms index to be in the public domain, preferably publicized as well as the Highway Code, in order to comply with human rights legislation which states that everyone must be able to understand what constitutes an offence and what the punishment for that offence will be. The statute would make it clear what constituted an offence and the schedule would set out the precise offences with the associated range of penalties. It would be the index, with its matrix of harms, that would make it possible to identify the offence that has been committed and the penalties that are appropriate. For the sake of clarity, however, the index should be supplemented by a table or regulatory ‘map’ setting out how each substance on the index is currently regulated.

Both the index and the table should be regularly updated to reflect changes in the evidence relating to the relative harmfulness of substances and consequent changes in the penalties attached to offences involving these substances, as well as to reflect the development of new substances. We believe strongly that this updating should be rooted in a regular review of all of the substances on the harms index. Professor Nutt has suggested that a five-year review cycle would be appropriate.⁶⁸⁵ If the Advisory Council on the Misuse of Drugs does not currently have the research capacity to conduct a review on this scale, then such a capacity should be created.

It is beyond our competence to draft the harms index or to prescribe in detail how each and every substance should be regulated, and we have not attempted to do so.

Instead, we provide here an example of a matrix for constructing a harms index with the aim of suggesting a method by which those who do have the appropriate expertise might create an authoritative index. The matrix below is based on the existing Blakemore/Nutt matrix. It sets out each of the categories of harm that a substance might cause. For the sake of illustration, we have given very rough and ready indications of the harms associated with a number of substances.⁶⁸⁶ To complete the process of generating the harms index, these general indications – high addictiveness, risk of adulteration, associations with crime, etc – would need to be translated into numerical scores based on expert assessments of the severity of the various harms caused. Each mean score would help to determine the ranking of each substance on the harms index.

⁶⁸⁵ Science and Technology Committee, *Drug Classification: Making a Hash of It? – Follow-Up*, evidence session with Vernon Coaker MP, Professor David Nutt and Professor Sir Michael Rawlins, 22 November 2006.

⁶⁸⁶ It is beyond the scope of this report to summarise the evidence on the harmfulness of these substances. The evidence is particularly hotly disputed in the case of cannabis. In giving rough assessments of its physical and psychological harmfulness, addictiveness etc., we have been guided primarily by the ACMD risk assessments referred to by Professors Nutt, Blakemore and colleagues in their paper ‘A rational scale for assessing the risks of drugs of potential misuse’ (unpublished) and by the recent Beckley Foundation publication ‘Cannabis and mental health: responses to the emerging evidence’ (2006), which is a review of the evidence not only in Britain but worldwide.

Matrix

	Physical harm Acute	Physical harm Chronic	Physical	Addictive? Psychological	Injected?	Polydrug?	Alcohol?	Purity?	Health costs (other than those related to deaths through overdose)	Crime	Sex	Other potential harms
Heroin	High	High	High	High	Yes	Yes	Yes	Yes	HIV, Hepatitis B and C	Yes	No	Family breakdown Child neglect
Alcohol	Yes	Yes	Yes	Yes	No	Yes	n/a	No	Liver failure, cancer, cirrhosis	Yes	Yes	Domestic violence Bingeing and public disorder Drunk driving Suicide Date rape
Tobacco	No	Yes	High	Yes	No	Yes	Yes	No	Cancer, heart and respiratory disease	No	No	Smoke pollution
Cannabis	Low	Low	Low	Moderate	No	Yes	Yes	Yes	Possible associations with long-term mental health problems	Possibly	Possibly	Lack of concentration Drug-driving

Physical harm: the distinction made here is between acute toxicity, which determines the risk of death or immediate and severe symptoms following an overdose, and chronic toxicity, which causes health harms over the long term.

Addictive: the distinction here is between physical dependence (broadly defined as including a growing tolerance resulting in the need to take ever larger doses to achieve the same effect and the appearance of characteristic withdrawal symptoms if the drug is suddenly discontinued) and psychological dependence, the need to continue taking the drug for the pleasurable effects resulting from its action on the brain's chemical systems.

Polydrug?: the question is whether the substance is commonly used in potentially dangerous combinations with other drugs.

Alcohol?: is the substance commonly used in a potentially dangerous combination with alcohol?

Purity?: are there risks from adulteration of the substance or fluctuating degrees of purity?

Health costs: does the use of the substance risk producing health impacts that will prove costly to the health system? Only the major impacts are listed.

Crime: is the use of the substance associated with criminal behaviour of any sort?

Sex: is the use of the substance associated with risky sexual behaviour of any sort?

Using the harms index

Basing the regulation of drugs on a harms index would present ministers and other policymakers with a range of new options when it came to the regulation of existing or new drugs.

How it might work for heroin

In the case of heroin, for example, its likely position at the top of any hierarchy of harms would virtually rule out any relaxation of the law relating to its supply. The production, manufacture, import, distribution and sale of heroin would almost certainly remain illegal and subject to the strictest penalties. Various questions might arise, however, over the possession of heroin for personal use and whether this should remain illegal.

The point of centring a legal framework on a harms index is obviously to seek to reduce the harms caused. Policymakers contemplating heroin's position at the head of a harms index would need to consider whether continuing to treat the possession of heroin for personal use as a criminal offence causes more harm than it prevents. Should personal possession of heroin be made legal? Should it remain illegal but be punishable only by civil penalties? Should it remain illegal but with those found guilty of possession required to undergo treatment?

On the one hand, making the possession of heroin legal would make it easier to identify and approach users with a view to persuading them to stop, or to reduce their use, or at least to minimise the harms associated with it. Legalizing possession would have the effect of removing one burden – the threat of criminal sanctions – from a group of people many of whose lives are already chaotic. Most agencies – including many within the police and prison services – would agree that there is little to be gained from punishing drug addicts by subjecting them to a prison environment. Drugs are readily available in prison, any efforts individuals may have been making on the outside to seek treatment or to maintain family relationships are disrupted, and the likelihood of their reintegration into society becomes ever more remote as they become increasingly stigmatized.

On the other hand, making it legal to buy and possess heroin while keeping production and supply illegal incorporates a basic inconsistency: for a condoned act to take place, a criminal one must already have been committed. Legalizing possession would make it harder to identify and punish supply offences without introducing the type of 'thresholds' for personal

possession that have recently been abandoned as impractical. Outright legalization would undoubtedly encourage suppliers to market their wares more aggressively, and, although it seems unlikely, it could have the effect of increasing significantly the number of those who use heroin.

One possibility that policymakers might consider would be to replace criminal penalties with administrative ones in order to avoid imprisoning or giving criminal records to drug users who have committed no other offence. That said, it is rare for drug users, even heroin users, to be sent to prison merely for possession. More usually, if they are imprisoned, it is for crimes they have committed to finance their habit – or, indeed, for non-payment of the fines that magistrates have imposed precisely in order to avoid imposing a custodial sentence.

How it might work for cannabis

Cannabis is likely to fall roughly in the middle of any harms index. Concerns over the age at which people are starting to use it, the levels at which some people use it, the wider availability of stronger forms of the drug, the frequent adulteration of what is sold on the street and the intensifying debate around its possible long-term links with mental illness, all indicate that cannabis should continue to be controlled. But its position on the harms index several places below both alcohol or tobacco suggests that the form this control takes might have to correspond far more closely with the way in which alcohol and tobacco are regulated.

In this connection, it is worth noting that cannabis is often most harmful when combined with alcohol and tobacco. Significant numbers of people are believed to drive under the combined influence of cannabis and alcohol, which is more dangerous than driving under the influence of either on its own. Smoking cannabis with tobacco (which helps burning) can promote tobacco use, which in turn, because tobacco is strongly addictive, increases the likelihood of cannabis dependence. Those who depend on both substances are harder to treat successfully for either. In addition, tobacco's health impacts are on the small airways of the respiratory system while cannabis primarily affects the large ones, with the result that the combining of the two is apt to cause more serious lung problems

Aligning the control system for cannabis more closely with the control system for alcohol and tobacco would help to remove a discrepancy that has done more than anything else to undermine the credibility of drugs policy over the last fifty

years, with cannabis users penalized and the users, producers and retailers of alcohol and tobacco left comparatively free.

If the harms index suggested a change in regulation was appropriate, ministers and other policymakers would need to consider some possible options. First, they would have to consider whether the large-scale production and distribution of cannabis might be licensed along the same lines as the controls applied to the production and sale of alcohol and tobacco, with careful quality controls and restrictions on when, where and to whom cannabis might be sold and with stricter penalties for unlicensed production and supply on any scale. Second, ministers would have to consider whether the small-scale growing of cannabis for personal use – like the making of home-made beer or wine – might be legalized, as it is, for example, in some Australian states. Finally, ministers would have to consider whether the possession of cannabis for personal use and so-called social supply might become legal, with the same kinds of restrictions as apply to the possession of alcohol and tobacco.

Licensing the production of cannabis would make it possible to control the strength and the quality of a substance for which there is likely to be a large and continuing demand. It would produce revenue that could be ploughed back into prevention and treatment. At the same time, exerting this kind of control over the supply of cannabis might have the effect of largely detaching it from the illegal market for drugs ranked far above it on the harms index. On the other hand, the existence of a legitimate market would be no guarantee that the illegal market would disappear, and the end result might simply be the multiplication of the sources of supply.

Legalizing the possession of cannabis would place it on the same footing as substances – alcohol and tobacco – that are used by large numbers of people in very much the same ways, in much the same social settings and for much the same reasons as cannabis. On the other hand, the mere possession of cannabis in practice is almost never severely punished, and there may be no need to take a controversial step that would be widely construed as condoning or encouraging the use of a substance that has the potential to cause harm: being less harmful than alcohol or tobacco does not make cannabis harm-less.

Indeed, the case for using the law to discourage more effectively people's use of alcohol and tobacco is at least as strong as the case for legalizing the possession of cannabis. If alcohol, tobacco and cannabis are to be brought more closely into line in the eyes

of the law, then perhaps the move ought to be in the direction of making alcohol and tobacco possession more difficult rather than in the direction of making the possession of cannabis easier.

The harms index, with its supporting matrix and map, would be a tool for every agency responsible for implementing a new drugs strategy. It could and would be used in connection with treatment, education and other kinds of prevention and discouragement as well as in policing and sentencing. With a means of calculating more precisely how much or how little harm an individual drug offence had caused, magistrates and judges would be able more easily to apply appropriate penalties, and, with a shared but independent reference of this sort to hand, there would be less scope for personal prejudice. Police services could use the index to prioritize their efforts to reduce the harms caused by drugs, much as the Metropolitan Police plans to use its Criminal Networks Prioritisation Matrix to target its operations against organized criminal networks. Treatment services could use it to help drug users set their own behaviours in context. Teachers, drugs workers and those responsible for public information campaigns would have a comprehensive source of up-to-date information, one that their audiences might actually take seriously – the more so if the index included alcohol and tobacco as points of reference. Policy makers and politicians would be able to point to an objective assessment of a drug's harmfulness to justify a change in the way it was handled, and drugs policy might even be taken to a considerable extent beyond the reach of partisan politics and media hysteria.

Concluding reflections

One of the themes of this report has been the need to shift drugs policy away from its current focus on crime reduction and the criminal justice system and onto a concern with drugs as posing a much more varied and complex set of social problems. Drugs in our society are not just about crime; they are about individual health, public health, family life and the health and well-being of entire communities. It cannot be good for the UK that it is currently the drug-using centre of Europe.

Nevertheless, although we want to shift the focus of policy, we are certainly conscious that drugs and crime are intimately interrelated and that a principal aim of any civilized drugs strategy must be to reduce the amount of crime, especially violent crime, related to drugs. Harm reduction certainly includes crime reduction. Under this heading, we would

want to emphasize two points. The first is that, in our view, the principal preoccupation of the police should be with the fight against organized crime; the focus of police work should be on the disruption of the criminal networks that profit hugely from the sale of drugs and have a monetary interest in ensuring that drugs, including dangerous drugs such as heroin and cocaine, are widely marketed.

The second point we would want to emphasize is that the overall approach advocated in this report, even if it were to prove only modestly successful, would almost certainly have the effect of reducing crime. There is no contradiction between providing a wide range of educational, treatment and other services and reducing crime. On the contrary, the best way to reduce crime is almost certainly to focus precisely on providing such services. Someone who has been made aware of the risks of taking drugs, or who is in appropriate treatment, or who has been properly housed, or who has been assisted in putting his or her family life back together, or who has been helped to find a job, is much less likely to commit crimes than someone who has not had support of this kind. Everything we know about the incidence of problematic drug use shows beyond any doubt that people who are emotionally, socially and economically deprived are far more likely both to abuse illegal drugs and to commit criminal offences related to drugs than those who are not. It follows that the best drugs policy may not be a ‘drugs’ policy at all but, instead, a range of policies designed to address the use of drugs in their wider social setting.

In this report, we have focused mainly on illegal drugs and to a lesser extent on alcohol and tobacco. But we need to make it clear that, although we have said little about legal drugs, we believe that many of them can be as problematic as illegal drugs, alcohol and tobacco and, for that reason, should be brought within the remit of a new Misuse of Substances Act. Over-the-counter drugs and prescription drugs, like solvents, can be, and are, frequently misused and abused. Some over-the-counter drugs and some prescription drugs are highly addictive, and many can be used in ways that harm those who use them and those around them. We are also conscious that in this report we have focused mainly on drugs and other psychoactive substances that already exist. But we are acutely conscious that new drugs – potentially harmful as well as beneficial – are coming onto the market all the time. One of the reasons we advocate the passage of a new, more flexible Misuse of Substances Act is to minimize the risk that harmful new drugs and other substances will, so to speak, slip under governments’ radar. The Advisory Council on the Misuse

of Drugs or some similar independent body needs to be given a significantly augmented role for the same reason.

It goes without saying that many of the practical measures proposed in this report will cost money. Additional staff may be needed, and many of those already working in the field need additional training. We would, in an ideal world, have liked to provide a rough estimate of what the total bill will be. But that was beyond our competence and resources. However, what should be clear is that public spending along these lines would almost certainly be, even in purely financial terms, cost-effective. At the moment, huge amounts of money are wasted on education that does not educate, on efforts at interdiction that fail to interdict, on police work that moves problems on rather than solving them, on coordination that fails to coordinate, on the meeting of wholly inappropriate targets and, not least, on banging up in prison people whose incarceration, often for very short periods, costs a fortune, benefits neither them nor society and is likely to increase rather than diminish the chances of their re-offending. No one has ever counted the amount of money wasted in these and a myriad other ways. It has never been in anyone's interest to do so. Even if it were in someone's interest, it would probably be impossible to do so. But it is hard to believe that the large amounts of the money that is wasted could not be better spent.

This Commission was established in large part because those of us who initiated it were conscious that politicians in all parties – perfectly understandably from their point of view – run scared on almost everything to do with drugs. No one wants to be seen as 'soft' on drugs. Illegal drugs and the people who use them are demonized. The press retails, sometimes with evident relish, horror stories of drug-related deaths, conveniently overlooking the far larger number of drink- and tobacco-related deaths. It is a curious but significant fact that no government in the past hundred years has dared to commission a wide-ranging inquiry into drugs and drugs policy. There is nothing in it for ministers; the downside risks of being seen to commission such an inquiry seem to them to be too great, especially as any inquiry would be bound to recommend major changes.

In fact, however, the large-scale survey of the general public that we commissioned from the polling organization YouGov suggests that ministers and other political leaders have more room for manoeuvre than they think they have, that the general public knows more about drugs and is readier to contemplate changes in the laws relating to drugs than most politicians realise. Some of the survey's more significant findings are included as an appendix

to this report. The survey reveals that almost no one believes that drugs can be eliminated entirely from our society. It also shows that a large majority of people believe sharp distinctions can be drawn between, on the one hand, so-called hard drugs such as heroin and, on the other, so-called soft drugs such as cannabis and, moreover, that public policy should also distinguish sharply between the two. A majority not only support the downgrading of cannabis from Class B to Class C but go further and believe the mere possession of cannabis for personal use should no longer be treated as a criminal offence. Perhaps most significant of all is the fact that roughly two-thirds of people believe that people who use illegal drugs but who have not committed any other crime 'should be treated as people who may need medical treatment and other forms of support' rather than as criminals who should be brought before the courts. Our view, in short, is that ministers' and other political leaders' caution in handling the issue of drugs is perfectly understandable but also somewhat excessive.

As we finish work on this report, we are conscious that whatever we have accomplished constitutes, at most, a beginning. We as a Commission will remain in being to take part in the debate about the future of drugs policy that we hope we succeed in provoking. We hope to put into practice some of the specific ideas contained in our report. But we are well aware that it will be up to others – mostly ministers, officials and people in local government and the voluntary sector – to build on the foundations that we hope we have laid. In particular, we urge ministers to set in train work on a new Misuse of Substances Act and to undertake with urgency the task of reorienting drugs policy and redirecting it towards a broader conception of harm prevention and reduction. As we said in the Introduction, current policy is broke and needs to be fixed. Needless to say, we hope that leading figures in the opposition parties will support the redirection of policy that we propose and, while subjecting the detail of any proposed changes to rigorous scrutiny, will resist the temptation to score points off ministers who will, after all, be undertaking a difficult task. Reforming drugs policy is already, politically, a thankless task. It should not be turned into a politically suicidal task.

One thing should be clear, to whomever is involved. This is not a field in which there are magic bullets, quick fixes or instant solutions. Reducing the amount of harms that drugs cause will take a long time, and there will be false starts and undoubtedly, from time to time, disasters along the way. Everyone involved will be in for a long haul. But, if by, say, 2010 or 2020 the abuse of drugs is no longer the blight on our society that it is now, it will have been worth it.

Appendix

RSA/*The Daily Telegraph* YouGov survey on the attitudes of the general public towards drugs and drug use

On behalf of the RSA Commission, YouGov elicited the opinions of 2,938 adults across Great Britain online between 21 and 26 June 2006. The data have been weighted to conform to the demographic profile of British adults as a whole. YouGov abides by the rules of the British Polling Council.

Full details of the survey's findings can be found on the Commission's website at www.rsadrugscommission.org. Only a portion of the findings have been set out below. All of the numbers in the tables are percentages of the total sample.

Which of the following do you think is the more realistic view?

	All respondents	Born before 1945	Born 1945-60	Born after 1960
It is possible to eliminate drugs completely from our society: that is, to stop everyone or almost everyone from using drugs	7	7	6	8
Whether we like it or not, there will always be people who use drugs, and the aim should be to reduce the harm that they cause themselves and others	89	91	91	86
Don't know	4	3	3	6

From what you know, which of the following do you think causes the most serious harm to the largest number of people and their families? And which causes the next most harm? (The percentages combine the results of the answers to both questions.)

	All respondents	Born before 1945	Born 1945-60	Born after 1960
Consuming alcohol	78	76	77	80
Smoking tobacco	60	50	56	60
Taking illegal drugs	55	70	60	48
Don't know	6	4	6	7

At the moment different illegal drugs are classified from A to C, roughly according to how much harm they are thought to cause individuals and society. For the guidance of the public, do you think different alcoholic drinks and different forms of tobacco should be classified in the same way?

	All respondents	Born before 1945	Born 1945-60	Born after 1960
Yes, they should	62	60	66	61
No, they shouldn't	29	33	28	29
Don't know	9	7	6	11

Thinking only of what are sometimes called 'hard' drugs, such as heroin and cocaine, which one of the following statements comes closer to your own view?

	All respondents	Born before 1945	Born 1945-60	Born after 1960
It is possible for some people to use 'hard' drugs quite safely, without doing themselves and those around them any more harm than drinking alcohol or smoking in moderation	17	12	11	21
Using 'hard' drugs almost always causes a lot of harm to the users and those around them – more harm than is caused by drinking alcohol or smoking in moderation	76	81	83	70
Don't know	7	6	6	9

Same question but asked only about what are sometimes called ‘soft’ drugs, such as cannabis.

	All respondents	Born before 1945	Born 1945-60	Born after 1960
It is possible for some people to use ‘soft’ drugs safely, without doing themselves and those around them any more harm than drinking alcohol or smoking in moderation	64	50	61	71
Using ‘soft’ drugs almost always causes a lot of harm to the users and those around them – more harm than is caused by drinking alcohol or smoking in moderation	28	43	31	22
Don’t know	7	7	8	6

From what you know, which one of the following statements about so-called ‘hard’ drugs, such as heroin and cocaine, comes closest to your own view?

	All respondents	Born before 1945	Born 1945-60	Born after 1960
A majority of those who use ‘hard’ drugs never become involved in other crimes at all	4	2	3	6
A majority of those who use ‘hard’ drugs become, as a result of using the drugs, involved in committing other crimes	72	78	77	66
A majority of those who use ‘hard’ drugs are the sorts of people who would become involved in committing other crimes even if they did not use these drugs	13	12	9	16
Don’t know	11	8	10	12

Same question but asked only about so-called ‘soft’ drugs such as cannabis.

	All respondents	Born before 1945	Born 1945-60	Born after 1960
A majority of those who use ‘soft’ drugs never become involved in other crimes at all	43	35	40	47
A majority of those who use ‘soft’ drugs become, as a result of using the drugs, involved in committing other crimes	30	42	33	25
A majority of those who use ‘soft’ drugs are the sorts of people who would become involved in committing other crimes even if they did not use these drugs	11	11	9	12
Don’t know	16	13	18	15

Thinking about ‘hard’ drugs, such as heroin and cocaine, which one of the following statements comes closest to your own view?

	All respondents	Born before 1945	Born 1945-60	Born after 1960
Not only the sale of ‘hard’ drugs but the possession of them for personal use should remain a criminal offence as now	73	82	78	67
The possession of such drugs for personal use should remain illegal but should be regarded as a lesser offence, like speeding or parking illegally, rather than a criminal offence	17	11	15	20
The possession of such drugs for personal use should no longer be illegal	6	4	5	7
<i>% saying possession for personal use should no longer remain a criminal offence as now</i>	23	15	20	27
Don’t know	5	2	3	7

Same question asked about 'soft' drugs, such as cannabis, but with different options.

	All respondents	Born before 1945	Born 1945-60	Born after 1960
Both the sale of 'soft' drugs and possessing them for personal use should be treated as criminal offences	38	51	37	34
Selling such drugs should remain a criminal offence as now, but possessing them for personal use should be regarded as a lesser offence, like speeding or parking illegally	30	29	33	28
Selling such drugs should remain a criminal offence as now, but possessing them for personal use should no longer be treated as an offence at all	13	11	12	14
Both the sale and the possession of 'soft' drugs should no longer be against the law: they should both be legalized	15	8	13	18
<i>% saying possession for personal use should be treated as a lesser offence or not treated as an offence at all</i>	58	48	58	60
Don't know	5	2	5	6

Suppose people use illegal drugs but have not committed any other crime. In your opinion, should such people be treated as criminals and brought before the courts, or should they be treated as people who may need medical treatment and other forms of support?

	All respondents	Born before 1945	Born 1945-60	Born after 1960
They should be treated as criminals and brought before the courts	30	36	31	28
They should be treated as people who may need treatment and other forms of support	62	63	63	62
Don't know	7	1	6	10

People often talk about treatment in connection with drugs. From what you know how effective do you think treatment can be?

	All respondents	Born before 1945	Born 1945-60	Born after 1960
With proper treatment and support, even confirmed drug users can be weaned off drugs so that they become and remain clean	42	37	40	46
With proper treatment and support, confirmed users can start to lead more normal, crime-free lives even if they are not entirely free of drugs	37	40	39	34
Even if they are given proper treatment and support, it is virtually impossible for confirmed users to lead normal lives or become free of drugs	9	11	9	8
<i>% saying 'treatment works'</i>	79	77	79	80
Don't know	12	12	12	12

In the case of heroin users who do not respond to other forms of treatment, which of the following do you think is the more appropriate course of action?

	All respondents	Born before 1945	Born 1945-60	Born after 1960
Doctors should be encouraged to prescribe maintenance doses of methadone or possibly even heroin so that the user's health can be monitored and he or she is less likely to steal in order to get money to pay for drugs	48	49	51	45
Doctors should not be encouraged to prescribe maintenance doses of any substance and the heroin user should be brought before the courts and either fined or required to undergo additional treatment	36	39	34	36
Don't know	17	12	16	18

If one or more drugs were either ‘decriminalized’ or legalized completely, what do you think would be the effect on the number of people using those drugs?

	All respondents	Born before 1945	Born 1945-60	Born after 1960
Many more people would use those drugs than now	30	40	33	24
Some more people would use them than now	32	33	31	32
Only a few more people would use them	21	15	19	25
No more people would use them	9	6	9	11
Don’t know	8	5	8	9

If drugs were either decriminalized or legalized, what do you think would be the effect on the number of street crimes and burglaries associated with drugs? Would the number of such crimes...?

	All respondents	Born before 1945	Born 1945-60	Born after 1960
Fall sharply	10	9	11	10
Fall a little	20	17	17	22
Neither increase nor fall	27	28	26	26
Increase a little	13	11	13	13
Increase sharply	18	27	20	14
Don’t know	13	9	11	15