The Phoney War on Drugs

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SUMMARY

- The Government has repeatedly declared that it is fighting a War on Drugs. The data presented here show that this is a Phoney War.

- It is currently spending £1.5 billion a year on its drugs policy. Yet enforcement of drugs laws is weak and underfunded, while treatment policy is counter-productive.

- The UK drug problem is the worst in Europe. The UK has one of the highest levels of recreational drug use. There are over ten Problem Drug Users (PDUs) per 1,000 of the adult population, compared to 4.5 in Sweden or 3.2 in the Netherlands.

- The UK has one of the most liberal drug policies in Europe. Both Sweden and the Netherlands (despite popular misconceptions) have a more rigorous approach.

- The UK faces a widening and a deepening crisis. Over the last 10 years, Class A consumption and 'problem drug use' have risen dramatically, drug use has spread to rural areas and the age of children's initiation into drugs has dropped. 41% of 15 year olds, and 11% of 11 year olds, have taken drugs.

- Drug death rates continue to rise and are far higher than the European average. The UK has 47.5 deaths per million population (aged 15 to 64) compared to 22.0 in Sweden and 9.6 in the Netherlands.

Government policy

- The election of the Labour Government in 1997 marked a new direction for drug policy. It developed a "harm-reduction" strategy which aimed to reduce the cost of problem drug use.

- The focus was switched from combating all illicit drug use to the problems of PDUs. Cannabis was declassified. Drug misusing youngsters were now to be "supported" by various agencies. Spending on methadone treatment increased threefold between 2003 and 2008.

- The aim of treatment for drug offenders was no longer abstinence but management of their addiction with the aim of reducing their reoffending. In practice, this meant prescribing methadone.

- Government targets were imposed on new quangos such as the National Treatment Agency in an attempt to increase the numbers of PDUs in treatment (which for most people meant methadone prescription).

- Of the 200,000 addicts currently in treatment, only 6,700 have undergone in-patient treatment (ie short detoxification stays), and only 4,300 have had residential rehabilitation.

- A Drug Intervention Programme was introduced to direct those guilty of drugs-related offences (ie acquisitive crime such as shop-lifting) into treatment (again, this meant in

practice prescribing methadone). There is little evidence that this has been effective.

- This harm-reduction approach has failed. It has entrapped 147,000 people in state-sponsored addiction. Despite the £10 billion spent on the War on Drugs, the numbers emerging from government treatment programmes are at the same level as if there had been no treatment programme at all.

Weak enforcement and prevention

- The UK drugs market is estimated to be worth £5 billion a year.

- In comparison, the Government is spending only £380 million a year – or 28% of the total drugs budget – attempting to control the supply of drugs (over £800 million is spent on treatment programmes and reducing drug-related crime). Only five boats now patrol the UK's 7,750 mile coastline.

- The numbers of recorded offences for importing, supply and possession of illicit drugs have all fallen over the last 10 years.

- At the same time, seizures of drugs have fallen and drug prices have dropped to record low. The quantity of heroin, cocaine and cannabis that has been seized coming into the UK has fallen by 68%, 16% and 34% respectively .

- It is now accepted (even by the Government) that SOCA, the new agency established in 2006 to confront the drugs trade, has been a failure.

An alternative

- Both Sweden and the Netherlands have far more coherent and effective drugs policies. These are based on:
  - the enforcement of the drug laws;
  - the prevention of all illicit drug use;
  - the provision of addiction care.
- All of these principles have been lost sight of over the last 10 years in the UK.
- While the UK spends the majority of its drug budget on its so-called treatment programmes, both the Netherlands and Sweden spend most of their drugs budget on prevention and enforcement. Their drugs problems are a half and a third of the size of the UK respectively.
- Labour's War on Drugs has not, despite the rhetoric to the contrary, been fought. It has been a Phoney War – and an expensive failure.
- A successful UK drug policy would:
  - focus on the illicit use of all drugs, not the harms caused by drug use;
  - abandon the harm reduction approach;
  - develop treatment support aimed at abstinence and rehabilitation;
  - include a far tougher, better-funded enforcement programme to reduce the supply of drugs.

1. THINGS HAVE ONLY GOT WORSE

> "Trae-blue Lane had just turned three when she died from an overdose of methadone, the heroin substitute supplied to her mother… Rio Ross was found dead clutching a Winnie the Pooh toy in July 2007. An inquest found the fourteen month old baby died from an overdose of heroin, cocaine and methadone."[1]

The UK drug problem is the worst in Europe. The UK leads in 'recreational' drug use with the highest levels of cocaine, ecstasy and amphetamine consumption. It has over ten Problem Drug Users (PDUs) for each thousand of the adult population, a rate that is three times higher than in the Netherlands where there are only 3.2 PDUs per thousand. It is more than double the rate in Sweden which has 4.5 per thousand (a figure which includes amphetamine use).[2]

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1 *The Sunday Telegraph*, 11 January 2009.

2 Problem Drug Users in the UK are defined as those addicted to heroin, opiates and crack cocaine. Data for PDUs from The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), *Statistical Bulletin*, 2008.

SWEDEN AND THE NETHERLANDS

Throughout this report, UK drug use is compared with that in the Netherlands and Sweden. These countries have been chosen because they have adopted drug policies that are markedly different to those of the UK and their drug use is lower. Both the Dutch and Swedish Governments put a greater emphasis on law enforcement and prevention.

It is noteworthy that, despite the perception that the Netherlands has a liberal drugs policy, 76% of Dutch municipalities now operate local zero tolerance drug policies.[3] Coffee shops are now increasingly tightly regulated and policed. A third have been closed in recent years.

The latest estimate of the number of PDUs in the population is over 328,000, for England alone.[4] In 1996, just 43,400 addicts were notified to the Home Office. In 1998 the Home Office's working assumption was that the problem drug using population was three times this number at around 130,000.[5] Since then the number of problem drug users has gone up by two and half times.

It is also a widening crisis. In the last ten years, the gender gap in drug use has diminished, drug use has spread to rural areas, children's age of initiation into drugs has dropped and cocaine, the drug of ascendancy, has become despite its dangers, all but socially acceptable.

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3 B Bieleman et al, *Coffeeshops in Nederland*, 2008.

4 G Hay et al, *National and regional estimates of the prevalence of opiate use and/or crack cocaine use 2006/7: a summary of key findings,* Home Office, November 2008.

5 M Edmunds et al*, Arrest Referral – Emerging lessons from research,* Home Office, 1998.

Drugs and children

> "A Channel 4 Freedom of Information request found that between 2005 and 2006 police caught more than 6,000 children selling drugs from Class A substances to cannabis and caught a further 53,497 in possession of drugs, with children as young as nine."[6]

The deaths of Trae Blue and Rio Ross are small windows on the world of Britain's worsening and chaotic drugs culture which Labour's drug policy has, inadvertently, promoted. Consider these trends:

- The number of babies born to drug-addicted mothers (dependent on heroin or other opiates) has almost doubled in recent years. In 2006/7, 1,970 women were addicted to drugs at the time of the birth of their children, compared to 1,057 just four years before in 2002/3.[7]

- In Scotland the rate of maternities recording drug misuse more than doubled from 4.6 per 1,000 maternities in 2000/01 to 9.4 per 1,000 maternities in 2004/05.[8]

- The number of children of addicts in England was estimated in 2002 at between 200,000 and 300,000 with a further 41,000 to 59,000 in Scotland.[9]

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6 Channel 4 News online, 15 September 2006.

7 These figures were obtained by Norman Lamb MP from Public Health Minister Dawn Primarolo MP, See Hansard, Written Answers, 3 April 2008, cols 1293W and 1294W.

8 Drug Misuse Statistics Scotland, *Statistical Publication Notice,* 19 December 2006.

- These children are at high risk of neglect, chaotic routine, absence from schooling, exposure to parents' drug use and criminality as well as the risk of an early introduction to drugs.

- Despite these risks, many children of drug-abusing parents are effectively hidden from social services. Although the Home Office has recommended that drug treatment agencies should record full 'parental status' details of drugs users, the National Treatment Agency still fails to do this.[10] Needle exchange and frequency of injecting is monitored but not children.

- One-third of families seen by social workers have substance misuse problems. In these families, the children tend to be considerably younger than children in other social work cases. However 48% of them are not put under a care order. In 71% of all these cases, substance misuse professionals are not involved.[11]

- Care leavers, homeless young people and young offenders have disproportionately higher levels of all drug consumption.

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9 Home Office, *Hidden Harm – Responding to the needs of children of problem drug users,* 2003.

10 For example, just one tick box question on the care plan effectively prevents the collection of a full set of information. Drugs workers are left to select just one from the following non-specific categories: children in care; children living with client; children living with other family members; children living with partner; client pregnant; no children; other. 'Other' is often chosen.

11 D Forrester and J Harwin, "Parental substance misuse and child care social work: findings from the first stage of a study of 100 families", *Child and Family Social Work,* 2006.

- These children are often now from second and even third generation substance misusing families.[12]

The next generation of addicts is coming along nicely

It is true that the English schools survey has reported a declining trend in 'last year' use of cannabis from 13.4% in 2001 to 9.4% in 2007.[13] This dip has been used to claim that the UK drug strategy is working, most recently by the Home Secretary:[14]

> "I hope that the Hon. Gentleman will recognise the progress made by those working in the drugs field over the past 10 or 11 years. Overall drug use and class A drug use among young people are now at their lowest levels ever, as measured by the British crime survey. Among school pupils, overall drug use has fallen. The rate of frequent drug use among pupils has also fallen."

Yet there is little reason for complacency. Schoolchildren's cocaine use has been rising steadily since 2001: for boys, last year use is up from 1.1% to 1.6%; for girls, from 1.3% to 2.1% (there is no such trend in either the Netherlands or Sweden).[15] And since 1998 the age of initiation has been dropping steadily. In 1998 only 1% of 11 year old boys and girls in the UK had tried drugs.[16] By

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12 Author's interview with Professor Marina Barnard, Glasgow University.

13 NHS, *Drug Use, smoking and drinking among young people in England in 2007,* 2008.

14 Hansard, col. 1095, 9 February 2009.

15 Author's correspondence with Karin Monshouwer of the Trimbos-institute, Netherlands Institute for Mental Health and Addiction; and with Bjorn Hibell of the The Swedish Council for Information on Alcohol and other Drugs (CAN).

16 Ibid. Estimates from 2001 onwards are not comparable with those from previous years because of changes in the way that drug use was measured.

2007, 13% had.[17] Yet early initiation into drugs before the age of 13 is extremely rare elsewhere in Europe. In Sweden only 1% of under 13 year old children have tried cannabis; in the Netherlands only 8% of them have.[18]

The UK still remains at the top of the European schoolchildren's cannabis league table. The latest ESPAD data show that 29% of UK schoolchildren had reported using cannabis, far higher than the European average of 19%.[19]

Use of cannabis by 15 and 16 year olds

	Used in lifetime	Used in last year	Used in last month
Netherlands	28%	25%	15%
Sweden	7%	5%	2%
UK	29%	22%	11%
EU Average	19%	14%	8%

Note: school surveys only measure drug use episodes, not volumes consumed.

And while the proportion of children using cannabis may have fallen slightly in the last few years, the strength of the drug has increased. As the ACMD has noted:[20]

> "The THC content of sinsemilla found on the UK market has more than doubled in the last ten years from 6% to 16% and its share in the UK cannabis market has risen from 15% in 2002 to 81% in 2007/8."

Today, 23,900 teenagers are signed up for drugs and alcohol treatment, over 1,600 of whom are addicted to heroin/opiates,

17 Ibid.

18 EMCDDA, *Statistical Bulletin*, 2008.

19 ESPAD, *The 2007 ESPAD Report, Substance Use in 35 European Countries*, 2009.

20 ACMD, *Cannabis Classification and Public Health,* 2008.

cocaine or crack.[21] There has been a 48% increase in under-16s admitted to hospital with drug related mental health or behavioural disorders.[22] And more than half of young people say it is very easy to get drugs – at school or near school. By the age of 15, 60% of all pupils said they had been offered drugs.[23]

The most recent published English schools survey data shows that, in 2007:[24]

- 11% of 11 year olds have taken drugs, 6% in the last year and 3% in the last month;
- 41% of 15 year olds have taken drugs, 31% in the last year and 17% in the last month;
- Of the 39% of pupils who reported taking two drugs in the last year, for over half of them one of these drugs was classified Class A.

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21 NTA, *Getting to grips with substance misuse amongst young people: data for 2007/8*, 2008.

22 NHS, *Hospital Episode Statistics, the NHS Information Centre for health and Social care,* 2008. Data is for hospital admissions, where the primary or secondary diagnosis was of drug-related mental health and behavioural disorders.

23 NHS, *Drug Use, smoking and drinking among young people in England in 2007,* 2008.

24 Ibid. Note that high risk groups are likely to be underrespresented in this data. For example, children in care who have been placed in private care homes far away from their own homes are often unknown to local youth drug teams and are therefore likely to be unrecorded.

The damage to children

> "Substance misuse by young people is also linked with substantial levels of psychiatric and other morbidities and, according to National Statistics data, levels of mortality in this age group that vie with cancer."[25]

Children's drug use impacts on their physical and mental health, education and welfare. It affects the non-drug using children around them, disrupting the classroom and school ethos, and adding to negative peer pressure. Furthermore experimental substance use among very young people is widely recognised as a predictor of future dependence and other drug problems.[26]

For example, ESPAD has analysed the relationship between substance use and anti social behaviour including depression, anomie, thoughts of self harm and suicide and running away from home.[27] This confirmed a strong correlation between the frequency of drug use and anti-social behaviour.

It also found that the percentage of high-risk users in the population corresponds to the prevalence of cannabis use in each country. In other words, the more cannabis users there are today, the more high-risk users there will be tomorrow. That is

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[25] NTA, *Young people's specialist substance misuse treatment – The Role of CAMHS and addiction psychiatry in adolescent substance misuse services,* 2008.

[26] A large representative survey of 17-year-olds in France found that two thirds of respondents who smoked cannabis for the first time before the age of 12 were daily cannabis users by the time they were 17, whereas those who did not start smoking cannabis until the age of 16 to 17 were mostly occasional smokers See *Drug Use and related problems amongst very young people (under 15 years old) EMCDDA,* 2007.

[27] ESPAD, op. cit. 2009.

why it is so worrying that the UK still has one of the highest prevalence rates of teenage cannabis use in Europe.

The percentage of adolescents in the UK having treatment for drug and alcohol problems has doubled in the UK since 1999 (from 0.8% to 1.9% in 2006). In contrast, in Sweden the proportions have stayed stable at 0.2% although in the Netherlands it has risen marginally from 0.3% to 0.4%.

However, in the UK, the value of the treatment received by young people is questionable. Young people's drug services are based not on trying to prevent or stop drug use but on a harm reduction philosophy. As an NTA spokesman has described services:[28]

> "A care planned medical or psycho-social intervention, aimed at resolving dependence or addiction or the reduction of current harm from substance misuse… will include needle exchange and other harm reduction initiatives aimed at reducing the current harm caused by substance misuse."

There is no state-funded adolescent residential treatment available in the UK.[29] Official government policy is that adolescents should be treated in the community, however desperate. In contrast Sweden's state-funded 'Maria Ungdom' programme sees 2,000 teenagers a year whose abstinence-based residential stays last between three days and three

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[28] Centre for Social Justice, *Breakthrough Britain: Volume 4, Addictions*, 2007.

[29] Middlegate Lodge, the only such centre, has helped the most socially needy and desperate cases with a 12 week programme of nutrition, rehabilitation and education. It is about to close because of the lack of state funding for referrals.

months depending on need. This is followed by regular outpatient clinic appointments and checks.

The adult shift to hard drugs

> "We now know that we can succeed in tackling drugs because the last ten years have seen progress and some notable successes."[30]

The UK Government has proudly pointed to the stabilisation of cannabis use as proof of a successful drugs policy.[31] However, this stabilisation should be seen in the context of a Europe-wide trend. And UK usage, at 31% lifetime prevalence, remains well above the European average of 20.8% (and higher than in 1998 when 26.8% of adults had used it).[32] 2.5 million young adults in the UK have tried cannabis, and over 600,000 used it in the last month.[33] Hospital admissions on mental health grounds resulting from cannabis use have gone up from 506 in 1997/98 to 946 in 2005/06.[34] Rates of adult cannabis dependency have

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30 From the Home Secretary's Foreword, Home Office, *Drugs: protecting families and communities – The 2008 Drug Strategy*.

31 Home Office, *Drugs Misuse Declared: findings from the 2007 British Crime Survey,* 2008. Note that there are many problems with data of drug use. For example, the findings of the British Crime Survey (BCS) on reported drug use are of little help in assessing the scale of the drug problem as the BCS is a self-reporting household survey which excludes the homeless, prisoners, residents in communal establishments such as students in halls of residence, or problematic drug users whose lives are so busy or chaotic that they are hardly ever at home or are unable to take part in an interview.

32 EMCDDA. See www.emcdda.europa.eu/themes/drug-situation/cannabis; and *Drugs Misuse Declared*, op. cit.

33 Ibid. It is accepted that this number is underreported. Unofficial estimates from the Independent Drug Monitoring Unit (www.imdu.co.uk) put the number of regular adult users at between 2 and 5 million.

34 Hansard, Written Answers, Column 583W, 6 June 2007.

also risen since 2000.[35] It is not unusual for cannabis smokers to have a habit lasting for 30 years or more.

Over the last decade there has also been a sharp rise in adult cocaine use and a notable shift in recreational use from cannabis to Class A and polydrug use.

Cocaine

In 1998, just 3.8% of UK adults had tried cocaine; by 2007, 7.7% had. This is double the European average of 3.6%. Among UK young adults (15 – 24 year olds) numbers increased over the same period from 7.1% to 11.2%. This put them ahead of the European average of 5.4%, and well ahead of the other 'high prevalence' countries, such as Spain, Ireland and Denmark. Lifetime adult prevalence of cocaine in the Netherlands is just 3.4% and amongst the youngest adults only 2.8%.[36]

A separate national estimate of PDUs lists 192,200 of them as crack users.[37] The number of cocaine users admitted to hospital in the UK has more than quadrupled in eight years. Official data showed there were 740 health emergencies caused by cocaine in 2006/07, compared with 161 in 1998/99.[38]

Ecstasy and amphetamines

The pattern is the same for ecstasy and amphetamines. The European average for adult lifetime use of ecstasy is 3%. But the rate is more than double this in the UK – at 7.3% the UK tops

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35 NHS, *Adult Psychiatric Morbidity in England*, 2007.

36 See www.emcdda.europa.eu/stats08/gpstab1a and www.emcdda.europa.eu /stats08/gpstab2 Only England and Wales report a lifetime prevalence estimate that is similar to that of the US.

37 G Hay et al., op. cit.

38 Druglink, *Rise in cocaine hospital admissions*, Institute for the Study of Drug Dependence, Drugscope, 2008.

all other European countries. While just 5.6% of young European adults on average have taken ecstasy, 13% of the UK's young adults have.[39] Even in the Netherlands, the home of ecstasy production, only 8.1% of their young adults have used it.[40]

The UK also has the highest prevalence rate in Europe for amphetamine consumption. 11.9% of UK adults population have used it compared to a European average of 5.1%. The prevalence rate for young UK adults is 16.5%, compared to a European average of 5% and just 3% in the Netherlands.[41]

Opiates

Trends and incidence of heroin and opiate use are more difficult to establish. Incidence is largely missed by the British Crime Survey which does not reach the majority of users who are concentrated within the subsections of the population it does not cover. One national estimate of PDUs lists 281,320 as opiate users.[42] National treatment data tell us that in 2007/08 out of 202,666 problem drug users in contact with treatment services, 123,522 presented with heroin as their primary drug of misuse and 10,112 with methadone.[43]

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39 EMCDDA, *Statistical Bulletin,* 2008.

40 Ibid.

41 EMCDDA. See www.emcdda.europa.eu/stats08/gpstab2

42 G Hay et al., op. cit.

43 Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2007 – 31 March 2008, NTA, September 2008.

Rising drug deaths and drugs related disease

> "99% of health authorities in England have needle exchange programmes and over 27 million needles and syringes are exchanged each year, reducing the risk of death and the transmission of Hepatitis and HIV."[44]

In 2001 the Government set a target to reduce drugs related deaths by 20% by 2004.[45] A nationwide expansion of existing harm reduction services followed.

By 2005 each of the 149 Drugs Action Team areas had, on average, two specialist drugs services and eight pharmacies providing needle exchanges.[46] Methadone prescribing doubled in general practice between 2003 and 2008 and spending on methadone went up threefold in the same period[47] (the number of methadone prescriptions in England had already increased by 86.5%, from 970,900 in 1995 to 1,810,500 in 2004).[48]

147,000 individuals are listed as receiving prescribing services.[49] The NTA estimates that the median cost for prescribing methadone is £2,020 per client. This suggests the state is spending almost £300 million a year on methadone treatment, half the total treatment budget.[50]

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44 Home Office, *The Updated Drug Strategy,* 2002.

45 Ibid.

46 *Findings of a survey of needle exchanges in England*, NTA, May 2006.

47 See www.nhsbsa.nhs.uk/

48 Summary of the NTA Prescribing Audit, 2006.

49 National Drug Treatment Monitoring System (NDTMS), September 2008.

50 NTA correspondence with David Burrowes MP, 2007; the treatment budget for 2007/8 was £604 million, Written Answer, Norman Lamb MP, 21 October 2008.

The main purpose of methadone treatment is to reduce the risk of overdose from illicit drugs. Yet the 2004 target for drug deaths has not been met. In fact the number of drug deaths in the UK has continued to rise:[51]

- There were 1,287 male deaths from drug poisoning in 2007, the highest level for five years.
- There were 829 deaths involving heroin or morphine in 2007, a 16% increase from 2006.
- The 196 deaths involving cocaine in 2007 was the highest number of deaths involving cocaine ever recorded. In 1993, there were only 11 deaths.
- The number of deaths involving methadone rose consistently between 2003 and 2007 to 325 in the last year, an increase of 35% from 2006 (and 62% compared to 2003).

Drug deaths in the UK are also significantly (proportionate to the population) higher than the European average, and considerably higher than in Sweden and the Netherlands.[52] Rates of over 20 deaths per million are found in 16 European countries, but over 40 per million in only five countries, of which the UK is one. Among males aged 15 to 39 years, the UK's mortality rates at over 60 per million put it the fourth highest in Europe. The chances of dying of a drug-related death in the UK are four times higher than in the Netherlands.

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51 NHS, *Health Statistics Quarterly*, Autumn 2008.

52 EMCDDA, op. cit,, 2008.

Drugs related deaths[53]

	1997	2006	Per million population aged 15-64 (2006)
Netherlands	108	112	9.5
Sweden	133	135	22.0
UK	1,558	1,979	47.5
ALL EU			20.9

The damage to the health of PDUs is also increasing. The incidence of HIV among the 140,000 Injecting Drug Users (IDUs) is now higher than it was in the late 1990s and is currently around one in 90 and in London around one in 20.[54] In 2002 incidence was about one in 400.

Despite nationwide needle exchange programmes, almost half of IDUs in the UK have been infected with hepatitis C. Current levels of hepatitis C transmission remain higher than in the late 1990s with a fifth of IDUs becoming infected within three years of starting to inject.

A maturing drug market

The UK is one of the easiest and cheapest places to get drugs. Prices have fallen to record lows since 2000, from £70 to £46 per gram today for heroin and from £65 to £49 for cocaine.[55] Drug seizure quantities are also down: 60% on just a few years ago.

As cocaine has become more affordable, so has the market been able to mature and expand. In many areas dealers are offering two grades of cocaine to buyers, effectively segmenting

53 Ibid.

54 Health Protection Agency, *Shooting Up, Infections among injecting drug users in the United Kingdom 2007 An update*, October 2008.

55 Drug Scope, *Street Drug Trends,* 2008.

their sales into 'economy' and 'luxury' cocaine, putting it in reach of more – and younger – users. This two-tier cocaine market sees dealers selling cheaper, more heavily cut cocaine to students, pub users and those on low incomes at around £30/gram, while targeting more affluent consumers with a higher quality drug at around £50/gram.

There is a similar two-tier market for ecstasy-type drugs. The average street price of a pill can be as low as £2.40, with pills most commonly sold in batches of three to five for £10. Pills sold as ecstasy often contain no MDMA and are instead made from an amphetamine base. In response, more drug users are willing to pay a premium for crystal or powder MDMA at an average price of £38 per gram.

In Birmingham, it has been reported that crystal and powder MDMA now take up 35% of the market share (compared to 5% ten years ago). The low MDMA content of most ecstasy pills in the area has seen teenagers as young as 15 turning to the hallucinogenic drug, ketamine.[56]

Good times for dealers

Dealers in the UK today have little fear of being arrested. Anecdotal evidence suggests that they can operate with little risk of being caught and imprisoned.[57] The statistical evidence suggests that the dealers are right. It is notable that while the number of drug offences has dropped in the UK since 1998, in

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[56] Drug Scope, *Street Drug Trends: two tier cocaine market puts drug in reach of more users,* 2007.

[57] Home Office Online Report, *The Illicit Drug Trade in the United Kingdom*, 2007. These findings were based on interviews with 222 convicted serious drug offenders in prison.

both Sweden and the Netherlands they continued to rise, in both countries by more than a third.[58]

Number of drug offences

	1998	2004/05
Netherlands	12,616	20,548
Sweden	11,490	18,844
UK	130,643	122,459

The declassification of cannabis accounts for part of this drop. 'Cannabis Warnings' (which involve neither arrest nor a criminal record) doubled between 2005 and 2007 when they reached 102,500. The overall fall however also reflects a drop in serious drug convictions. Those found guilty at all Courts for:[59]

- the unlawful importation and exportation of drugs fell from 1,283 in 1998 to 836 in 2007;
- supply and possession with intent to supply fell from 13,120 to 12,909 over the same period;
- possession for a controlled drug fell from 92,152 to 71,389 over the same period.

Between 1998 and 2007 the Government spent more on its war against drugs than on its combined operations in Iraq and Afghanistan.[60] Spending has continued to rise.

How did we get into this mess?

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58 See www.emcdda.europa.eu/stats07/dlotab01

59 Ministry of Justice, *Criminal Statistics, England and Wales*, 2007, Table 3.18.

60 The Prime Minister stated that the cost of the combined operation in Iraq and Afghanistan was £6 billion (Today Programme BBC Radio Four, 12 May 2007); Ian Martin, Head of the Drug Strategy, Home Office, stated that spending on drug policy budget to date was £7 billion (Future of the Drugs Strategy, Home Office London Conference, 13 March, 2007).

2. WHAT'S GONE WRONG?

> "Harm reduction as a policy is inherently infantilising the population; it assumes that the authorities are, or ought to be, responsible for the ill consequences of what people insist upon doing."

Theodore Dalrymple, *Junk Medicine*, Harriman House, 2007.

In 1997, the Labour Government inherited a significant drug problem. But it was one that the previous Conservative Government had begun to address by, for example, piloting a community based drugs prevention initiative and by supporting 2,000 prevention projects. They had also set up a country-wide network of interagency Drug Action Teams (DATs) aiming for coordinated local law enforcement, accessible treatment, education and prevention. Treatment was set to become a more central part of the drugs strategy.[61] Abstinence had been identified as the key treatment goal.[62]

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61 HMSO, *Tackling Drugs Together: A strategy for England*, 1995-1998, 1995.

62 Department of Health, *Report of an Independent Review of Drug Treatment Services in England*, 1996.

The arrival of Labour heralded a new approach, one based on the concept of harm reduction:[63]

> "Our new vision is to create a healthy and confident society, increasingly free from the harm caused by the misuse of drugs."

Its vision, set out in its new ten year drug strategy, was to create a society free, not from drugs, but from 'the harm caused to our citizens by the misuse of drugs'.[64] Labour's innovation was to translate what had begun as a public health strategy for dealing with the prevention of HIV into a broader drugs policy. It elevated the notions of harm reduction and harm minimisation – substitute prescribing and needle exchange in effect – above prevention, enforcement and recovery from addiction.[65] This also involved a change of priorities: policy was no longer to be aimed at the whole and potential drug using population but on Problem Drug Users.

> "All problematic users must have access to treatment and harm minimisation services both within the community and through the criminal justice system."

Thus the Government focused on 'those drugs that cause the greatest damage, including heroin and cocaine'. Young people were to be helped, not to resist drugs, but to 'resist drugs misuse'. Concern was with their Class A drug use.

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63 HMSO, *Tackling Drugs to Build a Better Britain, the Government's ten year strategy for tackling Drugs*, April 1998.

64 Department of Health, *Report of an Independent Review of Drug Treatment Services in England,* 1996.

65 Home Office, *The Updated Drug Strategy*, 2002.

In 2004 cannabis was declassified to Class C, on the advice of the ACMD, as part of this focus on Class A drugs. Drug misusing youths were now to be 'supported' by various agencies. Drug workers focused on helping addicts avoid abscesses and bacterial infections and on providing clean needles and safe injecting sites. Crucially, the emphasis was no longer on getting off drugs. As the Department of Health explained:

> "Getting users into treatment and keeping them there is the best way to save their lives and reduce the harm they cause to people around them and to society."[66]

Treatment now meant management, not recovery.

The Government's confidence that this would solve the country's drug problem rested on a narrow view of what constituted the 'drugs problem' in the first place; one defined solely in terms of the problem drug using minority. The 2002 Updated Drug Strategy made this clear:[67]

> "Around 4 million people use at least one illicit drug each year and around 1 million people use at least one of the most dangerous drugs (such as ecstasy, heroin and cocaine) classified as Class A. Many of these individuals will take drugs once, but for around 250,000 problematic drug users in England and Wales, drugs cause considerable harm to themselves and to others… [incurring] between £10 billion and £18 billion a year in social and economic costs."

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66 Spokesperson from the Department of Health, 30 October 2007.

67 Home Office, *The Updated Drug Strategy*, 2002. The ACMD had, in 1982, coined the term 'problem drug users, for those who 'experience social, psychological, physical or legal problems related to their drug use'.

Although popular with lobbies pressing for the decriminalisation of recreational drugs, this approach meant that those who could not handle or afford their drug use – those deemed to be the greatest problem for society and themselves – became the target of policy. This distinction, with its inconsistent interpretation of the drug laws, put Labour's policy onto two incompatible tracks: liberality for the masses but control and coercion for the socially excluded minority.

The house of straw

Labour's narrow definition of the drugs problem was justified by a selective interpretation of one study, the National Treatment Outcomes Study (NTORS).[68] This was a longitudinal study of a cohort of 800 addicts, which had been set up by the Conservative Government to compare the relative efficacy of community methadone versus residential rehabilitation treatment for addicts.[69] The majority of those recruited to the study were chronic opiate addicts with multiple problems. Although heroin was their drug of choice, 49% had used illicit methadone. This study claimed that:

> "For every extra £1 spent on drug misuse treatment, there is a return of more than £3 in terms of cost savings associated with victim costs of crime, and reduced demands upon the criminal justice system."[70]

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68 Its interpretation of treatment efficacy ignored the greater reductions in illicit drug use and higher abstinence scores both at one and five year follow-ups in residential settings than in community drugs programmes. It also ignored evidence of heightened alcohol intake as a result of methadone prescribing.

69 M Gossop et al, *The National Treatment Outcome Research Study, Changes in Substance Use, Health and Criminal Behaviour One Years After Intake,* Department of Health, June 1998.

70 The figure was later to inflate to a £9.50 saving in the 2005 *Tackling Drugs, Saving Lives* report.

The addicts in this survey claimed they had committed 70,728 offences between them in the preceding three months, half of which were drug selling offences. Of the remaining 31,575 offences, shoplifting was the most commonly reported, though only one third of the clients had in fact committed one such offence in this period. The number of arrests (over a two year period) were many fewer than the offences claimed – 4,466 arrests, 42% of which were for shoplifting.

On the assumption that their treatment, costed at £1.6 million a year, would give a 25% reduction in criminal behaviour and reduced street heroin dependence, the NTORS authors asserted savings for the Government of £5.2 million a year for this cohort of addicts in terms of reduced victim costs and savings to the criminal justice system.

From the start of Labour's initiatives the notion of 'treatment effectiveness' was ulititarian, defined, not in terms of the individual and his recovery, but in terms of reducing acquisitive crime or shoplifting costs.

A questionable diagnosis

> "Total economic costs range from £2.9bn to £5.3bn, based on low to high estimates of the number of problem drug users (the medium estimate is £3.5bn) – £10,402 per user per annum. Total economic and social costs for this group increase the range of figures to between £10.1bn and £17.4bn – £35,455 per user per annum."[71]

These Home Office estimates are based on a theoretical modelling exercise. This attempted to calculate the total

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[71] C Godfrey et al, *The Economic and Social Costs of Class A drug use in England and Wales*, Home Office Research Study 249, 2000.

'reactive' economic costs of all Class A drug users not in treatment. The conclusions of this exercise justified the Government's targeting of PDUs for treatment.

The model used the same NTORS data and the same presumption of drug-driven motivation for wider crime (theft and burglary). It arrived at a parallel figure for the cost of Class A drug addicts –between £2.9 billion and £5.3 billion a year.[72] It then put the total of reactive criminal justice costs and their wider negative costs to society defined in terms of failed health and negative social functioning at £16 billion a year.[73]

> "The main findings from the study provide the first real evidence that costs are mostly associated with problematic drug use and drug-related crime, in particular acquisitive crime. In addition, significant cost consequences are identified for health care services, the criminal justice system and state benefits."

This diagnosis was limited as well as flawed in several ways:

- It rested on the false assumption that drug misuse is the cause of crime. Yet as the Home Office itself had previously stressed, the causal links are complex, and can equally be read the other way round.[74]

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72 Ibid.

73 Ibid.

74 "The complexity of the causal links need stressing. Most of those whom we interviewed had long criminal histories, with an average of 21 previous convictions. Criminal and drug using careers seem to develop in parallel: acquisitive crime provides people with enough surplus cash to develop a drug habit, and the drug habit locks them into acquisitive crime." M Edmunds et al, *Arrest Referral, Emerging Lessons from research,* Criminal Policy Research Unit, South Bank University, Report prepared for the Home Office, 1998.

- Information on many other social costs (on prosecution costs, the impact of parental drug use on children, driving accidents for example) were incomplete, not included at all, or would possibly be the same regardless of treatment – further adding to a skewed picture. For example, earlier costing calculations put expenditure on the benefits bill (£600 million a year) higher than costs to the criminal justice system (£500 million a year).[75] There is also no evidence that retention in treatment invariably reduces welfare dependency.

- There was no attempt to calculate or compare this with the costs and impact of all drug use (cannabis convictions for example constitute the majority of drug offences and cannabis is a gateway to harder drug use).[76]

- The addition of hypothecated drug-related victim costs dramatically inflated the total 'crime cost' of PDUs.

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75 Ibid.

76 For example: "Drug misuse gives rise to between £10 billion and £18 billion a year in social and economic costs, 99% of which are accounted for by problematic drug users." The Home Office, Updated Drug Strategy 2002, Executive Summary. This statement was misleading. The 99% figure was not, as has been widely interpreted, the cost of problem heroin and crack cocaine use as a proportion of the costs of all drug use. This latter cost was neither dealt with nor calculated.

These figures have become the unquestioned rationale for Labour's policy (e.g. Audit Commission Report, *Changing Habits*, 2002). They are routinely recycled by both the Government and the harm reduction lobbies such as the UKDPC and also by the pro legalising lobby, the Transform Drugs Policy Foundation: "Illegal drugs cost the country £16bn a year, says charity Transform. The report said the combined effects of crime, health and costs relating to drug prohibition policies leave the taxpayer with an annual bill of £16.785 billion a year." *The Daily Telegraph*, 7 April 2009.

It is also the case, of course, that these costs can be interpreted as a result of inadequate enforcement of drug laws (see Chapter 4).

- Nor did the Government specify the type, intensity or real cost of treatment that would be required to change behaviour and reduce these costs over time.

- Variability in the fundamental drivers of problem drug use – such as the extent of general drug use, drug price and availability, social norms and dependency were all ignored as contributing to the Government's reactive costs.

The nationalisation of harm reduction

> "We are in the business of providing services to users, not in the business of providing service users to rehabs."[77]

In 2001, Labour set up a new Special Health Authority, the National Treatment Agency (NTA), to process as many PDUs into treatment as quickly as possible.

Since then, the actions of the NTA have been defined and driven by targets. 50% of the then estimated 200,000 PDU population was targeted for treatment. In 2002 an even more ambitious target was set – to increase the number in treatment by 100% by 2008. In 2005 new 'waiting time' and 'retention in treatment targets' were key elements of the NTA's 'treatment effectiveness' strategy.

Through hundreds of commissioning edicts and care protocols dictated to the 150 DATs, the NTA soon had the requisites of a national harm reduction strategy in place. Any DAT not meeting its targets did so at its peril. Future funding allocations became contingent on local needs assessments and treatment plans tailored to NTA demands.

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[77] Letter to the author from the NTA, quoting Paul Hayes (Head of the NTA), 16 December 2008.

Excluded from this new treatment funding was the existing network of charitable and private residential centres and programmes that provided time intensive abstinence-based recovery and rehabilitation programmes. Similarly ignored by the government and the NTA were the country-wide 24/7 non profit fellowships (recovery groups) of Narcotics Anonymous (NA) and Alcoholics Anonymous (AA).[78] Abstinence and recovery had no place in Labour's new 'evidence based' drugs treatment business.

Today, the NTA is the pinnacle of a monolithic bureaucracy. Its original staff of 30 has expanded to 150. Its operating (administrative) costs stand at over £14.5 million a year.[79] On its advice, the pooled treatment budget of £655 million a year is distributed to purchase treatment,[80] a figure that has more than doubled since 2002.[81] Senior staff are rewarded with performance-related bonuses if they meet their targets.[82]

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78 Since NA started in the UK in 1980 it has provided the main support for recovery and for maintaining drug free lives for thousands of addicts. NA encourages complete abstinence from drugs including alcohol as this has been found to be the best foundation for recovery and personal growth. It neither encourages nor prohibits the use of prescribed medication. There are now more than 500 hundred meetings a week held throughout the UK.

79 NTA, *Annual Accounts 2007/8*, 2008.

80 Reitox National Focal Point *Annual Review to the EMCDDA by the UK Focal Point,* 2008.

81 Its original budget in 2002 was £287 million. Written Answer to Norman Lamb MP, 21 October 2008.

82 Record Of National Treatment Agency Human Resources Committee Meeting, 9 October 2007. From the NTA Website.

The emperor's new clothes

> "The original Public Service Agreement (PSA) target to increase numbers in treatment to 170,000 by 2008 was achieved in 2006."[83]

The numbers of clients in 'treatment contact' rose to over 200,000 by 2007/08. 147,000 individuals were prescribed opiate substitutes even though some two thirds of the original problem using population had been defined as crack cocaine addicts for whom there is no approved pharmacological treatment interventions. Acording to the NTA, only 4,300 people (less than 2% of the total in treatment) accessed residential rehabilitation and just 6,700 (just over 3%) had inpatient detoxification.[84]

But this was of course a success: the NTA had beaten the original target of getting 50% of PDUs into some form of treatment.

The apparent pointlessness of the national treatment bureaucracy was first exposed by Mark Easton, the BBC's Home Affairs Editor, on the Today programme in 2007. He revealed that the numbers emerging from treatment free of addiction had barely changed from 5,759 to 5,829 despite a £130 million rise in the budget. This was the equivalent of £1.85m for getting each person off drugs over this three-year period.[85] Not only were fewer than 3% of PDUs drug-free after treatment but this proportion had actually fallen from 3.5% three years previously. It

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83 NTA, *Annual report,* 2008.

84 Correspondence from the NTA to the author (16 December 2008). Note that the NTA believes that its data are an underestimate as not all private and charitable residential providers give figures to the NTA. However, this may be because many residential providers have had the number of state-funded referrals reduced putting them into crisis.

85 BBC Today, 30 October 2007.

should be noted that the Drugs Outcome Research Project in Scotland has shown that this is the proportion of PDUs that would become drug free without any treatment intervention at all.[86]

Widening the scope of treatment – an alternative to custody

The idea that proactive 'drugs work' could bring PDUs into treatment and reduce their crime was based on an original Home Office commissioned study of just 128 offenders in the late 1990s.[87] This study, however, had concluded that:

> "We cannot say with certainty that the works of CJDWs [Criminal Justice Drugs Workers] triggered reductions in drug use and drug related crime…"

Nevertheless, the Government went ahead in 2001 with a new drugs treatment and testing order (DTTO) – a new form of community sentence – which gave courts the power to require offenders to undergo treatment as part of a community sentence in cases where there was a clear link between drug abuse and offending.

A Drug Intervention Programme (DIP) was subsequently introduced. This aimed to move drug-misusing offenders through the criminal justice system while retaining them in treatment. Treatment had previously been voluntary. But the

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86 N McKeganey et al, "Abstinence and drug abuse treatment: results from the Drug Outcome Research in Scotland study," *Drugs: Education, Prevention & Policy*, 2006.

87 The authors warned that the findings of substantial reductions in crime needed to be interpreted with caution as response bias and selection bias had played a significant part; and that causality could not be assumed. The process of arrest as much as contact with the 'scheme' may have triggered the reduction. See Mark Edmunds et al, *Arrest Referral, Emerging Lessons from Research, A Report Prepared for the Home Office*, Criminal Policy Research Unit, South Bank University, 1998.

2005 Drugs Act gave the police a new power to order a compulsory assessment.

The original study for the Home Office had been clear on what was needed if this approach was to be successful:[88]

> "On the basis of our experience in evaluating these three schemes and others which have achieved less success, we regard the essential ingredients of referral schemes as:
>
> - a proactive mode of work
> - a working style which wins the respect and trust of users
> - adequate resourcing
> - a capacity to provide ongoing support
> - appropriate treatment services to which to refer
> - adequately resourced treatment services to which to refer."

Many of these essential ingredients have been lacking. Arrest referral and community treatment orders have been beset with practical problems including:[89]

- contradictory roles for the police who now are expected to reduce the supply of drugs by targeting Class A drug users on the one hand while channelling PDUs into treatment on the other;

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88 Ibid.

89 See the Appendix for case studies of how these do not work in practice.

- a level of supervision that probation services are unable to provide;

- a decision to drugs test that is motivated more by the crime committed than by a professional diagnosis of addiction;

- confusing consent for treatment with motivation or need for treatment. The former can be required to avoid a custodial sentence, the latter is needed for treatment to work;

- a fast tracking of addicts without motivation into treatment ahead of addicts seeking treatment of their own volition (waiting time for those with arrest referral orders averages one week compared with three weeks elsewhere). As a result, the value of structured day care programmes can be compromised for genuinely motivated clients.

The DIP ambition was to provide through care and aftercare – to provide structured key working, access to prescribing services and signposting to other services. Has this worked?

Methadone: the panacea

The reality is more prosaic. It is one of offenders being prescribed high doses of methadone, increased incrementally to a total of between 60 and 120 mls a day on official advice.[90] They are often not given the psycho-social support or even the urine or swab testing to confirm compliance with the regime. Weekly pharmacy 'pick ups' can involve more than 500 mls being handed out in one go. Some methadone inevitably leaks into the illicit market. Trading methadone for money or heroin outside chemists is well known to police. There is little stimulus for addicts to change their behaviour.

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[90] Department of Health, *Drug Misuse and Dependence: UK Guidelines on Clinical Management*, 2007.

Re-offending realities

By late 2006, drug testing was operational in 170 custody suites with testing at arrest available as an alternative to testing on charge in certain intensive areas. Fast prescribing nurses had become a routine feature of custody suites provided on contract from a number of drugs charities.

But the impact on re-offending was limited. The reduction in the re-offending rate for those serving DTTOs between 2002 and 2005 (for re-offending within a year) was only 11.1%.[91] And the rate of re-offending for the 30% who had managed to complete their orders was still 53% at a two year follow up. As many as 67% had not completed their orders or had had their orders revoked. Their re-offending rates remained over 90%.[92] A Home Office's evaluation revealed that 80% of all those who could be traced had been reconvicted for at least some offence in the subsequent two year period.[93] Even the NTA admitted that the association with treatment could not be determined for those few results which were positive.[94]

David Hanson MP, the Minister of State at the Ministry of Justice, has also admitted that the long-term impact is even more uncertain. He explained that a Drug Rehabilitation Requirement (DRR) does not involve abstinence from drugs[95] on the grounds

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91 Written answers to James Brokenshire MP, 6 November 2008.

92 Home Office Findings 184.

93 K Holloway et al., *The effectiveness of criminal justice and treatment programmes in reducing drugs related crime: a systematic review,* Home Office, 2005.

94 NTA Parliamentary Briefing, December 2008.

95 Written Answer to James Brokenshire MP, 6 November 2008. A Drug Rehabilitation Requirement is "a community based penalty for people who have committed high levels of crime to support their drug use. It has replaced a similar penalty called the Drug Treatment and Testing Order

that "drug misuse is a chronic relapsing condition which can take many years to address successfully." He resorted to the language of aspiration:

> "The goal of the DRR is to move offenders through treatment toward abstinence and to manage episodes of relapse in a way which reduces harm to the individual and the community."

The realities of the DIP reveal the gap between intention and practice. A recent analysis of one programme revealed that clients received on average just four and a half hours of 'structured intervention' in the course of one year of DIP treatment. And that was assuming that they attended all their scheduled sessions. Less than 2% of clients receive structured motivational interventions and even then only around 11 minutes per session were spent on this. For the largely unqualified drugs workers, this is just one more thing to cram into their short and infrequent contacts with clients, from drug testing to monitoring 'compliance with medication' to job support, housing and other urgent needs.[96]

Between 2005 and 2008, 46,406 orders were made. Only 16,170 were completed. Yet the Government is unable to calculate either the cost or the benefit of their policy. It does not even know what the current unit cost of a DRR is.[97]

(DTTO)." See http://www.bsmhft.nhs.uk/our-services/yascc/addictions-service/drr-drug-rehabilitation-requirement/

96 D Best et al, "What treatment means in practice: an analysis of the therapeutic activity provided in criminal justice drug treatment services in Birmingham", *Addiction Theory and Research*, 2009 [in press].

97 The only costing available is that from the original DTTO pilot study conducted between 1998 and 2000. This was estimated at £6,000. Written Answer to Paul Flynn MP, 9 March 2009.

This is becoming apparent to the Courts. Judges and Magistrates no longer have confidence in the efficacy and value of DRRS and DTTOs.[98] They are frustrated by the limits of the sentencing options at their disposal. A judge sitting at one of the experimental Drug Courts (introduced in 2005) has complained that the young men put on treatment orders would come in for and pass their weekly drugs tests while stinking of methadone and alcohol. He despaired at the lack of abstinence orders and appropriate treatment support.

Arrest referral workers also complain of being bogged down in paperwork – some 30 pages to be completed for the Home Office for each case. Many are increasingly critical of a system which has left them unable to concentrate their efforts on those motivated for treatment.[99]

The most thorough international review of the effectiveness of drug treatment interventions in reducing drug use or drug-related crime was published in 2005. This concluded that:[100]

> "There is strong evidence that the most effective interventions to reduce drug related crime are therapeutic communities and drug courts."

But neither is a feature of Labour's national treatment portfolio.

The Home Office continues with its focus on PDUs entering the criminal justice system when picked up for trigger (non-drug) offences, mainly acquisitive crime. Whether it can be justified in terms of keeping PDUs out of prison – the bottom line –

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98 See the Appendix for two case studies illustrating the problems faced by the Courts.

99 See CSJ, *Breakthrough Britain: Volume 4, Addictions*, 2007.

100 Home Office Online Report, Holloway et al, 2005.

remains to be seen. No cost-benefit study of community sentencing has been carried out.

Increasing numbers of drugs-related or 'trigger' offences are now dealt with by DIP community sentences. Sentencing rates for straight drug offences remain at a low level. Between 1997 and 2006, a third of those convicted for illegal Class A drugs did not receive custodial sentences. Over the same period, convictions for the supply of Class B drugs dropped dramatically from 5,201 to 568; and the number of associated custodial sentences dropped from 643 to 170. Only three people received a maximum sentence for Class A supply and only one for Class B.[101]

[101] Written Answer to James Brokenshire MP, 11 November 2008.

3. THE DRUG DEALING STATE

"I started on 45ml of methadone and every three days they put me up by 15ml until I was on 90ml. I thought it was brilliant. I was getting stoned off the methadone, but at the same time people could see that I was making an effort…

Other than being told that I would only be on the methadone for 18 months, I wasn't given any other information. I didn't know at what rate they would be reducing me, when they would do it or anything like that. But because I was stoned off the methadone I didn't really think about those things. The only information that they gave me was a leaflet about changing your lifestyle and preparing yourself to be clean…

Because I was on a high dose I found that I was sleeping all the time… When I started my script I had to be at the chemist at 9am every day, which was a hard routine to get into, but I had to do it to get the methadone so I did…

> In the end, I was put on a lifetime script for methadone… After four and a half years, I decided to reduce off the methadone for a number of reasons including:
>
> 1. I felt that I was on too high a dose.
>
> 2. I was fed up of being controlled by having to pick up my methadone. I couldn't go on holidays and my days would revolve around picking it up.
>
> 3. I was fed up of the effects it was having on my body, i.e. constipation, sleep problems, sweating, lack of energy.
>
> 4. I wanted to be free of addictive drugs.[102]

Exactly what type of treatment would be most effective for realising the Government's aims rests with the National Institute of Clinical Excellence (NICE). The NTA relies on NICE expertise to inform the treatment protocols and guidance that it distributes to DATs. In turn these determine what services the DATs tender for and the requirements to be met by the drugs charities and Health partnerships to win these contracts. Both are influenced by the need to meet Government treatment targets.

For NICE 'evidence based' effective treatment interventions are limited to those treatments that have been subjected to randomised controlled experimentation and are clinically based. This automatically limits the knowledge they could draw on.

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[102] At the time of writing Mark was still on 60mls a day. Despite his high motivation to become drug free, his fear of withdrawal and his worries over his ability to cope and the lack of available support means he does not feel that he can reduce his prescription further. For a full account, see www.wiredin.com

The recommendation from NICE and the NTA for prescribing methadone has also disregarded the concerns and experience of general practitioners. Of 1,574 GPs interviewed in 2002, one half did not consider methadone prescribing to be an appropriate activity for general practice.[103]

There have long been reservations about methadone prescribing. Dr David Best, former research manager at the NTA, has argued that the "methadone evidence base is not what drugs workers have been led to believe and that it was never a panacea."[104] Earlier studies had found that methadone prescribing did not have the desired impact of reducing illicit heroin use, that it failed to reduce alcohol use and that it led to more frequent cannabis and crack cocaine use. 21% of the patients in this study also reported using more non-prescribed methadone in line with the increases they were being given in their prescribed dosage of methadone and diazepam.[105]

Apart from methadone prescribing, NICE approves only limited forms of psycho-social support, such as Cognitive Behavioural Therapy and Contingency Management. NICE guidance on residential rehabilitation is highly restrictive.[106] But social surveys and outcomes/follow-up analysis of client behaviour have, however, demonstrated the greater efficacy of abstinence, 12 step and other therapeutic programmes operated in residential settings.[107]

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103 Audit Commission Briefing, *Changing Habits*, 2002.

104 D Best, "Numbers And Tick Boxes Must Not Strangle Health, Hope And Humanity", *Addiction Today,* January/February 2009.

105 D Best et al, *Drug and Alcohol Review*, March 2000.

106 See, for example, NICE Clinical Practice Guideline No. 51.

107 For example, both the Drug Outcome Research Study in Scotland (DORIS) and NTORS found that abstinence outcomes from residential treatment are significantly higher than outcomes from methadone programmes.

Keeping addicts addicted

The NTA's statistics for 2007/8 show that out of 202,000 PDUs that the government is paying for drugs treatment, only 6,700 have undergone 'in patient treatment' (short detoxification stays) and 4,300 residential rehabilitation. Only 2.1% of cases are getting the service most likely to help them get better.

Addicts, though, are not normal patients. They are challenged even to keep an appointment. But they now must fight the state if they are to get better. The more extreme the symptoms of their 'illness', the more they are deemed unready for abstinence based recovery. Their chances of relying on their own resources for recovery are ever more diminished. This 'symptom' of the illness all too often is interpreted by drugs workers as 'unreadiness' for more interventionist treatment. It becomes a self-fulfilling prophecy.

Structured treatment services in fact are rarely cited by recovered drug users as contributing to their recovery. The only types of formal treatment cited as contributing to their abstinence is residential rehabilitation and mutual aid groups such as NA.[108]

A chronically relapsing disease and a self fulfilling prophecy

> "The recognition that addiction is a 'chronic, relapsing condition' has become both a mantra and a justification within medical-professional treatment services, and has been the basis of turning maintenance treatment into a treatment that is assumed to be lifelong… What this does is generate cycle of ennui and pessimism in treatment, with workers delivering sub-optimal

[108] See D Best et al, "Does treating people improve their chance for abstinence?" *Addiction Today*, May/June 2008.

> treatment in which the prescription dominates and the requisite psychosocial interventions limp along in the limited time available – around 10 minutes every two weeks."[109]

The Government's emphasis on harm reduction marked the triumph of a medical view of drug addiction as a 'chronically relapsing' condition, essentially incurable and at best manageable with continuing prescribed medication. This view reflects the experience of, and response to heroin addiction over the last 40 years. But it is the antithesis of the experience of thousands of recovered addicts whose recovery has resulted from participation in self-help, therapeutic and abstinence based programmes, or indeed, in simply their own determination. It ignores the fact that the explanation for addiction lies in the realm of psychology as well as medicine.

Evidence is emerging that the longer people are on methadone maintenance, the more difficult it may be for them to become abstinent.[110] Up to 40% of methadone maintenance clients are problem drinkers.

This is not a uniquely UK problem. In the Netherlands, nursing staff report having to restrict their activities to dispensing methadone. They have on occasion been unable to develop any other interventions because of the poor and sometimes aggressive state of their clients.[111] Methadone maintenance is associated with impairment over and above that associated with long-term opiate use. Cognitive speed, short-term working memory and decision making all appear to be affected.

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[109] D Best, op. cit., *Addiction Today,* January/February 2009.

[110] Ibid.

[111] D Best, op. cit.

Adolescents – accepting dependency or treatment?

The Government's aspiration to reduce young people's drug use is limited. Its commitment to prevention appears to be non-existent. For example, in 2002, it decided that its aim to reduce young people's Class A drug use was aspirational and not achievable.[112] This was replaced in the 2002 Updated Drug Strategy with non-specific targets for reducing Class A drug use while the reclassification of cannabis in 2004 signalled an official capitulation to its use.

This acceptance of the seemingly inevitable use of drugs is now widespread. For example, a drugs worker has described his response to young PDUs:[113]

> "I'll see a range of people earlier in their drug careers under 25 and some of them are on a journey and there's nothing I am going to be able to do to get them out of it. We make the transition into the adult system (of prescribing) as smooth as possible for them."

There has been a rapid expansion of adolescent treatment services under the aegis of the NTA. The official government line is that adolescents should be treated in the community whatever the level of their addiction problems. Although the majority have cannabis and alcohol problems, 1,600 under 18 year olds are deemed to have problems so severe as to prescribe them synthetic opiate substitutes. There is no rehabilitation strategy for them. Nor is there a clearly defined

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[112] The original targets, set in 1998, were a 25% reduction by 2005 and a 50% reduction by 2008. See Department of Health, *Tackling Drugs to Build a Better Britain: the government 's ten year strategy for tackling drug misuse*, 1998.

[113] DAT treatment manager interview, CSJ, *Breakthrough Britain*, 2007.

strategy for getting the majority who present with cannabis problems (well over a half) and the quarter plus who present with alcohol problems off these drugs. Many youth drug services workers are imbued with the idea that 'you cannot get them off drugs'.

This approach contrasts sharply with Sweden. There, the focus is on robust early intervention. Abstinence as the goal of treatment is taken for granted. Police, social workers and adolescent addiction psychiatrists work together. Plain clothes specialist youth drugs squads are empowered to bring adolescents (under 21) into what is effectively an informal 'treatment'/drugs court. After drugs testing, the young people are offered an assessment followed by appropriate levels of treatment (inpatient or outpatient) in return for an expunged criminal record if longer term abstinence is complied with.

The process is voluntary, not coercive and some 52% accept a first interview after they are apprehended. Of these 55% accept treatment. In the process associated issues of depression, anxiety, abuse, home problems, school failure are handled with support and professional help. Outpatient contact can last up to two years. Parents and schools are involved where appropriate.

Similarly, the Dutch have run health and prevention programmes in their schools since the 1980s. These centre on resistance skills and life skills training. Schools have strong relationships with local prevention specialists, responsible for the schools in their area, who are backed by a national team of prevention specialists. Selective prevention is also targeted at youths on the streets and is carried out by NGOs in co-operation with government services.

The Dutch Government has also implemented a national action plan to discourage cannabis abuse. It included specific

drug prevention campaigns aimed at high-risk groups and targeting young people between the ages of 12 and 18. To make the illicit cultivation of cannabis with a high percentage of tetrahydrocannabinol (THC, the active ingredient in cannabis) as unattractive as possible, the Dutch Government advocated new guidelines for prosecution providing a basis for swift action against cannabis cultivation, and a penalty of at least five years for large-scale illicit cannabis cultivation.

British young people, unlike their Swedish and Dutch counterparts, receive mixed messages about drug use from law enforcement and government information agencies as well as from adolescent treatment services. They can deal, possess and use cannabis with impunity and take ecstasy at clubs without fear of sanction. After the declassification of cannabis in 2004, formal warnings became the main police response. How much will actually change now that cannabis has been reclassified back to Class B remains unclear. A blind eye is turned to ecstasy use, although this is a Class A drug.[114]

The state's official drug messages to young people are similarly ambivalent – the aim being to achieve 'harm reduction' through education. Its key vehicle for achieving this aim is FRANK, an online interactive information and helpline service, whose literature is widely disseminated by schools and drugs charities. FRANK has been widely criticised for both misinformation and for being more concerned to place drug-taking in some kind of comfort zone of acceptable behaviour than addressing the risks or warning that it is against the law.

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[114] The AMCD's recommendation to declassify it to Class B and to distribute ecstasy testing kits in clubs illustrates a countenancing of youth drug use at the highest levels. See ACMD, *A Review of it Harms and Classification under the Misuse of Drugs Act*, 2009.

4. OUT OF CONTROL SUPPLY

Since 2003, drugs seizures quantities have plummeted, drugs prices have dropped to record lows and cocaine consumption has rocketed.[115]

The following table shows how the quantities of heroin, cocaine and cannabis seized coming into the UK have fallen by 68%, 16% and 34% respectively over the last seven years.[116]

Seizure of drugs entering the UK (kilos)

	2000	2001	2002	2003	2004	2005	2006/7
Heroin	3,387	3,929	2,730	2,732	2,260	1,970	1,087
Cocaine	3,948	2,841	3,577	6,858	4,644	3,862	3,321
Cannabis	73,861	85,747	79,188	99,773	86,416	71,045	48,610

[115] One example of how the Government has tried to conceal the fall in the amount of drugs seized was its press release of 30 October 2008. This claimed that "a record 186,028 drug seizures by police and HM Revenue and Customs in England and Wales in 2006/07, compared with 161,1132 in 2005; an increase of 15 per cent'. What was buried in the news release was the far more important data on the amount of illicit drugs seized. These had fallen substantially (as the above table shows).

[116] UK Reitox Focal Point Report to the EMCDDA, 2005; UK Reitox Focal Point Report (2007 data) to the EMCDDA, 2008.

The estimated market for heroin for 2003/4 was sized at 20 tons and for cocaine at 18 tons.[117] Unofficial reports have suggested the size of the heroin market today is 30 tonnes.[118] If these estimates are right, then the proportion of imports that are being seized has fallen from 13% to just 4% of the total market.

Cannabis seizures have also dropped since a high point in 2003. While the number of plants seized has increased, resin and herbal cannabis seizures at 49,617 kilos is significantly lower than in 2000 when 73,861 kilos were taken.

The failure to control imports is reflected in the lack of ambition in the following statement from the Prime Minister's Drug Strategy Group:[119]

> "Supply interruption has been ineffective world-wide in reducing the overall availability of drugs; and it has had little or no impact on reducing harms in the UK."

The argument is sometimes made that big drug hauls have little sustainable impact on street level availability. This has, for example, been posited by influential drugs policy advisers such as Dame Ruth Runciman, Chair of the UKDPC.[120] Professor Paul Reuter has also claimed that:[121]

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117 Home Office Online Report, *Estimating the Size of the UK Illicit Drug Market, Measuring Different Aspects of Problem Drug Use*, 2006.

118 *The Guardian*, 27 April 2009.

119 Prime Minister's Strategy Unit, *SU Drug Report Phase 2 Report: diagnosis and recommendations,* 2003.

120 For example, in a letter to *The Times* (1 August 2008), Dame Ruth Runciman stated that "big drug hauls have little sustainable impact on street level availability". Another example of the prevalence of defeatist thinking can be found in T McSweeney et al, *Tackling Drug Markets and Distribution Networks in the UK, A Review of the Recent Literature,* UKDCP 2008: "While

> "Despite substantial increases in drug seizures, drugs prices have gone down and there is therefore no indication that tougher enforcement has made drugs less accessible."

Yet the evidence is that the amount of drugs seized has *fallen*. There have been no "substantial increases". Other empirical studies have demonstrated that drug seizures can have a great impact on the market.[122]

Failure to control supply is not inevitable. In 2006, the Netherlands seized three times more cocaine than the UK (10,500 kilos compared to the UK's 3,300 kilos). Its heroin seizures have remained stable while the UK's have been diminishing.[123]

Comparison of UK and Netherland Class A drugs seizures

	2000	2001	2002	2003	2004	2005	2006/7
Cocaine (kilos)							
UK	3,948	2,841	3,577	6,868	4,644	3,862	3,321
The Netherlands	6,472	8,389	7,968	17,550	12,387	14,603	10,581
Heroin (kilos)							
UK	3,387	3,929	2,730	2,753	2,260	1,970	1,087
The Netherlands	896	739	1,122	417	1,244	902	984

the availability of controlled drugs is restricted by definition, it appears that additional enforcement efforts have had little adverse effect on the availability of illicit drugs in the UK.".

121 Professor P Reuter and A Stevens, *An Analysis of UK Drug Policy,* UKDCP, 2007.

122 N Dorn et al, *Literature Review on Upper Level Drug Trafficking*, Home Office, 2005.

123 Source data for both tables from UK Focal Points 2005 and 2008 and KLPD-Dienst IPOL Politie, *Drug Seizures and Drug Prices in the Netherlands,* 2007.

A new Serious Organised Crime Agency taking on Drugs

> "SOCA has been given somewhat of a free rein in addressing the illicit drugs trade. One Step Ahead established the clear expectation for SOCA to function as a harm reduction agency with law enforcement powers; defining harms only in terms of the damage caused to people and communities by serious organised crime. The lack of supply specific Public Service Agreement (PSA) targets gives SOCA the flexibility to set its own priorities, but the broad remit means the choices it must make in the deployment of its resources are not straightforward".[124]

A new agency, the Serious Organised Crime Agency (SOCA), was launched on 1 April 2006. Its remit was to include responsibility for the Government's supply reduction strategy and it inherited the resources associated with the investigation of Class A drugs cases. 40% of its initial £400 million budget was dedicated to dealing with drug trafficking.

SOCA was set no supply reduction targets at all. Its original PSA only committed it to building:[125]

> "...a knowledge of drugs supply, the harm it causes, and the effectiveness of different responses. On the basis of that knowledge, it will take action to reduce

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[124] Home Office, *The Illicit Drug Trade in the United Kingdom*, 2007.

[125] SOCA was conceived in the White Paper, One Step Ahead and the Serious Organised Crime and Police Act (2005). It amalgamated the National Crime Squad (NCS), the National Criminal Intelligence Service (NCIS), the section of HM Revenue and Customs (HMRC) dealing with drug trafficking and associated criminal finance, and the part of UK Immigration dealing with organised immigration crime (UKIS).

> the supply of drugs to the UK… On a risk and intelligence-led basis, Her Majesty's Revenue and Customs (HMRC) will act to disrupt the importation of drugs into the UK."

There has clearly been a confusion of roles: the quotation above suggests that HMRC, now with reduced resources, still had responsibility for disruption. Yet 43% of SOCA's effort is supposedly directed at tackling drug trafficking, even though SOCA admits that it "has no powers itself to seize drugs outside the UK". Even then, interdictions overseas are where SOCA claims the bulk of its efforts are directed. However these only involve SOCA in "providing key intelligence and/or operational support to others, not undertaking the physical act itself".

These confused roles have been further hampered by a lack of clarity over the data for international drug seizures. Not only are there no performance targets, but there is no way of identifying or quantifying the role SOCA has played in seizures annually. For example, SOCA's first annual report did not report UK specific seizures but only international seizures in which SOCA had participated in an unspecified way. In early 2008, in a written answer, the Home Office Minister Vernon Coaker MP said that SOCA could no longer extrapolate "take-outs destined for the UK". The contrast with the Netherlands is striking: there, all seizures for each and every drug in detail are recorded systematically and openly. SOCA has not engaged in any such transparent procedure.[126]

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[126] The UK has no comparable publication to that of the Dutch Police's annual detailed recording and monitoring of drug confiscations, factory dismantling and drug prices. For an example of a transparent and intelligible method of recording drug seizures, see *Confiscated Drug and Drug Prices in the Netherlands*, published annually by their National Criminal Intelligence Department.

Despite no evidence of either the breakdown or sourcing of the seizures, at the end of its second year SOCA still boasted its success:[127]

> "Tactical highlights of SOCA's work this year were: significant success in the interdiction of drugs flowing from SOCA work including:
>
> – in excess of 89 tonnes of Class A drugs, a 20% increase on the 2006/07 figures. These drugs probably cost the criminals who owned them at least £250m. The cocaine alone, with normal levels of adulteration, had the potential to realise £6bn on the streets of Europe;
>
> – in excess of 30 tonnes of cannabis; and
>
> – in excess of 60 tonnes of precursor chemicals principally in Colombia and Afghanistan. The quantities interdicted in Colombia alone could have been used in the production of 190 tonnes of cocaine."

These figures, as given, are meaningless. The only statistical breakdowns given in the SOCA Annual Report 2007/8 are ones that report and quantify activity and process rather than results. In the view of a former senior customs official:[128]

> "The new arrangement of SOCA, Border Agency, HMRC and Constabularies is not working as well or as quick on its feet as the HMCE/NCS arrangements in place eight years ago. The UK is

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127 SOCA, *Annual Report 2007/8*, 2008.

128 Author's interview with David Raynes, Former Assistant Chief Investigation Officer, HMCE.

almost unique in Europe because of our island status. If drugs supply is to be controlled, it makes sense, is cheaper and is much more efficient to intercept, disrupt and lead our anti drugs intelligence effort at our borders, even if every detection does not immediately lead to arrests.

If SOCA focuses the bulk of its effort on upstream disruption it can only *ever* have very limited effect on the supply in Britain. Upstream disruption is a part of the toolkit, it is not a solution.

SOCA is presumably attracted to it because it is very easy to do with modest resources. In the end the big UK wholesalers need to be understood and taken out or seriously damaged. There is no sign yet that SOCA are on top of that for heroin or cocaine. The SOCA intelligence effort is flat-footed."

It now seems that even the Government accepts that SOCA is not working. As *The Guardian* has reported:[129]

> "The Prime Minister's strategy unit is investigating the failure by the Serious Organised Crime Agency (SOCA) – which was billed as Britain's FBI – and the police to stop the rise of criminal gangs that run a multibillion-pound series of enterprises controlling the flow of drugs, human trafficking and illegal gun importation. The intervention is a measure of Gordon Brown's concern and raises questions about the Home Office's failure to get to grips with the problem at a time when agencies admit it has

[129] *The Guardian*, 27 April, 2009.

spread from the inner cities to the shires, eroding the fabric of almost all of Britain's communities."

Believing in enforcement?

Direct expenditure for tackling drugs in 2004/5 was budgeted at £1.344 million.[130] Of this reducing the supply of drugs was set at £380 million – 28% of the total budget for tackling drugs. In comparison, the proportion of the total drugs budget spent on enforcement in the Netherlands and Sweden is far higher (see Chapter 5). This is indicative of the low priority given to attempting to control the supply of drugs.

The majority of the drugs budget was committed to treatment (£512 million) and reducing drug-related crime (£297 million). In 2008/9, the total budget stands at over £1.5 billion. And budgets for treatment and reducing drug related crime elements will continue to rise – £568 million is budgeted annually for treatment through to 2010/11. Community sentencing budgets also anticipate year on year rises to 2010. The budget for reducing supply, on the other hand, remains at £380 million – a figure that has not changed since 2004 and remains the same through to 2010/11.[131]

Again, the conclusion that tougher enforcement measures have not necessarily deterred use looks curious in this light. The underfunding of drug enforcement measures was confirmed by the Home Office itself:[132]

> "In some regions, notably London, views were expressed that anti-drug enforcement efforts were

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130 UK Focal Point Reitox, 2005,

131 The 2008 Drug Strategy, op. cit.

132 Home Office Research Study 227, 2001

> comparatively under-resourced. Estimates offered by enforcement personnel in London and elsewhere indicated that available intelligence information could support a five-fold increase of operational capacity against heroin dealing, for instance."

An HMIC report has also warned that the enforcement activity necessary to deal with a substantial level of seizures should not be underestimated. This was against a backdrop of reforms to customs services which have left Britain's borders almost defenceless with only five boats to patrol Britain's 7,750 mile coastline.[133]

Drugs supply is naturally adaptable and flexible. It is sensitive both to market demand and to market restrictions. There is evidence that dealers themselves believe that law enforcement activity impacts on price; and that, while dealers view prison either as an occupational hazard or an unlikely risk, they go to considerable lengths to minimise their risk of arrest.[134] Asset recovery appears to be even more troubling for dealers – on which the UK also has a poor record.[135] It is also the case that while the high seizure rates required to put a trafficker out of business pose a substantial challenge to law enforcement, shortages in local availability, when they do occur, can influence short-term demand and can encourage users into treatment.[136]

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133 HMIC, *Customised for Control: An inspection of HM Revenue and Customs' Detection Directorate and considerations for its realignment to meet the challenge of their role within the new Border structure*, 2008.

134 Matrix Knowledge Group, op. cit. This report was based on interviews with 222 convicted serious drug offenders in prison.

135 Centre for Social Justice, op. cit.

136 S Gilmour et al, *Identification and quantification of change in Australian illicit drug markets,* BMC Public Health, 2006.

But this is not likely to happen while:

- law enforcement agencies in the UK are under-resourced;
- measurement of the effectiveness of law enforcement activity against the drugs supply is not a government priority;
- there is a growing void of enforcement activity and intelligence in the domestic market;[137]
- law enforcement agencies at the street level are compromised by a 'harm-reduction' policy focusing on retaining PDUs in 'treatment';
- responsibilities for interdiction are unclear.

[137] See G Pearson et al, *Middle Market Drug Distribution*, Home Office, 2001.

5. EFFECTIVE DRUGS POLICIES

The Netherlands: supply reduction, harm reduction & prevention
The Netherland's reputation for taking a particularly liberal view on drug use is misleading. So are the associated explanations for its low level of problem drug use.

The Netherland's commitment to enforcing its drugs laws goes back for decades and drug use is widely frowned on. Although geographically a hub country for the international drug market, the estimated PDU populations was 34,000 in 2005. This equates to a population prevalence of 3.1 per thousand of 15 to 64 year olds.

The underlying principle of Dutch policy has been, and still is, to balance public health with public order. All drugs there are illegal, including cannabis, the permitted small scale use and selling of which is strictly circumscribed. Rules for coffee shops are tough – no advertising, no selling, no use and no possession of hard drugs, no public nuisance in or around the coffee shop, no selling to under 18s, 5 grams per person per day. Local Municipalities can impose further rules and they can chose not to have them at all – 76% of local municipalities do not allow them. The administrative system is decentralised to the local authorities to a large extent, particularly where drug policy is concerned.

The number of coffee shops has dropped from 1,179 in 1997 to 729 in 2005 and there have been more closures on the borders with Belgium since then. In 2008, the Mayor of Amsterdam closed a fifth of the city's cannabis cafés pointing out that Dutch tolerance is not the same as indifference. At the heart of his project he said was his determination to drive back criminality surrounding drugs.[138]

While some observers believe that the Netherlands is moving towards legalisation of drugs, the reality is a long-standing and even increasing emphasis on prohibition and sanctions.

Enforcement in the Netherlands

The Netherlands spends three times more on its drugs policies than the UK (as a proportion of GDP); and it also spends a far higher proportion of its drugs budget on enforcement, as the following table shows:[139]

Composition of drug-related expenditure

	Drugs Expenditure as a % of GDP	Proportion spent on Health & Social Care (%)	Law enforcement (%)
UK	0.13%	51%	49%
Netherlands	0.43%	25%	75%
Sweden	0.46%	60%	40%

It has been argued authoritatively that enforcement has been the financially dominant component of drug policy in the Netherlands for decades. For example: [140]

138 *The Times*, 27 December 2008.

139 EMCDA 2007 Report.

140 Henk Rigter, "What drug policies cost", *Addiction*, 2006.

> "The total drug policy spending estimate in 2003 of the Netherlands was €2,185 million. Allocation to functions amounted to €42 million for prevention, €278 million for treatment, €220 million for harm reduction and €1,646 million for enforcement. Drug law enforcement is clearly the dominant expenditure. This can be said with certainty despite the noted pitfalls in estimating drug policy expenditures."

Special police enforcement units have been set up to fight the production and the trafficking of all major categories of illegal drugs. Police have a considerable degree of discretion and local regions have considerable autonomy.[141] Their enforcement efforts focus on dealing and trafficking as opposed to use (66.3% of all drug offences compared to 13.6% of all drug offences in the UK).[142]

The balanced approach taken by the Netherlands was explained by the former Head of the Narcotics division of the police force:[143]

> "Drugs are not legal in the Netherlands. There is a lot of misunderstanding about this.
>
> But we have the principle of discretionary powers. The principle of discretionary power does mean

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141 Ibid.

142 ECMDDA, Offence types involved in reports for drug law offences: percentage of all reports for drug law offences, Table DLO-2. Note also that in the UK, the number found guilty of importing drugs dropped from 1307 in 1997 to 871 in 2006 (Written Answers to James Brokenshire MP, 6 November 2008).

143 Author's interview with Andre Elissen.

that the public prosecutor does not have to prosecute – he can drop charges – so we can set our priorities and our priority is definitely not the individual user. We do not want to criminalise him.

Formally if the THC is above 21% then it called hash oil and then it would be considered as a hard drug. We are focusing on organised crime, drugs dealing and producing drugs. Of course we have clear guidelines for that – its from our prosecutors office (national level) focusing on combating serious organised crime that is protecting the trade – that is the main focus for us as law enforcers.

We are a small country – we have 25 police regions including the national agency but we have clear guidelines from the top and of course it has harmonised the approach and the guidelines are also from the national level. We have space for policy at the local level but mostly that is to combat nuisance where the mayor can have special rules."

But enforcement and interdiction are clearly coordinated and with clear lines of command:

"We have the national crime squad, and international serious organised crime squad whose responsibilities include the production, import and export of illicit drugs and also at regional and sub-regional level and with national and international cases, so we have quite good information flow from local to regional to national to international – in this network all the regions are represented. It is an easy way to share best practice and expertise.

> All investigations are led by the public prosecutor. Preferably we have the multi disciplinary approach for example the unit of synthetic drugs. This is the national facility for dismantling illicit labs. We have people working together from the customs, the police, traffic police, border police, special economic surveillance team – all those disciplines will be rushed into one unit/building sharing their pieces of information with regard to whatever case – including fiscal intelligence service."

Treatment in the Netherlands

The Dutch have a comprehensive system of addiction care. It is organised on a regional basis. 17 centres, funded by public money, have more than 200 locations or units attached to them. Their evaluation has been driven by the privatisation of health care with insurance companies demanding proven effective treatment as a pre-requisite of funding.

Treatment encompasses addictions for alcohol, heroin, cocaine, gambling and cannabis (whereas in the UK drug treatment is separate from other addictions). It aims at abstinence or reduction of drug use, or at personal and social stabilisation – methadone programme with psycho-social counselling. Addiction care centres have probation duties with counselling and case management.

In contrast to the UK, the numbers of private addiction treatment programmes and specialist clinics are growing. Most people with drug problems however are still treated in outpatient care and methadone maintenance is still a predominant outpatient treatment arrangement for opiate users. Psycho-social interventions are used in treating opiate addiction to complement medically assisted treatment. There is also

limited treatment capacity for medical heroin prescription. In 2006, 815 treatment places in 18 municipalities were approved.

Drug-free treatments are found in both experimental settings and in general addiction care settings. Cannabis, cocaine or ecstasy problems are focused on for drug free treatments. Two years ago self-help groups for young people did not exist. Now there are several for alcohol and drugs run by AA and NA.

Treatment is separate from harm reduction services, both conceptually and in terms of funding and administration. Assertive harm reduction programmes, which involve an intensive form of case management involving physicians, psychiatrists and social workers, is the preferred approach.

Municipalities receive funding from the National Government specifically for prevention and harm reduction. These services include counselling, sheltered housing, day-care, needle exchange and general health care. The Judicial Treatment of Addicts Act aims to achieve abstinence and rehabilitation of inmates by coercing them into special detention programmes. Drug-free treatments are also used in judicial settings. The Penal Care Facility for Drug Addicts (SOV project), a long-term experiment running since 2002, is showing a moderate but positive effect.

Sweden

Sweden's drug budget, as a proportion of its GDP is also three times higher than the UK's. Its PDU population is also much smaller, at just 26,000 in 2005 out of a total population of nine million. This equates to a population prevalence rate of 4.5 per 1000 people aged 15 to 64 years.

The Swedish National Institute of Public Health recently articulated the principal factors which determine drug use –

price, availability, norms and dependence. Its policy, like that of the Netherlands, rests on the assumption that the rules of total consumption apply: the number of people who take drugs is related to the number of people who develop drug problems. If consumption goes up, so will problem usage. Hence the uncompromising approach to drugs law enforcement taken by both countries.

In the Swedish view, ordinary citizens habits need to be targeted, not only the marginalised misusers. Sweden therefore operates a restrictive policy for dealing and use with no principle of discretionary power as in the Netherlands. This was explained by the Office of the National Drugs Co-ordinator:[144]

> "We don't talk about hard or soft drugs at all. The legal system doesn't recognise that explanation. We have drugs and they are all illegal drugs.—whether you talk about cocaine, heroin, amphetamines, cannabis, or whatever. In the legal system here what we talk about is the seriousness of the crime. If the police catch you with a maximum of 59 grams of cannabis, you get fined. If you have 60 grams up to two kilos you get six months in prison and if you have more than two kilos, it is at least two years."

The range of schedules and penalties available through legislation appears to be well understood by the public, to be consistently and transparently applied in practice.

The United Nations Office on Drugs and Crime has highlighted the success of Swedish policy in limiting problematic drug use and highlighted the importance of widespread popular support

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[144] Centre for Social Justice, *Breakthrough Britain, Addiction*, 2007.

for a restrictive drugs policy in Sweden.[145] Qualitative studies show that a large majority of those who have tried illegal drugs consider drug use as an exception, not as a central or normal part of their lives. Legislation appears to be well understood by the public, to be consistently and transparently applied in practice.

It is the responsibility of the National Drugs Policy Coordinator to implement the national action plan on drugs. The 2006-2010 plan prioritises children, young people and parents as target groups to help with associated budgets. At its heart is a policy for prevention. With central government support, two-thirds of the 290 local authorities in Sweden have appointed local drug coordinators for alcohol and drug prevention work..

The aim of a wide variety of activities – research, supply reduction, demand reduction, opinion forming, treatment and rehabilitation and including prison and probation work – is normative: to reduce the demand for drugs.

Treatment in Sweden

The social services in the municipalities are responsible for the treatment of problem drug use, even if the cases require medical treatment. Thus most treatment for problem drug use is organised outside hospitals by the social services. Most treatment is drug-free and the vast majority is delivered in outpatient settings. There are treatment facilities specifically for problem drug users, but as a rule of thumb treatment of problem drug use takes place alongside treatment of alcohol and/or other addictions.

Only treatment centres – and not pharmacies as in the UK – can supervise substitution treatment. Methadone is subject to

[145] UNODC, *Sweden's Successful Drug Policy, a Review of the Evidence*, 2006.

strict regulations. Pharmacies are also not entitled to exchange needles or syringes.

In 2006, a total of 2,739 people were in substitution treatment – 1,270 with methadone and 1,469 with buprenorphine according to the National Board of Health and Welfare. The conditions for participation are strict: the patient must be over 20; have demonstrated at least four years of intravenous opiate abuse; must have tried several forms of drug-free treatment; and must have entered the programme on a voluntary basis (for example, the person must not be detained, under arrest, sentenced to a term of imprisonment or be an inmate of a correctional facility). For those participating in methadone substitution programmes, other drugs are not permitted and the patient must visit the clinic on a daily basis.

Most treatment is abstinence-based, not drug-based. Interventions for children are robust and effective and involve police, parents and schools. But as Sven Andreasson at the Swedish National Institute of Public Health commented:[146]

> "Measures to reduce availability are decisive to affect the scope of the drug problem. Treatment and support for established misusers can certainly be important, but have a very limited impact on the extent of the problem."

[146] S Andreasson, *Drugs in Sweden: Methods of Prevention – a review of the evidence*, Swedish National Institute of Public Health, 2008.

6. CONCLUSION

A successful drugs policy should be based on three simple principles:

- reducing the supply of drugs;
- reducing recruitment to drug abuse;
- encouraging people with drug problems to give up their abuse.

The UK has lost sight of each one of these basic aims in its attempt to reduce crime by managing problem drug use.

Current policy is based on the premise that drug harms can be reduced without reducing drug use. This is a false premise.

The Netherlands and Sweden have straightforward, practical and successful drugs policies which, though different in emphasis, focus unambiguously on:

- the enforcement of the drug laws;
- the prevention of all illicit drug use;
- the provision of addiction care.

Both countries see their drug policy as part of a broader public health policy. Yet this has not undermined their commitment to reducing either the demand for or the supply of drugs. For the Dutch and the Swedes harm reduction is just one aspect of their public health policies.

It is the UK, not the Netherlands, that is in the vanguard of the liberal movement to normalise drug use. Our attempt to target its harms alone has impinged on more than treatment and public health; it has shaped approaches to enforcement and prevention making for hopelessly confused policy and practice.

Sweden turned its back on its liberal experiment with heroin prescribing over 30 years ago. Since then, it has implemented a restrictive policy that has seen drug use amongst adults and children drop. And the Netherlands now also rejects the idea that the 'normalisation' of drugs is desirable. Tolerance of both low threshold drugs programmes and cannabis use are coming under increasing pressure from Dutch citizens.

Enforcement

The UK's commitment to enforcement of the drug laws has become uncertain. Swedish and Dutch policy is clear and confident.

Drug use targets and drug seizure targets in the UK have both been progressively lowered in recent years. Government drug advisers and senior MPs question the efficacy of the supply reduction strategy, further undermining it. Drug seizure quantities have dropped dramatically. Yet Sweden took record drug quantity seizures in 2006 – for heroin, cocaine, and ecstasy.[147]

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[147] 2007 Country Report to the ECMDDA by the Reitox National Focal Point, Sweden, 2007.

Dutch cocaine seizures are also significantly higher than the UK's and follow an upward trend.

Nor is there any sense of certainty over sentencing for drugs offences in the UK. In Sweden and the Netherlands, the idea that sentencing acts as a deterrent is accepted. But in the UK, very few offences receive maximum sentences. And the Sentencing Advisory Panel is now asking "whether sustaining long custodial sentences for drug offences solely for the purposes of deterrence can be justified." It advocates cutting the maximum sentence from 14 to 12 years.[148]

The Panel's proposals reflect the liberalising trend of UK drugs policy of the last ten years – one which has produced an environment in which drugs suppliers indeed have little to fear, in which families and communities remain unprotected and in which drug harms have escalated.

Prevention

Prevention, the driving principle of policy in Sweden (one which encompasses early intervention, enforcement and abstinence treatment) barely exists in the UK.

In the Netherlands, the commitment to prevention is also clear and defined. It encompasses drugs education, mass media campaigns, publicly funded prevention projects, national help lines and prevention activities at Addiction Care Centres.

Here in the UK the Government's contribution is limited to non-specific school age drugs education as part of the national curriculum and the 'communication service' provided by FRANK (see box).

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[148] Sentencing Advisory Panel, *Sentencing for Drug, Offences, Consultation Paper*, 2009.

THE FRANK FAILURE TO PREVENT YOUTH DRUG USE

The Frank helpline and website was established in 2003. It now epitomises the Government's low aspirations for reducing young people's drug use.

When first established, it was widely welcomed as a departure from what was perceived to be the outdated "just say no" campaign. However, it now endorses, rather than seeks to prevent, young people's drugs use. Its advice is based on the premise that young people will continue to and cannot be stopped or dissuaded from taking drugs; and that harm reduction is the most that can be achieved.[149]

From the outset, it took a non-judgemental approach based on the "harm reduction" ideology. It now effectively endorses drug taking – with limited and non-scientific warnings, even of poly-drug use. On "mixing drugs", for example it has given the advice: "Give the first drug plenty of time to kick in or wear off before taking another one".

Frank has 75 "fully trained drug workers" manning its helpline. In 2008/09 it received £2 million from the Department of Health, £2.7 million from the Home Office and £1.8 from the Department of Children, Schools and Families.

Children and adolescents are directed by public information sites and by their schools to use this service. So are their teachers and drug charities. Many charities used to run their own 24/7 advice lines until they were instructed by the Government to steer all their advice calls to Frank.

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[149] For an exposé of how FRANK fails ther children it is meant to be helping, see *The Sunday Telegraph*, 18 April 2009.

Treatment

The UK's default treatment of methadone substitution is only appropriate at all (if at all) for opiate addicts. This is despite rising numbers of cocaine and cannabis addicts, polydrug and alcohol abusers. The UK treatment goal is harm reduction not abstinence or recovery.

The goal of treatment in both Sweden and the Netherlands is abstinence. Treatment in Sweden and the Netherlands is based on the notion of addiction care, is needs-driven and does not discriminate between alcohol and drugs.

Abstinence-based treatment is not provided at all by the state in the UK and is only supported for very few patients. Of the treatment targets set out in the latest Drugs Strategy, there were still none for numbers becoming free from drugs, despite some lip service paid to abstinence-based treatment.

Yet abstinence-based approaches to addiction can work. They must confront all aspects of addictive behaviour, must encompass all dependencies (licit and illicit), and be available in prisons and in the community. Investment in robust interventions with adolescents, on Swedish lines, could break the intergenerational cycle of dependency.

But investment in 'recovery' will be undermined if the country remains awash with cheap, easily available drugs; and if prevention messages remain weak and mixed. Investment in, and commitment to, interdiction and enforcement would see a declining availability of drugs on the streets.

There is no perfect policy solution to the problem of drugs. But the efforts of Sweden or the Netherlands are clearly more straightforward and more effective than those of the UK. Neither reducing the supply of drugs, nor the discouragement of drug

use, are ever going to be easy. But the lesson from Sweden and the Netherlands is that a clear commitment to them can contain, and can lessen, drug use – and therefore lessen the harms caused by illicit drugs.

APPENDIX: THE MAGISTRATE'S DILEMMAS

Dilemma One: prison or community service?

You could tell from his appearance the minute he came into the dock that he was an addict.

He pleaded guilty to five charges: two of store thefts, one of perfume bottles, the other of clothes; an assault of beating up a store detective who had apprehended him in another shop while he was attempting to steal meat; possession of heroin, which was found concealed in a wrap in his foreskin when he was searched by police; and finally failing to turn up at an earlier hearing, thereby breaking bail conditions. After that, he had been picked up by police, which is why he was in custody.

The charge sheet against him was almost identikit. Although I have been on the bench only just over a year, it could have applied to any one of dozens of similar cases I have dealt with.

We learned from the Crown Prosecution Service that the man had a string of convictions of a similar nature going back to 1999, although he had been out of circulation for four years because he had also committed a much more serious offence of aggravated burglary, which our legal clerk told us was probably breaking into a house while in possession of a weapon.

The CPS lawyer also told us that after a range of sentences for his lesser offences involving possession of a Class A drug and low-level thefts, he was already in breach of a community service order and drug rehabilitation order for an earlier crime. The probation officer in court reported that to us that, as a result of their experiences with the defendant, she now believed that the man was unsuitable for community treatment. This view was reinforced by his solicitor. She made no effort to mitigate his behaviour and said that her client now accepted that he needed treatment for drugs while in prison.

So, this was an engrained addict; a repeat offender who had been given numerous chances to try improve his behaviour; a petty thief who was clearly a menace to society in that he was prepared to use violence to get what he wanted.

But in dealing with him, we faced a major dilemma. Because he had breached a community service order, and he also needed to be punished for his seriously criminal behaviour, the next step up was prison. But as magistrates, if we decide on prison, that's all we can do.

If the sentence is a community treatment order, we can link that to all sorts of other conditions, including curfews, tagging, and the requirement both to do unpaid work and to take alcohol or drug rehabilitation programmes, providing that the probation service feels that the defendant will respond.

But if we choose jail, there is no other requirement we can impose. The need for rehabilitation moves completely out of our hands. Once he was sentenced, his welfare becomes the sole responsibility of the prison service.

As magistrates therefore, we are faced on a routine basis with this dilemma."

Dilemma 2:
Another example recently is one I still worry about. In this case the defendant was an alcoholic in his thirties. He had committed a nasty attack on two policemen when drunk. They had been called when he became offensive at a garage forecourt shop. He had punched and spat at and kicked them, and had to be restrained in the end by six officers before he could be taken to the cells to sober up and be charged.

When the CPS read out his previous offences, it emerged that he was a repeat offender and his offences were getting worse. Our dilemma was that the combination of the nastiness of the attack and his previous convictions suggested that he should go to jail for the maximum term of six months. But the probation officer in court said that he was responding well to a community service order that had been imposed a few months earlier and was about to start a drink rehabilitation course. She recommended strongly that he should be allowed to do this. Against this, what we discussed most was that we felt we should be both supporting the police by imposing a tough sentence and sending out a message to the wider community that attacks on police will not be tolerated.

In the end, after more than an hour of concentrated discussion between ourselves and with our legal adviser, we reluctantly gave him the chance to take the rehabilitation course. What swayed the decision finally was that our legal advisor told us that he would not necessarily receive treatment in prison and the probation link with him would be severed. But I worry that the police (and the rest of the community) think that this is perceived as a 'soft' option, in that those who assault policemen deserve the most serious punishment."

PRISON AND ADDICTIONS FORUM (PandA)

The Prisons and Addiction Forum is a working group at the Centre for Policy Studies. Its aim is to challenge the prevailing wisdom on drug policy; and to advocate practical and realisable reform of this area of policy.

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Kathy Gyngell (Chair).

Deirdre Boyd (CEO, Addiction Recovery Foundation)

Mary Brett (Drugs Education Consultant, UK Representative EURAD).

Huseyin Djemil (ex London Area Drugs Strategy Co-ordinator, HM Prison Service).

Andy Horwood (ex Drugs Action Team Co-ordinator for Bedfordshire and Luton).

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